Wednesday, 29 August 2018

# Meeting of the Health and Wellbeing Board

**Thursday, 6 September 2018**
**1.30 pm**
**Meeting Room 1, Pamona House, Oakview Close, Edginswell, Torquay, TQ2 7FF**

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**Members of the Board**

Paul Johnson, South Devon and Torbay Clinical Commissioning Group (Vice-Chairman)
Caroline Taylor, Director of Adult Services
Pat Harris, Healthwatch Torbay
Caroline Dimond, Director of Public Health
The Elected Mayor, Gordon Oliver
Dr Liz Thomas, NHS England
Alison Botham, Director Children - Torbay/Plymouth City Council
Councillor Parrott
Councillor Stockman (Chairwoman)
Councillor Darling (M)
Councillor Barnby
Councillor Stubley

**Non-Voting Co-optees**

Ian Ansell, Torbay Safeguarding Children Board
Alison Brewer, Primary Care Representative
Julie Foster, Torbay and Southern Devon Health and Care NHS Trust
Tara Harris, Executive Head of Community Safety
Alison Hernandez, Police and Crime Commissioner
Matt Johnson, Community Safety Partnership
Keith Perkin, Devon and Cornwall Police
David Somerfield, Devon Partnership NHS Trust
Tanny Stobart, Community Development Trust
Ann Wagner, Torbay and South Devon NHS Foundation Trust

**Lisa Antrobus, Town Hall, Castle Circus, Torquay, TQ1 3DR**
**01803 207064**
Email: governance.support@torbay.gov.uk

# HEALTH AND WELLBEING BOARD
# AGENDA

**1. Apologies**
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

**2. Minutes** (Pages 4 - 9)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 23 May 2018 and 12 July 2018.

**3. Declaration of interest**

**3(a) To receive declarations of non pecuniary interests in respect of items on this agenda**

**For reference:** Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

**3(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda**

**For reference:** Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

**4. Urgent items**
To consider any other items that the Chairman/woman decides are urgent.

**5. Public Question** (Page 10)
To respond to written questions and statements from Members of the Public which have been submitted in accordance with Standing Order A24.

**6. Draft STP Mental Health and Wellbeing Strategy - Development and Engagement Update** (Pages 11 - 40)
To consider and discuss the draft Mental Health and Wellbeing Strategy.

**7. Integrated Care System - Strategy** (To Follow)
To consider a report on the above.

**8.** **Torbay Influenza (flu) Vaccination Plan 2018/19** (Pages 41 - 54)
To note the update on the 2018/19 Vaccination Plan.

**9.** **Adult Social Care Eligibility Policy and Guidance** (Pages 55 - 78)
To note the report.

**10.** **Promoting Active Ageing** (Pages 79 - 86)
To note the report.

# Minutes of the Health and Wellbeing Board

**23 May 2018**

**-: Present :-**

Tara Harris, Paul Johnson, Councillor Julien Parrott, Councillor Jackie Stockman, Councillor Jane Barnby, Councillor Di Stubley, Alison Brewer and Kevin Dixon

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## 55. Election of Chairman/woman

Councillor Stockman was elected Chairwoman for the 2018/2019 Municipal Year.

## 56. Apologies

Apologies for absence were received from Ann Wagner, Alison Hernandez, Tanny Stobart, Caroline Taylor, Pat Harris who was represented by Kevin Dixon, Caroline Dimond, Elected Mayor Oliver, Liz Thomas, Andy Dempsey, David Somerfield and Councillor Darling (M).

## 57. Minutes

The Minutes of the Board held on 23 March 2018 were confirmed as a correct record and signed by the Chairwoman.

## 58. Pharmacy Site Consolidation

The Board were advised that in accordance with Paragraph 19(5), Schedule 2 of the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (as amended) they were required to make representations to NHS England on consolidation applications. Members considered the application for the consolidation of Units 2&3 Pembroke House, 266-276 Torquay Road and 237 Torquay Road and were of the opinion that the closure would not create any gap in the provision of pharmaceutical services.

Resolved:

That the response set out in Appendix 3 to the submitted report be approved and forwarded to the NHS England.

## 59. Communications

Board Members shared positive news such as the Care Trust being rated as good following a recent CQC inspection, Healthwatch have launched an advice and

information service led by the Citizen Advice Bureau and all GP practices in Torbay had joined together to submit a bid for increased GP provision.

Chairman/woman

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# Minutes of the Health and Wellbeing Board

**12 July 2018**

**-: Present :-**

Tara Harris, Julian Pezzani, David Somerfield, Tanny Stobart, Ann Wagner, Pat Harris, Caroline Dimond, Councillor Julien Parrott, Councillor Jackie Stockman, Councillor Jane Barnby, Councillor Di Stubley and Alison Botham

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## 60. Apologies

Apologies for absence were received from Alison Brewer, Ian Ansell, Liz Thomas, Alison Hernandez who was represented by Lyn Gooding, Matt Johnson who was represented by Rich Morris, Caroline Taylor who was represented by Judy Grant, Paul Johnson and Councillor Darling (M).

## 61. Minutes

This item was deferred to the next meeting.

## 62. Urgent items

The Board considered the items in Minute 63 and 68, and not included on the agenda, the Chairman being of the opinion that they were urgent by reason of special circumstances i.e. the matter having arisen since the agenda was prepared and it was unreasonable to delay a decision until the next meeting.

## 63. Addressing inequalities in outcomes for children

Members received a presentation from Alison Botham, Director of Children Services. Alison explained that she would focus on two areas of Children Services the number of children with special educational need (SEN) and the number of children in care.

Alison advised that Torbay was a statistical outlier regarding the number of pupils with statements or Educational Health and Care Plans (ECHP), so much so that Torbay skews the average for its statistical neighbours. Despite such high levels of SEN pupils Torbay is positively recognised for its ability to assess the needs of children and put in place statements and ECHPs within statutory timeframes such positive action has received commendations from government ministers with Torbay being asked to share our experience and practices across the peninsula.

Alison also explained that Torbay was an outlier in the number of children looked after. Historically Torbay has always had a relatively high population of children

looked after, whilst numbers steadied they have shown an upward trend in recent months. Statistically Torbay is out of sync with national averages and statistical neighbours and ranks 5th in the country for the number of children looked after. Traditionally this problem has been seen as a 'children services' issue however children looked after is a whole system issue, how services for adults respond to the needs of children is just as important as how services for children respond. Assessments for adult provision is based on the need of the adult, at what stage is the impact of the adults condition taken into account when considering the child? How seamless does a young person move through the system from children services to adult services? How can partners assist?

Members recognised that when commissioning services the specification of outcomes for providers could be amended to assist in a shift toward a whole system change rather than focusing on just adults or just children. Members further welcomed the establishment of the Children and Young People's Strategic Steering Group as set out in the Children's and Young People Plan the membership of which includes representatives from education, social care, health and youth justice sectors. Members were also of the view that statutory services could more affectively engage with the voluntary sector who had undertaken various projects and consultation with children, young people and families to assist the assessment of the needs of the whole family.

**Actions:**

1) Tanny Stobart to circulate 'Imagine this… what young people think would make Torbay a better place to live and grow up in'.

2) Caroline Dimond to consider how to bring together all the survey work undertaken around children and young people.

3) To form a Children's Partnership Board.

## 64. Suicide Prevention Action Plan

The Board considered the refreshed Torbay Suicide and Self-harm Prevention Action Plan 2018-2019. The Board was informed that the government's national strategy and other national reports recommend local areas should develop multi-agency suicide prevention strategies and action plans in order to help reduce local suicides. Locally the suicide prevention strategy is a collaborative document produced and shared by Devon County Council, Plymouth City Council and Torbay Council which also aligns to the Devon Sustainability Transformation Partnership. The action plan is framed around the seven national action areas and account for universal as well as targeted interventions as outlined in the Devon wide Suicide Prevention Strategic Statement.

The plan will be co-owned by a range of statutory and voluntary agencies, which will all participate by incorporating organisations' actions into plans and working collaboratively to identify priority areas.

Members raised concerns with medication that may remain in the household following a suicide, of particular concern was stockpiles of medication in a household within which a vulnerable person was left behind.

**Action:** Paul Johnson to ask the Medicine Optimisation Group to consider systems that would avoid medication stockpiling.

Board members also raised examples where new buildings and infrastructure had created places that were easily accessible for those wanting to commit suicide such as bridges and wondered whether suicide prevention could be included in planning documents.

**Action:** Andrew Gunther to consider incorporating suicide prevention in the Healthy Torbay Supplementary Planning Document.

## 65. Implementation of the Domestic Abuse and Sexual Violence Strategy

Tara Harris, Executive Head of Community Safety informed the Board that the Council formally adopted the Domestic Abuse and Sexual Violence Strategy on 19 April 2018. The governance arrangements set out the levels of responsibility and accountability with any significant issues ultimately being reported to the Health and Wellbeing Board. The Domestic Abuse and Sexual Violence Executive Group was chaired by Andy Dempsey, the former Director of Children Services, Alison Botham the new Director of Children Services had confirmed that she would assume the role. Tara informed Members that she would present a performance dashboard at a future meeting of the Health and Wellbeing Board in order for the Board to have oversight of the impact of the Domestic Abuse and Sexual Violence Strategy.

Tara advised the Board that the Council had gained accreditation from White Ribbon UK, White Ribbon UK works with men and boys to challenge male cultures that lead to harassment, abuse and violence. Volunteer ambassadors engage with other men and boys to call out such behaviour among their peers and promote a culture of equality and respect. Councillor Parrott implored partners to identify and encourage colleagues to become Ambassadors or Champions.

**Action:** Jason Preece, Domestic Abuse and Sexual Violence Coordinator, to circulate marketing material regarding White Ribbon UK to all partners.

## 66. Draft Joint Health and Wellbeing Strategy

The Board considered a report that recommended the Elected Mayor commence public consultation on the refreshed Joint Health and Wellbeing Strategy. Following a workshop in February 2018, the Health and Wellbeing Board agreed a set of priorities for the health and wellbeing system, as a whole, in Torbay. It was recognised that there were a range of plans and strategies of a number of partnerships and organisations which aim to address these priorities.

Members were advised that the draft Joint Health and Wellbeing Strategy appended to this report collates the goals and outcomes of those plans and

strategies, as they relate to Torbay, into one Strategy. As part of Torbay Council's Policy Framework, the draft Strategy will be subject to consultation for at least six weeks.

Resolved:

That the Health and Wellbeing Board recommends that The Elected Mayor commence public consultation on the Joint Health and Wellbeing Strategy.

## 67. Work Programme 2018/2019

Members noted the work programme and requested an update on the Ageing Well Programme be added to the agenda for the 6 September 2018 meeting of the Health and Wellbeing Board.

## 68. Appointment of Vice-Chairman

Paul Johnson of the South Devon and Torbay Clinical Commissioning Group be appointed the Vice-Chairman for the 2018/19 Municipal Year.

Chairman/woman

Statement:

JSNA does not provide the full waiting list for primary care and secondary care services for assessment and diagnosis. Given that it is up to the statutory authority to deal with making sure that public sector equality is upheld will they do the following:

Questions 1) Will the chair including all associated bodies that commission local services, now ask or provide waiting lists for each contract in place for assessment and diagnosis, in the NHS and provide the total cost of clearing each waiting list?

Question 2) Will the chair request that the waiting list for all Social Care services are published on a monthly basis where people are waiting for a review emergency or otherwise, and the first assessment and provide a cost for each month to clear that waiting list?

Question 3) Will the board then provide the list to the Sectary of State for Health and Social Care, to make sure they are aware of the waiting list and hold them to account on funding the clearing of such waiting list under the health and social care act and the care act?

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|---|---|---|---|
| **Title:** | **Draft STP Mental Health and Wellbeing Strategy- Development and Engagement Update** | | |
| **Wards Affected:** | All | | |
| **To:** | Health and Wellbeing Board | **On:** | 6 September 2018 |

**Contact:** Derek O'Toole
**Telephone:** 07830 529 255
**Email:** derekotoole@nhs.net

## 1. Purpose

1.1 To formally introduce the draft STP Mental Health and Wellbeing Strategy and invite the Boards consideration and feedback.

## 2. Context

2.1 Over the last two years the Sustainability and Transformation Partnership (STP) has been a positive catalyst for Devon. It has helped leaders build a collaborative, system approach to the NHS and local government. Three local authorities, seven NHS organisations, and one Community Interest Company have been working together to tackle historic challenges and put services onto a strong foundation for the future.

2.2 The original case for change set out clinical, social and financial drivers for working in partnership and identified mental health as one of the shared priorities. It was recognised that there was a need to:

- continue to close the investment gap between mental and physical health
- improve physical health care for people with mental health problems
- improve provision for people with severe, long-term mental illness
- provide psychological support for people who have physical health problems

2.3 The Devon Sustainability and Transformation Partnership (STP) plan two year report identified four key shifts:

1. from care setting to places and communities
2. from organisations to networks of care and support
3. from 'what's the matter with you' to 'what matters to you'
4. from illness management to wellness support

2.4 The key shifts will be brought about by the four strategic priorities:

**Priority One:** Enable more people to be healthy and stay healthy
**Priority Two:** Enhance self-care and community resilience
**Priority Three:** Integrate and improve community services and care
**Priority Four:** Deliver modern, safe and sustainable services

2.5 Over the last two years the STP Mental Health Programme has worked to address these needs set out in the case for change through its key projects. The projects have focused on children and young people's mental health and wellbeing, crisis and urgent care, dementia and the interface between primary and secondary care services. Alongside these projects the STP Mental Health Programme has also included the development of the Mental Health Care Partnership and the development of an STP Mental Health and Wellbeing Strategy. All of these areas are reflected and agreed in the mandate for the Mental Health Programme with the STP.

**3. STP Mental Health and Wellbeing Strategy and Engagement**

3.1 The Mental Health and Well Being Strategy was developed by the STP Mental Health Programme; it has been presented to the STP Mental Health Programme Group for feedback prior to the engagement version of the strategy (appendix 1) being produced.

3.2 The STP Mental Health Engagement Panel has contributed to the development of the engagement plan.

3.3 The STP Mental Health Programme Group is attended by leaders from organisations across the STP, this forum has agreed that engagement should be undertaken to inform the further development of the draft STP Mental Health and Wellbeing Strategy. In recognition of the short timescale the STP Mental Health Programme Group also set the expectation that continuous, meaningful engagement in the implementation of the strategy should become routine; the programmes set out in the strategy will be iterative to enable meaningful impact and involvement.

3.4 This engagement will be a short, intense period of focused listening which will create the platform for the evolving Mental Health Care Partnership to change the way it involves, listens and responds to people, carers and a broader range of system stakeholders. This change in approach to involvement will become apparent in the way we develop our plans to implement the strategy and the way we work to understand our impact by measuring and monitoring outcomes and experiences that matter to people.

3.5 This initial engagement will focus on the vision, areas and priority; in doing so we will produce content for the stakeholder voices and engagement section of the strategy. The engagement process will enable the STP Mental Health Programme to make connections to the networks and intelligence held in neighbourhoods and places across Devon so that the change in approach described above is enabled.

3.6 At the time of writing we have spoken to or received back from around 70 people representing system partners and leaders across Devon. Over the coming weeks we will work with our STP partners to listen to people and carers and networks that support them in places and neighbourhoods.

3.7 The emergent themes from our listening so far are that the strategy is a clear and comprehensive document, however, it could be strengthened by more fully reflecting the breadth of the vision statement including:

- greater reference and alignment to the STP plan and two year report
- placing greater emphasis on prevention, promotion, enablement, intervening early, the wider determinants of health and wellbeing and risk factors
- greater emphasis and clarity on needs and views:
  - at place and in neighbourhoods
  - of children and young people
  - carers
  - voluntary/ third sector
  - wider system partners
- ensuring a positive focus on strengths, independence, self- help, whole people, resilience, parity of esteem, wellness, recovery, thriving and fulfilling lives, community assets
- describing more clearly the approach to delivering the impact and outcomes that matter to people across Devon.

3.6 Over the coming weeks our engagement we use a variety of methods to listen, learn and discuss people's views. This will include:

- Online engaement and survey
- Attending existing forums to discuss the Strategy
- Delivering interactive workshops (1 STP wide, 1 System Partners, 4 People and Carers)
- Undertaking Semi-Structured Interviews
- Enabling open feedback via our email account (d-ccg.mhwbstrategyengagement@nhs.net)
- Collating previous engagement reports and learning

**4. Ask of the Health and Wellbeing Board**

4.1 We welcome the boards views and consideration of the Draft STP Mental Health and Wellbeing Strategy and request that the board undertake the following:

4.1.1 Discuss the appended strategy including the strengths, areas which need to be strengthened and the emergent themes of engagement identified in 3.5 of this document.

4.1.2 Share further feedback through the open feedback email account- (d-ccg.mhwbstrategyengagement.nhs.uk)

4.1.3 Tell us if you would like to be part of one of workshops to contribute more to the strategy engagement and development

4.1.4 Note the engagement activities planned and the change in approach to engagement described

4.1.5 Identify any local forums or networks (such as the Brixham Mental Health Group) whom we need to connect with and involve.

4.2 We are collating all of the feedback we receive through these discussions, via email and across our engagement. The findings will be presented in a short report; this will include identifying a range of suggested developments or adjustments in the strategy.

4.3 We intend to return the strategy, together with the engagement report, to the Health and Wellbeing Board in December/January.

**Appendices:**
Appendix 1- Draft STP Mental Health and Wellbeing Strategy

**Background Papers:**
The following documents/files were used to compile this report:

http://www.devonstp.org.uk/wp-content/uploads/2018/07/STP-two-year-report-05.07.2018.pdf

# Draft Mental Health and Wellbeing Strategy

1) **Foreword**
2) **Vision**
3) **Current position in Devon**
4) **Examples of great practise in Devon**
5) **Stakeholder engagement and voices**
6) **National policy context**
7) **Economic Case**
8) **Areas of priority**

## Foreword

[Additional content for foreword to be prepared following engagement]

## Vision

Our vision is to improve the mental health and wellbeing of all ages, from children through to older adults, in Devon working in partnership with people with lived experience, families, communities and the third sector. The quality of service and clinical outcome will not depend on where a person is resident in the county.

We will do this by ensuring there is both parity of esteem with physical health and that service (health and social, mental and physical) meets the whole needs to the person. We will work together to create new models of support that focus on people's strengths, recovery, self-care and encourage independence - reducing reliance on hospital care.

There will be a clear focus on the prevention of ill health, early intervention, health promotion and the development of more resilient communities that can support people with mental health needs.
The strategic aims for improving mental health and mental health services within the context of the Wider Devon STP are:

- We will ensure our services meet local needs;
- We will ensure that we maximise the effectiveness of mental health spend and investment to achieve better outcomes;
- We will improve the promotion of mental health and the prevention of mental illness in primary care and in communities; and
- We will improve provision for those with severe long-term mental illness and people who have both mental health and physical health needs

## Current position in Devon

There are over 1.2 million people living and working in the county of Devon with more people living into their later years than elsewhere in the country, many live in relative isolation due to transport links and loneliness is an issue. The following outcomes measures have a relationship to mental health, including some of the wider determinants which can impact on mental health and wellbeing throughout life. These indicators suggest a mixed picture when compared to the England average

at Devon STP level. There is also variability within the county when comparing to the local authority areas to the Devon STP total.

| Type of Indicator | Indicator | England | South West | STP | Devon | Plymouth | Torbay |
|---|---|---|---|---|---|---|---|
| Mortality | Suicide rate | 9.9 | 10.8 | 11.5 | 10.7 | 9.5 | 14.1 |
| | Excess <75 mortality in Serious Mental Illness | 370 | x | 337.6 | 329.9 | 369.7 | 319.3 |
| | Infant mortality rate | 3.9 | 3.4 | x | 3.6 | 2.6 | 4.4 |
| | Killed and seriously injured on roads | 39.7 | 39.7 | x | 45.5 | 32.9 | 32 |
| Admissions | Hospital stays for self-harm | 185.3 | 246.3 | x | 219.6 | 273.3 | 362.8 |
| | Hospital admissions - self harm (age 10-24) | 430.5 | x | 670.2 | 614.1 | 617.2 | 1167.9 |
| | Alcohol related admissions (broad) | 2225.7 | x | 1979.7 | 1722.4 | 2264.1 | 2293.7 |
| Diagnosis and Support | Health related quality of life (LTCs) | 0.737 | x | 0.727 | 0.75 | 0.699 | 0.714 |
| | Dementia diagnosis rate (%) | 67.9 | 62.8 | | 60.6 | 58.9 | 63.2 |
| | Emotional difficulties in looked after children | 14 | x | 16.2 | 16.7 | 15.4 | 14.9 |
| Healthy Start In Life | Smoking status at time of delivery | 10.7 | 11.3 | | 12.3 | 11.7 | 15.2 |
| | Breastfeeding initiation | 74.5 | 79.5 | x | x | 69 | 72 |
| | Under 18 conceptions | 18.8 | 15.8 | x | 16.4 | 19.6 | 25.7 |
| Healthy Lifestyles and Behaviours | Physically active adults | 66 | 70.4 | x | 73.9 | 67.6 | 67.1 |
| | Excess weight adults | 61.30% | 60.30% | 62.50% | 61.60% | 66.50% | 61.20% |
| | Excess weight Children 10/11 years old | 34.20% | x | 30.30% | 29.30% | 31.20% | 33.70% |
| | Excess weight Children 4/5 years old | 22.60% | x | 23.90% | 22.80% | 26.30% | 24.40% |
| | Obese children (aged 10-11) | 20 | 16.2 | x | 15.2 | 17.2 | 19.9 |
| | Smoking prevalence in adults | 15.5 | 13.9 | x | 12.6 | 17.2 | 16.7 |
| Education and Employment | GCSEs achieved | 57.8 | 58.4 | x | 60.2 | 50.2 | 56.6 |
| | Employment rate (aged 16-64) (%) | 74.4 | 77.6 | 74.9 | 74.7 | 74.8 | 76 |
| Deprivation and Poverty | Deprivation score (IMD 2015) | 21.8 | x | x | 17.1 | 26.6 | 28.8 |
| | Children in low income families (under 16s) | 16.8 | 13.7 | x | 11.9 | 19 | 20.2 |
| | Children in poverty | 20.10% | x | 17.20% | 14.30% | 21.50% | 23.60% |
| | Fuel poverty | 11.00% | x | 12.00% | 12.20% | 12.00% | 10.80% |
| Home | Dwellings (with category one hazard) | 10.40% | x | 15.10% | 15.40% | 20.80% | 3.10% |
| | Statutory homelessness | 0.8 | 0.4* | x | 0.5* | 0.3 | 0.9 |
| | Rough sleeping (per 1,000 households) | 0.18 | x | 0.22 | 0.22 | 0.18 | 0.33 |
| Crime | Violent crime (violence offences) | 20 | 17.7 | x | 12.6 | 24.8 | 25.4 |

Source: Combined December 2017 STP Outcomes and Prevention Challenges and Public Health Fingertips Data downloaded July 2017:(https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/1938132701/pat/6/par/E12000009/ati/102/are/E10000008/iid/20201/age/1/sex/2)

There are a number of existing strategies relating to prevention, health and wellbeing and service delivery that are vital to the delivery of the strategy aims of this Devon STP Mental Health and Wellbeing strategy. Working from the principle that we want mental health to be everyone's business this strategy will link with, and in parts inform the following other strategies and programmes of improvement work;

- Prevention and early intervention (STP workstream)
- Children and young people (STP workstream)
- Primary Care (STP workstream)
- Integrated care model (STP workstream)
- Learning Disabilities (STP workstream)
- Acute Services Review (STP workstream)
- Children and young people (STP workstream)
- Workforce (STP workstream)
- Local Authority Health and Wellbeing Strategies
- Communities Strategy Devon County Council
- Five Year Forward View, Mental Health Concordat (suicide prevention, wider prevention)
- Wider Provider Networks

In addition to these strategies, careful thought will be given to the great impact that individuals and communities can make to health and wellbeing when statutory organisations do not over intervene or disrupt the environment in which these agents thrive. Activation of this community based asset is a critical success factor in improving the mental health and wellbeing of the population. Devon has high-levels of volunteering and almost twice as many registered charities compared to the national average. We have enthusiastic and skilled voluntary and community sector infrastructure organisations that have extensive experience in developing and promoting volunteering activity.

<u>There are a set of complex needs in Devon</u>;

1) Seasonal and migratory work means that for some income is insecure. We have our share of families in difficulty, people struggling with debt, poor housing, relational breakdown and addiction.

2) Depression affects over 100,000 of us at any one time and 4 in every 1,000 of us will be experiencing severe mental illness. Suicide rates in Devon are higher than the national average, although the Devon County Council footprint is similar to the national average.

3) Over 13,000 people are living with dementia across Devon, a figure predicted to rise by 77% over the next 12 years. Alzheimer's Research UK state that 1.3% of the UK population is living with Dementia (c850,000 people). As noted dementia diagnosis rates (in primary care) are below the national average so it is likely there are more people than stated. It is estimated that with appropriate alternatives and supporting services in the community that 40% of acute hospital dementia admissions are avoidable and 95% of mental health dementia admissions are avoidable.

4) Independent analysis shows that people with severe need account disproportionately for secondary care resource consumption.

5) Independent analysis indicates a shortfall of mental health beds for the population of Devon which means some residents are care for away from their community. We know that this

increases the length of time someone stays in inpatient environment as they are in less familiar surroundings, away from family and friends.

6) There are inequalities in outcome for people accessing mental health services as compared to those who do not as well as outcomes for those with Mental Health illness based on the place they live within the county;

- There is a gap of around 19 years for men and 17 years for women between those who use mental health services and those who don't across the Devon population. This means they live roughly 20-25% less years. (strategy unit)
- As people age life expectancy between mental health services users and those not in contact with mental health services becomes more marked. Those aged 65 are likely to have around 50-55% less remaining life expectancy if they are mental health services than those who are not. (strategy unit)
- The complexity of population needs within the county and the mental health outcomes vary with a strong correlation between outcomes and complexity. (CF analysis)
- People who use mental health services are 2-4 times more likely to die from cancers, circulatory disease and respiratory disease than the rest of the Devon population. (strategy unit)
- Rates of emergency hospital admissions are more than 3 times higher amongst people who use mental health services than the rest of the population. (strategy unit)

7) Based on national data around 30% of people with a long term physical condition also have a mental health problem and a further 46% of people with a mental health problem have a long term physical condition (Kings Fund). Applying this to locally means approximately 110,000 (around 1 in 10) people in Devon have a need for services that address more than one aspect of health and social care needs.

8) At times there is a lack of collaboration between mental health and physical health settings which means that people with co-morbidities are receiving medicalised and fragmented care and treatments. This results in a high cost through use of services and poor outcomes for people. Those who present to services with medically unexplained symptoms are one example of the current state.

9) The first experience of those suffering lifetime mental health problems is significant in the early years of life with 50% by the age of 14 years and 75% by the age of 25 years. Nationally, 10% of children and young people (aged 5-16 years) have a clinically diagnosable mental problem, yet 70% of children and adolescents who experience mental health problems have not had appropriate interventions at an early age. (MH Foundation, Fundamental Facts about MH 2015). The transition to adult services can be difficult and disjointed for children and their families.

10) 1 in 7 mothers will experience a mental health problem during pregnancy or postnatally

11) The commissioning of mental health services for the population of Devon is the responsibility of 3 local authorities, NHS England and 2 CCGs.

12) Devon has a geographical footprint which includes both rural and urban populations. This means that to achieve the same outcomes for people, services might be delivered differently.

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**Examples of good practise in Devon**

[We are collecting positive experiences of Mental Health and Wellbeing from people with lived experience to strengthen this section]

There are many examples of good and innovative practise in Devon in terms of service design, wellbeing programmes and support for people with lived experience live fulfilling and productive lives. Some examples of this include:

**Thrive Plymouth** is a 10 year programme to get everyone working together to improve health and wellbeing and narrow the gap in health status between people and communities in the city of Plymouth. 2015/16 was the Thrive Plymouth year of focus on schools was able to build on the foundations developed by schools and supported through programmes. It provided an opportunity to promote the Thrive Plymouth approach, to recognise the work that schools were already doing and how this could develop further and create new partnerships for action to support the health and wellbeing approach in schools. Schools and partners have recognised the impact of the common risk factor of poor mental health on a wide range of outcomes for children, including health and attainment, and have worked together to address this, by developing whole-school approaches for mental wellbeing and co-commissioning services in secondary and special schools. Schools have been working to create healthy environments, for example, through learning in the natural environment, creating healthy dining experiences or opening their doors for partners to deliver a range of health interventions directly to the children. This year the focus for Thrive Plymouth is on mental wellbeing and the 5 ways to wellbeing. The aim is to raise awareness of the 5 ways to wellbeing amongst the whole population and to create more opportunities for local people to participate in the 5 ways. This is an opportunity we must use to drive forward our collective efforts to improve mental wellbeing in all age groups but we are particularly looking at 16-25 year olds to try to embed 5 ways to wellbeing as life skills for young people as they move to independence.

Plymouth has recently been announced as a pilot site for **Community Sentence Treatment Requirement** which is a formulated programme, delivered by health as an alternative to a custodial sentence for some individuals with a MH problem. This includes Mental Health Treatment Requirements, Drug Rehabilitation Requirements and Alcohol Treatment Requirements.

The **Torbay Healthy Learning Website** has recently launched. It was designed to support educational staff in promoting health and wellbeing in their setting. It provides centralised site for information, guidance, teaching resources and service signposting. A section of this website covers emotional health and wellbeing.

Established in 2013, the **Devon Recovery Learning Community** arose from the initial cohort of NHS Trusts working with the Centre for Mental Health's supporting recovery programme, Implementing Recovery through Organisational Change (ImROC). The purpose of a Recovery Learning Community is to enable people to access co-produced educational opportunities that are experienced as hopeful and helpful in supporting them in their recovery. It offers effective opportunities to learn how to get well and stay well. Recovery leads in Devon elected to develop a

‘learning community’ rather than a ‘college’ in recognition of our geography, the aspiration to grow a wide network of community partners and the preferences of those involved. It currently has over 500 registered students, provides around 100 co-produced courses, involving more than 40 peer tutors, working with 16 community partners, delivering courses in 24 sites across Devon.

**Workways** is the Individual Placement and Support Service (IPS) in Devon. It is an integral part of the vocational rehabilitation Services. Workways has been helping people with a mental health condition to find or remain in paid employment since November 2001. It is funded by the NEW Devon Clinical Commissioning Group and Devon County Council. Originally set up for Exeter residents, the service expanded to cover East and Mid Devon in 2004. Workways have been working using the IPS approach since 2011 and have been a Centre of Excellence since 2013. In 2017 Workways team supported people to achieve 52 successful job outcomes.

**Early Help 4 Mental Health** is a prevention and early intervention programme, operating across Devon; with culture change at its core. The programme works with schools to promote and build mentally healthy behaviours and resilience, helping children to lead happy and healthy lives. It was co-designed with stakeholders and partners and strong connections remain between people, the service and other services across the NHS, social care and third sector. Children and young people can get support online, face to face in groups or individually. Schools can access support to develop a whole school approach to support emotional, psychological and social wellbeing. In a recent evaluation, 74% of children and young people who received face-to-face counselling experienced an improvement in their emotional wellbeing and 94% demonstrated progress against the goals they set. 69% of logins online were made outside of normal office hours offering flexible support to young people. The programme is recognised as a positive example by the Local Government Association

**MINDFUL EMPLOYER**® is a NHS initiative run by Workways. This supports people with a mental health condition to find or remain in employment. MINDFUL EMPLOYER was developed by employers in Exeter and launched in 2004. Initially intended as a purely local initiative, it has since developed throughout the UK and has been launched abroad. MINDFUL EMPLOYER has been recommended as good practise by the UK government and other national organisations. 2017 2017 saw over 200 employers sign the Charter for Employers who are Positive About Mental Health.

The budget for all people who are placed out of area because there are currently no specialist local services to meet their needs has been delegated by commissioners to the local specialist Mental Health Trust. This is known as the individual patient placement (IPP) budget. The Trust has commissioned a service from third sector organisations to provide support locally for people who are ready to leave hospital but still require support to live independently. This enhanced community recovery service offers up to 24/7 support for people in their own tenancies and has been very successful in providing personalised care in homely settings.

A multi-agency team is working in Exeter from the CoLab (an innovative centre which provides a base for a range of services) to develop a more integrated approach to supporting people who are homeless and vulnerably housed who face multiple disadvantages. This team includes two mental health practitioners who work from the Clocktower GP Surgery which is co-located with CoLab and

provides a primary care service. The Clocktower Surgery is rated as ‘outstanding’ by the Care Quality Commission.

**Langdon Hospital** (Dawlish) provides a range of medium, low and open inpatient secure services for men. Dewnams is a 60 bedded medium secure unit – was opened in 2013 and is regarded as ‘state of the art’ in terms of its design and quality of care. The services provided at Langdon Hospital are rated as ‘outstanding’ by the Care Quality Commission and it has received awards for the work to develop a Service users Council, the Discovery Centre (a Recovery College) and its ground breaking primary care centre which is ensures people get excellent care with both their physical and mental health.

The **South West Zero Suicide collaborative** in Devon has been involved in a cross community collaborative approach to suicide prevention since 2014. This started as part of South West Zero Suicide collaborative initially funded by and hosted in the Strategic Clinical network. This won an HSJ award for Patient Safety in 2016. The collaborative has now been wound up, but a local 'grassroots' organisation 'The Devon and Torbay Suicide Alliance' has been formed and continues the work. The DTSPA involves a broad range of stakeholders; these include statutory services, voluntary sector services, and many people with lived experience. There is an extensive range of work taking place. This includes work to reduce suicide in public places, training in suicide prevention, support for families bereaved by suicide, Samaritan support for those leaving inpatient services to name but a few. The range of projects reflects the varied nature of the stakeholders and the organic way that this work has developed. Devon has produced a suicide prevention implementation plan coordinated by public health. All three local authority areas work closely together around suicide prevention; including the roll out of Suicide Prevention Training across the STP area.

The **Devon memory Café Consortium** has been established to represent the best interests of memory Cafes in Devon, whilst ensuring that they maintain their own independence. The aim is to support people living with dementia and their carers through the Memory Café movement – making sure they have access to peer support, information, advice and meaningful activities.
Devon County Council is working with the Alzheimer’s Society to help support people with dementia.

The new contract with the Alzheimer’s Society means that **Dementia Support Workers**, which are highly valued by carers of people with dementia, will continue to work in local communities across Devon. Dementia Support Workers work in towns and villages, helping people with the condition, and their families, to identify and make use of local services that can help them. Helping communities to be more resilient and able to respond to residents’ needs will help people with dementia live independently for as long as possible, without need for ongoing care.

A new **Mother and Baby Unit** is currently under construction, in Exeter, which when operational will support mothers who have mental illness either during pregnancy or in the year after birth. There is an interim provision of 4 beds in a temporary unit available from April 2018 with the permanent 8 bedded unit due to open in 2019. There are also supporting perinatal community services. This increases provision in the South West from 4 beds in Bristol and seeks to address the ambitions described for perinatal care in the Mental Health 5 Year Forward View.

Devon has well established **IPAT/Depression and Anxiety services** in place across the County with over 16,000 new referrals each year including people with long term conditions such as diabetes, obesity and COPD. Performance is better than national targets set against treatment waiting times and recovery rates. This provides a strong base from which to build the extended services into a wider group of people with long term physical conditions.

These examples of good practise provide a foundation on which to build a wider geographical and consistent offer to the residents of Devon.

[Prevention Concordat for Better Mental Health- to be included]

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**Stakeholder engagement and voices**

[(Intention Statement- to be removed from final document) We are committed to working with our population. We will engage with our population, including people with lived experience, children and young people, carers and the people who support them to better understand what they want from mental health and wellbeing services and how we can improve their experiences and outcomes. We will be mindful in undertaking this work of the need to consider how those with protected characteristics are heard in this process.]

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**National policy context**

The 5YFV for mental health identifies 3 areas of priority which contribute to the development of the strategy for Devon. They are broadly consistent with the themes from local engagement and are;

1) 7 day NHS

| Action | Outcome |
|---|---|
| People in crisis should have access to MH care 7 days per week, 24 hours per day | by 20/21 CMHT 24/7 crisis response |
| Services adequately resourced to offer intensive home treatment as an alternative to acute admission | not prescribed |
| Liaison Mental Health in acute hospitals | by 20/21 all age MH liaison service in acute |
| | by 20/21 @ least 50% acute meet 'core 24' |
| People experiencing a first episode of psychosis should have access to NICE approved care package <2weeks of referral | by April 2016 50% should have access to early intervention in psychosis services |
| | by 20/21 60% should have access to early intervention in psychosis services |
| Expand proven community based services to people of all ages with | not prescribed |

| | |
|---|---|
| severe Mental Health problems who need support to live safely as close to home as possible | |
| More step down from secure i.e. residential rehabilitation, supported housing and forensic or assertive outreach teams | not prescribed |
| Out of area placements for acute care should be reduced and eliminated as quickly as possible | No out of area placements by 20/21 |
| Reduce suicide rates | by 20/21 reduce by 10% |

2) Integrated mental and physical health approach

| **Action** | **Outcome** |
|---|---|
| More women with access to evidence based specialist Mental Health care during perinatal period | By 20/21 increased care provision for at least 30,000 more women nationally. This is equivalent to around 300 women in Devon. |
| People living with severe Mental Health problems should have physical health needs met | By 20/21 at least 280,000 offered screening and secondary prevention reflecting the higher risk of poor health. This is equivalent to around 3,000 people in Devon. |
| Mental Health inpatient services should be smoke free | by 2018 smoke free |
| Increase access to evidence based psychological therapies to reach 25% of need - adults with anxiety and depression (IAPT) | By 20/21 600,000 more adults each year (350,000 complete treatment). This is equivalent to around 6,000 more people (3,500 completing treatment) in Devon. |

3) Promoting good Mental Health and preventing poor Mental Health

| **Action** | **Outcome** |
|---|---|
| Children and young people are a priority groups for mental health promotion and prevention | By 20/21 at least 70,000 nationally more children and young people should have access to highest quality MH care. This is equivalent to around 700 more children and young people in Devon. |
| More people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to individual placement and support (IPS) | By 20/21 each year up to 29,000 nationally more helped to find or stay in employment. This is equivalent to around 300 more people in Devon. |

The national planning guidance for 2018/19 sets out the following requirements in addition to the requirement to deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages;

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral;
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases; and
- Reduce suicide rates by 10% against the 2016/17 baseline
- CCGs are also required to meet the minimum investment standard in Mental Health in 2018/19 (where mental health spending grows faster than its overall funding growth)

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**Economic case**

Nationally, mental health accounts for 23% of 'burden of disease' (a composite measure of premature mortality and reduced quality of life) but spending on mental health services is equivalent to around 11% of secondary health care budgets (Kings Fund).

At least £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing (Kings Fund), another way to consider this is that underinvestment in mental health provision leads to a higher physical health expenditure.

This means that between £8bn and £13bn of NHS spending in England is attributable to mental illness co-morbid with long-term conditions. These people generally use more healthcare resources and contribute to wider costs in the community such as sickness absence, cost of informal care and support from friends and family. This has also been established as the case in Devon.

The NHS figures do not include the wider costs of mental health associated with unemployment, social care, children, disorderly conduct, alcohol, substance misuse and suicide.

Poor mental health carries an economic and social cost of £105 billion a year in England (Centre for Mental Health) – roughly the cost of the entire NHS. Taking a Devon share of this (based on national finding allocation as a rough guide), Devon's economy could expect around £1-£2 billion as an economic and social cost from poor mental health. The figure includes the costs of health

and social care for people with mental health problems, lost output in the economy, for example from sickness absence and unemployment, and the human costs of reduced quality of life
An independent analysis of Devon's mental health services identified that without system-wide investment in integrated physical and mental health there is a potential shortfall in funding of between £18.9 and £21.1m by 2021.

There is a potential opportunity to save c£55m from the Devon health system over the next 5 years as well as improving outcomes and health and wellbeing by investing in evidence-based integrated mental health services. This would contribute to the financial wellbeing of the whole health and social care economy as well as address the potential shortfall in funding shortfall identified by 2021.

**Cost of Long Term Conditions in Devon**

Long term conditions (LTCs) are a significant cost to health and social care services in Devon. The table below illustrates the estimated numbers of people with a variety of LTCs and their associated costs.

| Long term condition | No. of people in Devon affected (estimated) | Annual costs (millions) |
|---|---|---|
| Coronary Heart Disease | 43,759 | £64.7 |
| Stroke | 19,154 | £52.4 |
| Diabetes | 53,733 | £45.9 |
| Asthma | 71, 853 | £43.6 |
| Chronic Obstructive Pulmonary Disease | 21,405 | £23.3 |

Source: Devon County Council: Devon Health and Wellbeing

As set out in stating the complex needs in Devon, the overlap between LTC and MH is stark: 30% of people with LTC have a mental health problem, and 46% of people with a MH problem are suffering from a LTC.

The majority of people with lower complexity of needs can be referred to Improving Access to Psychological Therapies (IAPT) which has had a significant success rate. Data from April 2012 to March 2015 shows that across Devon, of around 24,000 people were seen, 60% experienced a reliable improvement in their mental health and most positively, 40% were deemed to have recovered.

Data from NHSE's first and second wave early implementation sites for integrating IAPT services with physical health pathways show significant savings are already being made. Cambridgeshire and Peterborough CCG found introducing IAPT services to diabetes, cardiovascular and respiratory pathways saved £193k per annum by reducing the number of times these people needed to visit GPs, physiotherapists, specialist and practice nurses, and A&E as well as being admitted to hospital.

The evaluation found that for the 500 people involved in the integrated IAPT for long term conditions in the area:

- A&E attendances fell by 61% and hospital IP admissions by 75%
- GP appointments across the 3 specialties fell by 73%

**Medically Unexplained Symptoms (MUS)**

People with somatoform disorders (mental illnesses that cause bodily symptoms that cannot be traced back to a physical cause) account for as many as:

- 20% of new consultations in primary care
- 7% of all prescriptions
- 25% of outpatient care
- 8% of inpatient bed days
- 5% of A&E attendances

The estimated cost to the NHS of MUS nationally is £3.1bn. Approximately half the cost (£1.2bn) was associated with inpatient care of less than 10% of people with MUS, thus a relatively small number of people receive very expensive and inappropriate care. (NHS Confederation Mental Health Network 2015).

Translating this to the Devon population, 80% of which are over 18, that means that people with severe MUS account for approximately 1% of each GP's population and therefore there are about 10,000 people with severe MUS. We estimate that we spend in Devon between £3.6m and £8.3m on diagnostic, outpatient and inpatient stays for people presenting with functional symptoms with no organic pathology.

A fully functioning integrated psychological and medical service based on the service implemented in Oxford could tackle the variation in A&E attendances and acute admissions. Not only does this make a more effective use of healthcare resources it also improves the experience and outcomes for people who can become locked into a medicalised approach to their care which will not meet their needs.

**Acute Physical Healthcare Utilisation**

It is estimated that by reducing the variation in how frequently people with mental health needs access acute services as compared to people who don't have mental health needs the STP could save up to £1.2m in A&E attendances and up to £28m by reducing acute hospital activity for those with mental health needs to the same level as the rest of the population.

**Complex MH Care – what it currently costs in Devon**

Treating complex mental health problems in Devon represents significant cost for a relatively small percentage of the population as set out below;

£2m per year in acute hospitals on 'specialising' – where people need 1:1 ward care

£3m on out of area adult MH inpatient beds

£13m on Individual Patient Placements
£250k per year for a secure bed
£100k - £200k per year in locked care
£600 per night in a PICU
£80k per year for intensive community care

Investment in and focus on the top complex cases could result in significant savings for the system. For instance, by focusing on the top 50 people who experience complex Personality Disorder (who have been identified as having a high morbidity) and investing in Community Intensive Recovery Teams (CIRTs) as Sheffield has, the cost per annum reduces from £200k to £90k – a £5.5m saving per annum for this patient group.

The next group of people with complex mental health needs (220 people) could be supported in settings outside of acute beds through focussed assertive community treatment (ACT). Investment in this community service would reduce the annual cost per patient from £90k to £50k, a saving to the system of £8m per annum.

**Dementia**

At a conservative estimate, the number of people in hospital beds in Devon who are medically well enough to leave and have dementia account for 142,350 bed days per year at a cost of £36m. Targeted investment in evidence-based interventions such as IPMS, Psychiatric liaison and co-ordinated dementia care could help improve the physical health of people with mental health needs and prevent the need for admissions to both local acute beds and out of area mental health placements. Support for carers is also a significant area of consideration.

**Summary**

The economic case shows that there are material opportunities to make qualitative improvements and financial efficiencies through targeted investment to focus on supporting the integration of physical and mental health and community based teams.

The saving opportunity is in the region of c£55m (net of investment) but these savings will only materialise when resources and pathways are reorganised. This would also reduce the wider economic impact of mental health on the Devon economy.

This is not intended to read as a priority investment schedule as a there are a number of hypothesis currently being tested with partial investments.

| Area of Investment | Investment | To improve | Saving Opportunity |
|---|---|---|---|
| IPMS expansion | £1.5m | Medically Unexplained Symptoms | £3.6m - £8.3m |
| IPMS expansion | £1.5m | Acute admissions / A& E attendances | £28m |
| CIRT / ACT | £1.5m | Mental Health placements – change settings in which care is delivered to community | £13.5m |
| Dementia | £1.2m | Acute hospital stay and admissions avoidance | £13m |

| | | | |
|---|---|---|---|
| Total | £5.7m | | £58.1 - £62.8m |

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**Priority areas**

Taking into account the current position in Devon, the views and feedback from our stakeholders, the examples of great practise, the national policy context and the economic case the following areas of immediate priority have been identified (in line with the strategic aims);

| Current State | Future State |
|---|---|
| Secondary care mental health accounts for 8.4% of Devon health expenditure which is low compared to a national average expenditure of 14% and national average activity levels accounting for 23% of total secondary care in health. | Secondary mental health care funding increased year on year above and beyond 'parity of esteem' funding to establish Devon in line with national average by 2020/21. Increased funding linked to service developments showing a demonstrable contribution to improvement in experience, outcomes and cost release in acute sector. |
| Health and social care services and support for children with mental health problems and their families are insufficient and not sufficiently aligned to physical health services and adult services as they transition to adult care services. | An integrated, personalised model of provision that can respond to the holistic needs of a child or young person, their families and carers.<br>Seamless pathways of care and support that transcend policy, organisational and service boundaries.<br>An improved offer of local, universal support with timely access to targeted and specialist services.<br>Improved opportunities for children and young people at transition points in their life |
| There are insufficient care and service alternatives to admission to inpatient care (both secondary care hospital and specialist mental health) setting for people who could be supported in their communities, many of whom are placed out of area. | Community based resources are sufficiently funded, aligned and connected to communities such that clinical teams have confidence to not recommend admission because appropriate alternatives are in place and/or people receive support in advance of reaching a point of crisis. |
| Health and social care services do not consistently meet the needs of people with both mental and physical health needs.<br>People with mental health needs who also experience physical conditions have a significantly impaired life expectancy as compared to those who do not access mental health services. | People consistently experience a coherent and joined up service offer where there holistic needs are met and the life expectancy gap is narrowed. |
| Commissioning of mental health and wellbeing services for the c1m residents of Devon is fragmented as it is the responsibility of 3 local authorities, 2 CCGs and specialised commissioners. There are many different improvement initiatives, not all coordinated, | Mental Health Care Partnership for Mental Health and Wellbeing across Devon.<br><br>Standardised outcomes framework with minimum standards, outcomes and access across all providers of health and social care and shared |

| | |
|---|---|
| and outcomes for people vary depending on where they live in the county. | approaches to strengthening communities and voluntary sector effectiveness.<br><br>Service delivery models consistent, not uniform, to reflect the need and circumstances of the local care partnership footprints and strong link to local community and charity resources. (appropriate governance and oversight) |
| 'Mental Health and Wellbeing' support could do more to support and engage with prevention, promotion and wider determinants of health and wellbeing. We could do more to engage a broader range of partners in a person centred, strengths driven system. | Mental Health Care Partnership offers a broader partnership approach bringing together:<br>• expertise in prevention, promotion and the wider determinants of health and wellbeing from other STP programmes, with;<br>• expertise from a full range of mental health, care and support providers.<br><br>The Mental Health Care Partnership will use outcomes as a common language across all partners to ensure a clear and consistent person centred, strengths driven approach at all times. |

In describing the outcomes we will achieve against each of these priority areas and the transformation programmes below we will ensure that we consider and reflect the views of our population, including people with lived experience, children and young people, carers and the people who support them to better understand what they want from mental health and wellbeing services and how we can improve their experiences and outcomes.

Through the delivery of the transformation programmes we will seek to ensure that the vision and strategic priorities are acted upon and result in a positive impact on experiences and outcomes for people in Devon. In doing so we will enable people to improve their life chances, we will help more people to be and stay healthy; and, we will enhance self-care and community resilience. We will achieve this by ensuring we consistently deliver modern, safe and sustainable service and by integrating and improving strengths based care in our communities by working in partnership with all providers and commissioners of health care and support.

The transformation programmes that will deliver the improvement from the current state to future state are as follows;

1) **Children and Young People's services**
2) **Crisis and Urgent Care**
3) **Dementia Care**
4) **Primary Care interface with specialist mental health services**
5) **Development of Mental Health Care Partnership (MHCP)**

**Transformation programme 1 – Children and Young People's services**

Devon County Council, Plymouth City Council, Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group are tendering a range of children's and young people's services including emotional health and wellbeing. The full tender documentation can be found on the following link;

www.newdevonccg.nhs.uk/children-and-young-people/procurement-102759

As a part of this process the following principles have been identified as being required to underpin future service provision to children and young people;

- **Prevention is a Fundamental Aspect of Provision**: whereby the provider priorities the early identification of each child or young person's needs and risks to health so as to help avoid them becoming ill.
- **Early Help Should be Embedded Across the System**: children and young people, their families and carers will be offered help and information early in their life and early in the development of specific needs, whether these are by health and/or care or educational needs.
- **Innovation and Evidence Based Provision**: commissioners and providers will continuously strive to improve the lives of children and young people through innovation and ensuring the best and most current evidence is used by existing practise and systems. Together we will use technology and different ways of working with children and young people, using methods of communication that will engage them effectively.
- **Sustainability is Key**: commissioners and providers will use early help and proactive intervention, will help drive sustainability of the system. However, we will also need to ensure efficiency and effectiveness through the use of technology and good workforce management.
- **Systems Should be Responsive and Accessible**: the system will respond to the changing needs of the population delivering support that is designed with children, young people, their families and carers and that is delivered at the right time and in the right place.
- **Services Should be Personalised and use a strength based approach**: this develops choice and control for children, young people, their families and carers using known information to tailor and personalise the response.
- **Systems and Services Should be Integrated**: to ensure that it is united by a common focus on delivering outcomes for children, young people, their families and carers within a co-ordinated seamless experience. There is 'no wrong door' and professionals are able to work across the system to deliver the best possible care. The integrated system uses information and data to develop and deliver effective practise. It is also capable of understanding, managing and accepting risks with children, young people, their families and carers.
- **Build Upon the Strength and Resilience of Individuals, Families and Communities**: recognise that children and young people live in families and communities; value and enable the role these play in developing and sustaining happiness, wellness, health, and safety. Empower children, young people and their families to help themselves, build resilience and safely manage risks.

These principles build on the feedback taken from engagement with people and stakeholders as well as national policy and good practice.

By late **June 2018** complete the completive procurement dialogue process with bidders

By **August 2018** formally award contract

**April 2019** contract start date

**Transformation programme 2 – Crisis and Urgent Care**

The goal is delivery of a comprehensive range of services, community resources and support networks that avoid crises escalating where possible, and provide timely, accessible and compassionate support to those in a crisis. As already outlined this is also a key area of national policy outlined through the 7 day NHS priority in the Five Year Forward View for Mental Health.
A number of the developments within the programme will support providing alternatives to admissions and through doing so the national standard of no inappropriate out of area placements by 2021. Significant expenditure is incurred through placing people out of area; this expenditure could better invested in local services.

A gap analysis demonstrates that the current system is focused on providing mental health assessments (tier 2) and inpatient and psychiatric intensive care beds (tier 4 and 5) with significant gaps in the provision of alternatives (tier 1 and 3). It is in these areas, in particular, that further strategic planning is required.

- **Tier 1- Low need, high volume**

A number of the services at this level require multi agency co-ordination and support and significant working through partnership across health, social care, voluntary organisations and local communities.

Investment in this tier will have system wide benefits to acute care, mental health and social care by reducing escalation to primary and secondary care services by supporting a citizen led approach with more resilience and support built into local communities.

By the **end of December 2018** an outline plan will be developed to consider the partnerships required to provide support and capacity to avoid the escalation to crisis and support in the community.

- **Tier 2 - Access routes**

Single point of access (SPA) – Urgent or emergency mental health help and support to people not currently receiving care and treatment from a Community Mental Health Teams. The single point of access (available 24 hours a day and 7 days a week) provides a single route to obtain urgent advice across mental health services in urgent situations. The access and triage elements of the SPA will support the allocation of urgent assessment slots and enable this part of the pathway to become more operationally efficient. This will enable Crisis Resolution and Home Treatment (CRHT) teams to focus greater capacity on intensive home treatment and not assessments. By the **end of August 2018** SPA will be in place across Devon.

First response service – **by the end of September 2018** a full evaluation of the existing national best practice service model from to determine service specification for Devon and roll out plan/investment.

Psychiatric liaison – continue the roll out of existing plans to achieve core 24 standards

- **Tier 3 - Alternatives to admission**

By the **end of September 2018** an outline plan will be developed to consider the partnerships required to provide alternatives to admission and support in the community.

This will include capacity of Crisis Resolution and Home Treatment teams, 'step down' and crisis housing capacity (including supported living) and rehabilitation.

- **Tier 4 - Inpatient services**

The number of inpatient beds required for the population of Devon is not only a function of the health and wellbeing of the population but also the capacity and effectiveness of the other levels of service and support described in tiers 1 to 4. The bed requirement over the life of the strategy will be considered in the context of these other plans and developments.

- **Tier 5 - Psychiatric Intensive Care Unit**

There is currently no Psychiatric Intensive Care Unit available for people in Devon. People who require this service currently receive treatment out of area. Plans are in place to build a local Psychiatric Intensive Care Unit in Exeter by November 2018, with the unit becoming fully operational by **the end of January 2019**.

**Transformation programme 3 – Dementia Care**

By providing consistency of service available to individuals with Dementia and their families, the experience and the care received will improve, and allow them to 'live well with Dementia' which should also reduce admissions to both physical and mental health secondary care services.

There will be further benefits in relation to a reduction in escalation of the condition, the appearance of Behavioural and Psychological Symptoms in Dementia (BPSD) and the need for admission to nursing/residential care homes.

To assess the Devon baseline position against NICE guidance, a gap analysis has been completed. Primary and Secondary Care organisations, Local Authorities, Voluntary Sector Providers and Mental Health organisations within Devon participated through completion of a self-assessment tool. Through this work the following immediate areas of priority have been identified as a part of the strategy;

- **Expansion of the Dementia Adviser Service**

Within the NICE Guidance for Dementia (Draft January 2018) there is a clear need to for individuals with Dementia to have a named coordinator, to support them post diagnosis to live well with Dementia. This will ensure that there is early support for individuals before they reach crisis. This will improve outcomes for individuals and their carer/family.

Additionally, evidence has indicated that there is also a need for specialist support to staff within a physical Acute and Community setting, to avoid non-elective admissions where possible, to reduce lengths of stay and to support decision making in terms of discharge location.

Therefore, the existing Dementia Advisor Service will be expanded to deliver an integrated service with secondary care and primary care and also to achieve a lower ratio of advisors to population (specification of which will require further definition) **by the end of July 2019**.

- **Specialist support within Care Homes**

There has been a successful implementation of a Care Home Education and Support Team across some parts of Devon, including Torbay, which has been partly funded by the Improved Better Care Fund (iBCF). The Team was created in response to the fact that improved health outcomes mean that people are living longer with dementia and are much more likely to reach the latter stages of the illness when both behavioural challenges and frailty are much more common.
The team support staff and individuals within Care Homes, to reduce the risk of escalation of symptoms, inappropriate admissions to acute hospitals or specialist Dementia wards, allowing individuals to remain within Care Homes for as long as is appropriate.

There will be a phased implementation of this support to Care Homes such that by the end of September 2018 the service will have been implemented in North Devon and a complete roll out to include East and West Devon (including Plymouth) **by the end of April 2019**.

- **Replacement respite care**

One of the key difficulties identified within the evidence used for the hypothesis was carer/family breakdown, which then led to an escalation in the behaviours and need for the individual with Dementia.

It is clear that a 'one size fits all' approach is not always appropriate and therefore a range of options must be provided. Within Devon there are examples of activities which are being undertaken, as commissioned, voluntary sector or self-funding activities.

**Through the life of this strategy** there is a clear need to engage with charities, people, carers and communities to encourage and stimulate innovation.

- **Prevention**

Informing people of the lifestyle factors that present a risk in terms of developing dementia and supporting them to make informed choices to reduce those risks is recognised as an area where further work is required. Alignment with the wider prevention strategy within the STP is essential and dementia will have a voice in that strategy rather than a separate work stream as a part of this strategy.

- **Awareness and training**

Awareness and training provision has been identified as inconsistent. This also highlighted a lack of clarity and understanding of roles and responsibilities across the different parts of the health and social care sector. It was also noted that whilst there were pockets of excellence in terms of Dementia Friendly Organisations and Communities and that this needed to be expanded across Devon.

A consistent STP wide approach to Dementia Training and to support voluntary sector organisations, by providing them with training materials, is required. A training needs analysis will be undertaken by **March 2019** and implementation plan formulated and delivered from the beginning of **June 2019**.

- **Dementia Diagnosis**

The national target has not been met within Devon. It was also noted that whilst there is a known pathway to the Memory Service, with the release of the NICE Guidance and comments around referrals from Community Services, the pathways should be reviewed by both provider organisations.

The aim is to achieve 67% **by 31st March 2019**, however work will need to be done as part of the Memory Pathway review work to ensure that primary care are fully informed and supported to either make a Dementia diagnosis themselves or to refer in for further evaluation with the Memory Service.

**Transformation programme 4 – Primary and Secondary Care interface**

The case for more integrated mental and physical health services to support patient needs with an emphasis around the transition between acute and primary care services has been clearly established both in terms of outcomes based evidence, feedback from stakeholders and is one of the key drivers within the Five Year Forward View.

It is acknowledged that primary care providers have the largest number of patient contacts in the health system across both physical and mental health (c93%) and as such this programme also needs to complement and align to the Primary Care Five Year Forward View and STP Primary Care strategy.

**Physical health needs**

Best practice evidence indicates that where primary care teams deliver care collaboratively with secondary care services outcomes are improved for people. The lead responsibility for assessing and supporting physical health will transfer depending on where an individual is in their pathway of care.

To ensure that people with mental health conditions receive the necessary physical health checks shared care protocols will be established between acute and primary care providers.

- By the **end of September 2018** there will be an agreement in place to ensure the physical health checks associated with antipsychotic medication are clearly defined between primary and secondary care
- **By End of September 2018**, there will be a consistent approach across the whole of Devon for the delivery of physical health checks for Mental Health. There may be differences in terms of methodology; however the outcomes will ensure compliance with the targets as set out within the Five Year Forward View for Mental Health.

**Pre referral advice and Guidance**

As in physical healthcare pathways, allowing GPs timely access to secondary care specialist opinion reduces the transactional nature of a referral from primary to secondary care. Utilising Information Technology clinicians are able to seek advice and guidance in a timely manner to better assess the nature of a patient condition before deciding whether a referral into secondary care services is the most appropriate course of action. People also benefit as there is often a reduced delay in their progression to the best service to meet their need. By the **end of March 2021**, there will be a comprehensive IT enabled advice and guidance service universally available to GPs in Devon into specialist mental health services.

**Education and training**

Supporting people to recognise the characteristics of the varying degrees of mental illness and supporting them in knowing how to respond in the most appropriate way is a key aspect of the knowledge and experience that can be provided by secondary care clinicians to primary care colleagues.

By the **end of December 2018** a comprehensive and structured programme of education and training for primary care staff will be established with a delivery plan identified. We will also link in with the Regional Teams to ensure best practice.

**Integrated Psychological Medicine Service (IPMS)**

We are proposing integration in our approach to the care of people with physical and psychological symptoms because it will improve the outcome for people with long-term medical conditions, improve the care for people with unexplained symptoms and improve the medical care of people with mental illness. This innovation in partnership with the Centre for Mental Health, the University of Exeter Medical School and the Royal College of Psychiatrists aims to find the right model of integration for the people of Devon.

A consultant delivered service drawing from psychiatry, psychological therapies and medicine integral to the multidisciplinary teams working on medical and surgical care pathways.
The team will have the expertise to understand:

- Biomedical care and the creation of an evidence-based medicine management plan
- Psychological care and set a psychological therapies intervention plan to evidence based outcome.
- Social care and set a social care intervention plan to evidence based outcome.
- Skilled to offer brief intervention in all areas.
- Experienced in working with young people in a preventative way

The team will direct people to the most appropriate service for the intensity and complexity of the condition including IAPT (for psychological therapy), support for self-management of condition, medical psychotherapy for people with high complex needs or a link to specialist services such as eating disorder, substance misuse, dementia etc.

A pilot of this service has been undertaken in Exeter. This pilot will be evaluated by the **end of September 2018** and consideration given to the expansion of the service across Devon.

**Improving Access to Psychological Therapies (IAPT)**

IAPT is essentially a primary care service which has significantly expanded in recent years and more recently to include a small number of long term conditions from secondary care referrers in North, East and West Devon.

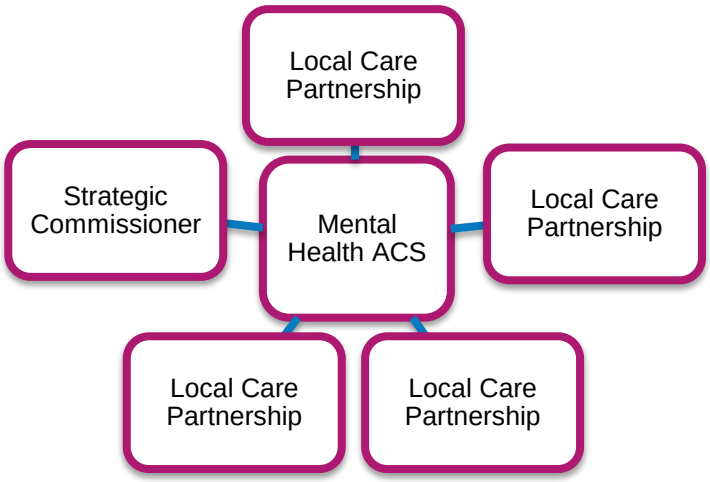
By the end of **June 2018** the South Devon will also have the first phase of long term conditions included in the service specification.

Building on the IAPT services in place across Devon, **by the April 2019**, these services will expand access to a larger number of people through a more comprehensive list of long term physical conditions being referred from secondary care specialists. **Transformation programme 5 - Development of Mental Health Care Partnership (MHCP)**

Devon has recognized that in the context of rapid change and demographic and fiscal challenge there is a need to:

- Safeguard the strategic prioritisation Mental Health
- Secure delivery of improvements in the mental health of our population
- Secure the improvement of physical health of people with mental illness

To support the achievement of the STP ambitions and the Mental Health strategy, connectedness of the mental health is essential. Some of the interdependencies are identified below;




The goals of the MHCP are set out below;

**Less mental illness.**
**Better patient experience**: joined-up care; getting early help; engaging young people; supported self management; influence on the whole system of care; supporting the whole of me; learning better by experience.
**Relieved pressure on primary care** by working in local integrated teams: better screening; electronic consultations; ambulatory case management; telepsychiatry, psychiatric consultants working in a consultation-liaison model, shared data and information.
**Better support to secondary acute and social care.**

**Resources moved** (money and scarce MH expertise) from centralised high cost interventions **towards local prevention** of the illness that requires those interventions, like suicide prevention

**Re-balanced investment in whole person care** through joint design and implementation of whole life (all age) systems of support for people, surrounding excellent clinal pathways.

Systems of support that **reduce the effect of MH conditions** on those with principal physical health issues and **reduce the effect of physical health issues** on those with principal MH issues

new models of care; bringing people back to Devon; parity of investment

Poor patient experience; pressured primary care, secondary acute and social care; inefficient use of scarce MH resource; ineffective prevention; missed opportunity to empower local leaders and learn from others

| Ask of MHCP | Offer from MHCP |
|---|---|

| | |
|---|---|
| Co-commission adequate housing, accommodation and occupation with relational care support for the most vulnerable people in Devon | Sharing of mental health provision for aftercare to help sustain and promote third sector support for pathways for the most vulnerable people |
| Co-create NEW IAPT LTC , Core24 and Primary Care Home models to drive mental & physical integration and connect with social care and third sector | Management of delivery of IAPT and Core24 to CQC outstanding in hospitals and general practice and support the creation of Primary Care Home |
| Fully commission specialist mental health teams and beds in Devon including PICU supported by new CIRT & FACT higher intensity community models | Will optimise out of county care bed use for only those with needs met at the 5million or 50million population level and supply mental expertise to Primary Care Home integrated care teams from those specialist teams face to face and by tele-health |
| Commission the Dementia Case in full | Will own and deliver the pathway from consultants to navigators engaging all sectors |
| Lead for suicide prevention | Deliver whole population suicide prevention through Project Zero |
| Share sites, supporting functions and have common IT | Will share our space, our risk management, financial, operational and IT expertise developing a clinical research electronic patient record |
| Co-produce the workforce of the future | Provide excellent education training and development in mental health practice, coaching, mentoring and supervision |
| Risk stratify the population for targeted evidence based interventions | Support the 'place' delivery for high volume lower cost, complexity & risk whilst we deliver lower volume higher cost, complexity & risk and share quality improvement expertise. [include link to STP Risk Stratification work] |
| Pool budgets around risk stratified populations | Devolve budget to partners in Primary Care Home Model for delivery |
| Commission services to an established evidence base and where salient commission robust evaluation | With University partners attract international level research in every therapeutic area we provide for and conduct robust research evaluation on behalf of the system using the UK-CRIS clinical research information system to drive audit, evaluation, QI and research. |

By **May 2018;**

- complete broad engagement to develop options appraisal for the scope and form of the MHCP
- present options appraisal to the Mental Health Programme Group

By end of **May 2018** we will have in place;

- Agreed terms of reference

- Confirmed chairing arrangements
- Established partnership arrangements
- Those with control over material resources and those who have material influence over how those resources are used
- Wider stakeholders
- Established baselines for finance and performance
- Accountability agreement
- Contractual arrangements

By end of **May 2018** develop an engagement plan

By **June 2018** develop implementation plan for form of MHCP

By **September 2018** implement plan and deliver shadow contractual governance

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

| | | | |
|---|---|---|---|
| **Title:** | Torbay Influenza (flu) Vaccination Plan 2018/19 | | |
| **Wards Affected:** | All | | |
| **To:** | Health and Wellbeing Board | **On:** | 06 September 2018 |
| **Contact:** | Rachel Bell | | |
| **Telephone:** | 01802 207386 | | |
| **Email:** | Rachel.bell@torbay.gov.uk | | |

## 1. Background

Flu is a major cause of harm in the population and is a key factor in NHS winter pressures. Preventing flu infection through vaccination also contributes to preventing bacterial infections such as pneumonia. This can help reduce the need for antibiotics and contribute towards preventing antibiotic resistance.

This highlight report outlines Torbay's Influenza (flu) Vaccination Plan for the 2018/19 season. This local plan is informed by wider national and regional plans as outlined below.

### 1.1 National Overview

The National Flu Plan 2018/19 (Appendix 1) sets out a co-ordinated and evidence-based approach to planning for and responding to the demands of flu across England, taking account of lessons learnt during previous flu seasons. It aids the development of robust and flexible operational plans by local organisations and emergency planners within the NHS and Local Government.

The National Flu Letter (flu letter: no.1) [Appendix 2] provides information about which patients and children are eligible for vaccination in the flu immunisation programme for 2018/19, what vaccines are appropriate for each eligible group and useful appendices which cover evidence base, vaccine supply and ordering, contractual arrangements and communications. A second letter will follow with information about frontline healthcare workers and social care workers imminently.

#### 1.1.1 Eligible Groups and Ambitions

In 2018/19 the one change in eligibility is the additional cohort of children, those in school year 5 (school year 6 will be the only cohort that is not vaccinated). For a full list of eligible groups, vaccination ambitions for 2018/19 and vaccination coverage for 2017/18 please see Table 1 over the page.

### 1.1.2 Vaccine Types

Based on the Joint Committee on Vaccination and Immunisation advice, providers should offer:

- **The adjuvanted trivalent vaccine (aTIV) for all 65s and over.** This is the most effective and cost effective vaccine currently available for this group (including the quadrivalent vaccine). An adjuvant is a substance that is added to a vaccine to increase the body's immune response to the vaccine – vaccine response tends to wane as we get older.
- **The quadrivalent vaccine (QIV) for 18-64 years at risk, pregnant women and frontline workers.** This protects against four strains of flu.
- **Live attenuated vaccine (LAIV) used for the children's programme is also quadrivalent.** An attenuated vaccine is created by reducing the virulence of a pathogen (rendering it harmless without killing it). This is a nasal spray vaccine so generally more acceptable to children.

**Table 1: Eligible groups, ambitions and previous uptake**

| Eligible group | National vaccine uptake ambitions 2018/19 | Torbay vaccine uptake 2017/18 |
|---|---|---|
| All children aged two to nine (but not ten years or older) on 31 August 2018 | Pre-school children aged 2 and 3 years – 48% with most practices aiming to achieve higher | 44% |
| | School aged children (in reception class & year 1 to 5) – An average of at least 65% to be attained by every provider across all years | ~61% |
| Those aged six months to under 65 years in clinical risk groups* | At least 55% in all clinical risk groups and maintaining higher rates than have already been achieved | 49% |
| Pregnant women | At least 55% and maintaining higher rates than have already been achieved | 50% |
| Those aged 65 years and over | 75% (reflecting WHO targets) | 71% |
| Those in long-stay residential care homes | No specific target but 75% for those 65 years and over and 55% for those under 65 years in a clinical risk group. | Unknown |
| Carers | No target set | 40% |
| Social care workers** | 75% (part of Front-line Health Care Workers) | ~49% |
| Front-line Health Care Workers | 75% (reflecting WHO targets) | 63% |

*Chronic respiratory disease, COPD, chronic heart disease, chronic kidney disease, chronic liver disease, chronic neurological disease, diabetes, splenic dysfunction, weakened immune system, morbidly obese (BMI of 40 or above)

**A recent announcement has been made by NHS England to continue to make funding available in 2018/19 to support the vaccination of social care workers that offer direct patient/client care. This will supplement any established occupational health schemes that employers have in place to offer the flu vaccination to their workforce. In addition, funding is to be extended to include health and care staff in the voluntary managed hospice sector that offer direct patient/client care. Detailed guidance is awaited.

### 1.1.3 Timing

Ideally vaccine should be completed before the end of November; however in general it is appropriate to still offer vaccination to eligible patients at any subsequent point in the flu season. This can be particularly important if it is a late flu season or when newly at risk patients present. The decision to vaccinate should take into account the level of flu-like illness in the community, bearing in mind that the immune response can take about two weeks to develop fully.

### 1.1.4 Communications and marketing

An integrated communications strategy will be produced for the national flu immunisation programme 2018/19. The strategy is led by PHE and will provide communications colleagues in partner organisations with information and resources to assist the delivery of the programme. Template letters and information will be made available for GPs, schools, healthcare practitioners delivering the vaccine and different eligible groups. All materials will be made available on the GOV.UK website at: https://www.gov.uk/government/collections/annual-flu-programme.

## 1.2 Regional Overview

The South West 2018/19 Vaccination Plan is awaiting sign off and will be circulated imminently by NHS England and Public Health England. This will provide a robust operational plan to be used across the South West to support health and social care partners to deliver the 2018/19 annual flu immunisation programme effectively and safely. **Local plans will hinge on this South West plan.**

System leadership and oversight for the planning and implementation of the 2018/19 season flu immunisation programme will be managed through the North and South Strategic Flu Groups. Group membership includes NHS England Commissioning, Public Health England, Local Authorities/Public Health, CCGs, Local Pharmaceutical Committee (LPC) and the Local Medical Committee (LMC). The groups will meet monthly throughout the flu season (September to February) and local organisations will be required to feedback as relevant. An example of local authority feedback is included in Appendix 3.

## 1.3 Local Overview

The South West 2018/19 Vaccination Plan is the main plan which Torbay and South Devon organisations will be working towards as a system. Locally the Torbay Public Health team, with CCG colleagues, convened a Torbay and South Devon flu planning group for 2018/19. The main objectives are to:

- Agree priority areas for additional local targeted action; and
- Support Torbay contributions to the South West Strategic Group planning process and implementation of the South West Flu Plan.

Membership of this group includes representatives from the Local Authority, Integrated Care Organisation (ICO), CCG, LPC, and LMC. Teleconference meetings are held on a 4-6 weekly basis. Priority areas for action are outlined below and detailed further under heading 4 of this report:

- Care home and domiciliary care staff – this will help to protect the vulnerable groups they care for;
- People with a chronic health condition aged 6 months – 65 years;
- Children 2-3 years; and
- Frontline health and care staff

## 2 What has been achieved in the past six months?

- Torbay and South Devon multi-agency flu planning group established to help coordinate and support local action;
- Devon-wide online survey co-created with colleagues in Devon and Plymouth to retrospectively estimate numbers of staff vaccinated during the 2017/18 flu season. This provides a template for this year. Summary report provided in Appendix 4.

## 3. What are the blockages?

3.1 Barriers to increasing vaccination uptake are multiple and complex. Some of the key areas are:

- Public awareness of eligibility for vaccination;
- Individual reluctance to be vaccinated or lack of understanding of the effectiveness of the vaccine in protecting against flu (myth busting);
- Understanding the crucial importance of staff vaccination in helping to protect vulnerable clients and patients;
- Operational issues – finding time and convenient GPs/Pharmacies for vaccination, having enough trained staff available to deliver vaccine, vaccine supply/storage issues and financial constraints.

3.2 Identified risks

- Financial constraints mean that Torbay Council will not be in a position to provide staff with free flu vaccination vouchers for the 2018/19 season. This is at odds with recommendations as an employer to provide a flu vaccine for children's social care staff (https://www.gov.uk/government/publications/flu-vaccination-who-should-have-it-this-winter-and-why) and has implications in terms of staff business continuity during the flu season.

- Potential vaccine supply issues for aTIV: GPs and Community Pharmacies will receive 40% of their aTIV order in September, 20% in October and 40% in November. Appropriate planning is required to ensure all patients aged 65 years and over receive their vaccine before the flu season starts (generally December, although sometimes earlier). NHS England has suggested prioritisation is as follows in descending priority order: 75 years and over and those in care homes; 65-74 year olds in clinical risk groups and 65-74 years NOT in a clinical risk group.

## 4. What is the planned activity for the next six months?

| Priority | Action | When |
|---|---|---|
| Increase vaccination coverage in: **6 months to under 65 years clinical risk groups** | • Send promotional flu material (including myth busting quiz slides) to patient support groups for conditions that fall under a clinical risk group.<br>• Targeted CCG, ICO, LA, CDT and Healthwatch communications to individual risk groups including those amongst their own staff. | Oct<br><br>Oct-Nov |
| Increase vaccination coverage in: **children 2-3 years** | • Send promotional flu material via early year's settings distribution lists.<br>• Some GP practices (e.g. Chilcote Practice) running incentivised 'flu parties' for 2-3 year olds in low coverage areas. | Oct-Nov<br><br>Sep-Nov |
| Increase vaccination coverage in: **Care home and Domiciliary Care Staff** | • Update Care Homes and Domiciliary Care Managers at the Care Managers Forum of current vaccine arrangements, further promote the NHS Care Home Toolkit, myth busting and request total staff and vaccination numbers for regional monitoring purposes.<br>• Ongoing promotion via newsletter to Care Homes and Domiciliary Care Providers.<br>• iBCF business case to fund a small team to vaccinate staff on-site or in convenient locations, at times suitable for staff. To be used this year if possible (and vaccine refund can be provided by NHSE) or in preparation for next year as it is likely that NHSE will not continue to fund care staff vaccination year on year. | Oct<br><br>Oct-Jan<br><br>Aug-Sep |
| Increase vaccination coverage in: ICO staff **(Front-line Health Care Workers)** | • Recruitment of voluntary peer vaccinators who will cover clinics and opportunistic vaccination across ICO hospital settings.<br>• Workforce comms promoting flu vaccination via emails, screensavers and staff newsletters.<br>• Potential to incentivise vaccination with the 'Get a Jab. Give a Jab' scheme which offers vaccinations to third world countries every time a staff member is vaccinated and/or be | Aug-Feb<br><br>Sep-Jan<br><br>Sep-Feb |

| Priority | Action | When |
|---|---|---|
| | enrolled in a competition for additional annual leave. | |
| Multi-agency communications strategy | • Torquay museum is running a flu exhibition on the 100th anniversary of Spanish Flu from October to February. Agencies are encouraged to link their comms with the museum to promote local delivery of flu vaccination.<br>• LA, ICO and CCG communication leads to link up to coordinate messages and delivery channels throughout the flu season in accordance with national communications and marketing materials.<br>• Potential for Councillor Flu Champions to promote vaccination and 'myth bust' in their communities. | Oct-Feb<br><br>Sep/Oct<br><br>Sep/Oct |

**Appendices**

1) The National Flu Plan 2018/19: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/600532/annual_flu_plan_2017to2018.pdf
2) The National Flu Letter (flu letter: no.1): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694779/Annual_national_flu_programme_2018-2019.pdf

[Appendices continued over the page]

3) Example Local Authority feedback table for regional flu monitoring

| | **Local Authority: Enter name of LA name & job title of person providing report** |
|---|---|
| **1.** | **Progress report** |

| | | |
|---|---|---|
| **1.1** | Employee vaccination rates* | |
| **1.2** | Care Homes Staff rates | |
| **1.3** | Campaigns – e.g. Carer's Networks | |
| **1.4** | Promotion with hard-to-reach groups | |
| **2.** | **Issues to report** | |
| **2.1** | Insert details of issue | Insert commentary on key issues and developments |
| **3.** | **Any challenges or requests for support from the Flu Group** | |
| | Insert details of challenge | Insert comments |

4) Post-season flu vaccination uptake in care home and domiciliary care staff. Devon, Plymouth and Torbay (see next page).

# Post-season flu vaccination uptake in care home and domiciliary care staff Devon, Plymouth and Torbay

In May 2018, two online surveys were sent to care home and domiciliary care providers in wider Devon to retrospectively measure flu vaccination uptake in their staff for the 2017/18 flu season. The surveys were run over a one to two week period (17th May to 1st June) dependent on the local authority area.

35 care homes and six domiciliary care providers responded to the surveys – giving an extremely low response rate overall. Please note that due to the low number of responses from domiciliary care providers, it is recommended that percentages (unless based on individual staff) should not be directly compared with care home provider percentages.

The follow report summarises the responses received from the surveys in question order and, based on the data, gives recommendations for the 2018/19 flu season.

## Respondent demographics – care homes

***Which local authority area is your care home in?***

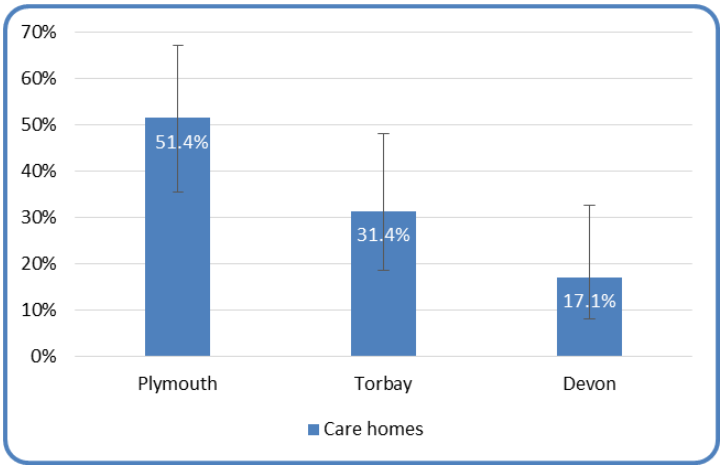



**Fig1: Percentage of care home respondents split by their Local Authority area**

The majority of respondents (51.4%, n=18) were from Plymouth, 11 from Torbay and 6 from Devon.

This question is not reported for domiciliary care providers due to small numbers.

***What is your nursing home type?***

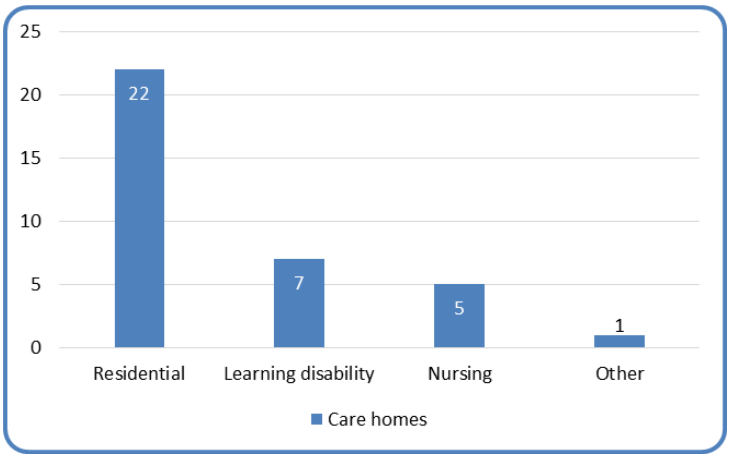



**Fig2: Count of care home type**

The majority of care homes (62.9%) were classified as residential homes.

The description for 'Other' is as follows: 'Residential with nursing for dementia/mental health'.

## Staff flu vaccination uptake

***Did you/your care home provide flu vaccines for staff last flu season (September 2017 to March 2018)?***

| | Care home | | Domiciliary care provider | |
|---|---|---|---|---|
| **Answer choices** | **Number** | **%** | **Number** | **%** |
| Yes | 27 | 77.1% | 5 | 83.3% |
| No | 8 | 22.9% | 1 | 16.7% |
| Total | **35** | **100.0%** | **6** | **100.0%** |

**Table 1: Responses by provider type**

The majority of respondents provided flu vaccines for their staff.

***If 'Yes', how were they offered?***

29 (82.9%) care homes and 5 (83.3%) domiciliary care providers answered this question. The majority offered free NHS England funded vaccinations as shown in Table 2 below.

**Table 2: Responses by provider type**

| | Care home | | Domiciliary care provider | |
|---|---|---|---|---|
| **Answer choices** | **Number** | **%** | **Number** | **%** |
| Free NHSE funded vaccinations (via GP or pharmacy) | 22 | 75.9% | 4 | 80.0% |
| Combination of free NHS England funded vaccinations and care home offer to staff | 4 | 13.8% | 0 | 0.0% |
| Solely funded by the care home/domiciliary care provider | 2 | 6.9% | 0 | 0.0% |
| Other | 1 | 3.5% | 1 | 20.0% |
| **Total** | **29** | 100.0% | **5** | 100.0% |

The descriptions for the answer 'Other' are as follows:

- 'The home didn't provide vaccinations , but staff were advised to go to the pharmacy or the GP'
- 'Most were free as the regs changed, but also paid for 1 member of staff. There were also staff that were eligible due to health reasons'

***If 'No', why not?***

Seven (20%) care homes and one (16.7%) domiciliary care provider answered this question. The main reason flu vaccines were not provided was that staff went to their own GP surgeries/arranged vaccines for themselves.

**Responses by care home providers:**

'All staff who wanted the vaccines did so after receiving the information supplied by the appropriate people from own GP surgeries. Staff that were experiencing financial difficulties had the vaccines paid by the home'

'We surveyed the Staff and those who wanted one arranged their own vaccines'

'Staff went to own surgeries'

'staff were informed to have vaccination'

'Each clients surgery sent nurses out'

'Care staff independently went to their own GP'

'Majority of staff went to their surgeries to get a vaccine done prior to the home trying to access any due to a shortage of vaccines'

**Response by domiciliary care provider:**

'costs involved, unaware of any support that could have helped'

***How many health and social care staff do you employ and of these how many received a flu vaccination during September 2017 and March 2018?***

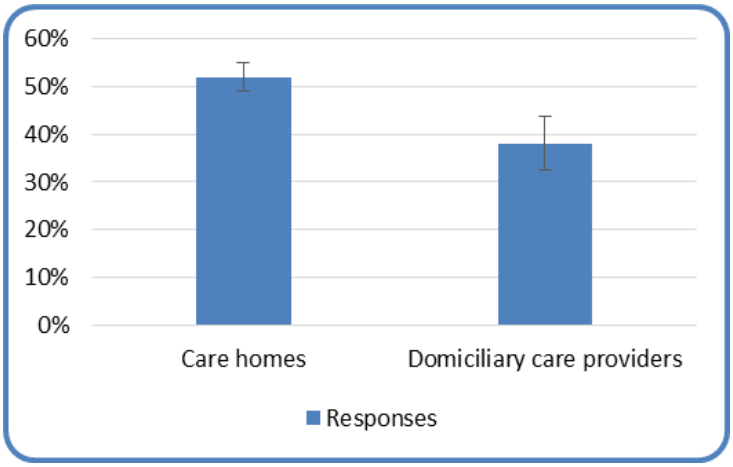



**Fig3: Percentage of care and domiciliary care staff who received a flu vaccine**

A significantly higher percentage of care home staff had a flu vaccination than domiciliary care staff.

107 of the 283 domiciliary care staff had a vaccine. 555 of the 1063 care home staff had a vaccine.

The percentage of staff in each care home who received the vaccine ranged from 0% to 100% with a mean of 51%. The percentage working for each domiciliary care provider who received the vaccine ranged from 10% to 67% with a mean of 40%[1].

***Please indicate whether this uptake information was collected throughout the season or if you have provided a retrospective estimate?***

Around half of care homes and domiciliary care providers provided a retrospectively estimated figure of the number of staff that were vaccinated as shown in Table 3 below.

**Table 3: Responses by provider type**

| | Care home | | Domiciliary care provider | |
|---|---|---|---|---|
| **Answer choices** | **Number** | **%** | **Number** | **%** |
| Recorded throughout the season as staff were vaccinated | 17 | 48.6% | 3 | 50.0% |
| Retrospective estimate | 18 | 51.4% | 3 | 50.0% |
| **Total** | **35** | **100.0%** | **6** | **100.0%** |

## Promotion of staff flu vaccination

***Did you use any of the following resources to promote flu vaccination to your employees?***

**Table 4: Responses by provider type**

| | Care home | | Domiciliary care provider | |
|---|---|---|---|---|
| **Answer choices** | **Number** | **%** | **Number** | **%** |
| NHS Employers Flu Fighter Campaign | 13 | 37.1% | 3 | 50.0% |
| NHS England/Public Health England Infection Control and Winter Readiness Pack for Care Homes | 19 | 54.3% | 0 | 0.0% |
| The winter checklist within the NHS England/Public Health England Infection Control and Winter Readiness Pack for Care Homes | 14 | 40.0% | 0 | 0.0% |
| Other resources | 9 | 25.7% | 3 | 50.0% |
| **Total respondents** | **35** | | **6** | |

Respondents could choose multiple answers to this question. The majority of care homes used the Infection Control and Winter Readiness Pack provided by the NHS and Public Health England. Domiciliary care providers used a mix of the NHS Employers Flu Fighter Campaign and 'other' resources – mainly posters and flyers. Two providers answered 'None'.

[1] Matching the individual response for staff receiving the vaccine with the individual response for total staff employed has been carried out using the date, time and order the responses were input, but there is a possibility of mismatching.

The comments for ‘Other resources’ were:

| **Responses by care home providers:** |
|---|
| ‘Our own flu campaign - notice board / flyers etc.’ |
| ‘Caring for care homes flu special’ |
| ‘www’ |
| ‘Risk assessment and catch it, bin it, kill it posters etc.’ |
| ‘contacted by the pharmacy we put a notice up’ |
| ‘Discussed importance of Flu Vaccine at Staff Meeting’ |
| ‘in house poster’ |
| ‘unknown’ |
| **Response by domiciliary care providers:** |
| ‘Emailed staff with info’ |
| ‘Our own in house awareness’ |

***Do you have any comments about the resources listed in the previous question?***

23 (65.7%) care homes and six (100%) domiciliary care providers made no comment. Themed responses from the remaining care homes that answered this question are shown below.

| **Theme** | **Examples of responses by care home providers:** |
|---|---|
| Useful, helpful information (10 responses) | ‘All these provided useful information and toolkits. It was very easy to download and order flyers / posters etc. from the internet and other Flu sites to support a campaign’<br>‘Very useful resources to provide my staff with information and guidance’ |
| Suggestions for improvement (2 responses) | ‘Single approach please’<br>‘Maybe resources should be sent through the post without applying for them’ |

***Did you undertake any additional activity to promote flu vaccination to your staff?***

Six care homes (17%) and four domiciliary care providers (66%) answered ‘no’ to this question. Themed responses from the remaining care and domiciliary providers are shown below*.

| **Theme** | **Examples of responses:** |
|---|---|
| At supervision and staff meetings (12 responses) | ‘Advised staff through staff meetings, having been to the forum gaining feedback from there and communicating with staff the importance if the flu vaccine’ (CH)<br>‘During individual supervision flu vaccines were actively discussed’ (CH) |
| Posters and written information (10 responses) | ‘Notice board and leaflet drop’ (CH)<br>‘Yes we provided information to Staff as to who was eligible for the Vaccines and where they could get Vaccinated, we also put up |

| | |
|---|---|
| | posters for Staff and told them the importance of having a Flu Vaccination' (CH) |
| Verbal communication and recommendation (8 responses) | 'Personal recommendation' (CH)<br>'Spoke to staff individually and recommended the vaccine…' (CH) |
| In house awareness (4 responses) | 'In house information' (DC)<br>'Made staff aware about protecting Residents and their own families' (CH) |
| Worked with the pharmacy (2 responses) | 'Partnership with local pharmacy in relation to cost and drop in times…' (CH) |

*CH denotes a response from a care home provider and DC shows a response from a domiciliary care provider

***Do you have any other comments, particularly in terms of how we can support you with promoting uptake of flu vaccinations next season (2018/19)?***

16 (45.7%) care home and three (50%) domiciliary care providers responded 'no, none or not sure (one response)' as their comment to this question. Themed responses from the remaining care and domiciliary providers are shown below*.

| **Theme** | **Examples of responses:** |
|---|---|
| Written information and displays (4 responses) | 'maybe have a flyer we could hand out to all staff and relatives to give them a better understanding of the importance of having a flu vaccination' (CH)<br>'Sending Poster to Care Home ready to display well in time' (CH) |
| Staff concerns (i.e. side effects) (4 responses) | 'General perception amongst staff is negative regarding the side effects of the flu jab. We have tried to promote the positive effect of having the vaccination for both staff and our residents. So I feel more promotion on the myths/ perceived negatives of the vaccinations would help' (CH)<br>'Dispel some of the myths around the flu vaccine (making people ill being one)…' (DC) |
| Accommodating staff availability (3 responses) | '…dedicated Dom Care facility (roaming) to enable care workers to attend during visits (or specifically when Dom Care is not busy i.e. 2pm - 4pm)' (DC)<br>'I feel staff would be more willing to have a Flu Vaccination if it was done in the Home when the District Nurses come to vaccinate the Residents as I think some staff couldn't be bothered or never had the time to go to the Surgery' (CH) |
| Cost, and free of charge vaccines (3 responses) | 'Due to the vaccination being provided for free I feel this encouraged staff to get the vaccination.' (CH)<br>'In the past GPs have refused to provide the flu jab to domiciliary staff and the agency has had to pay for it…' (DC) |
| Advice, updates and feedback (3 responses) | 'Regular feedback' (CH)<br>'Keeping the manager up to date with any new research and best practice, and benefits with regards to the flu vaccine' (CH) |
| Promoting uptake next year (2 responses) | 'No - uptake was better this year and we hope we can improve on that next year' (CH) |

| Theme | Examples of responses: |
|---|---|
| Miscellaneous (4 responses) | 'Access to jabs is not easy' (CH)<br>'Further emphasis placed upon vaccinations, if not already, included within PCC Provider Contracts' (CH)<br>'Staff will listen more to other professionals for the reasons why flu vaccinations are recommended, perhaps a visiting professional could reiterate the importance of... (funding permitting of course)' (CH) |

*CH denotes a response from a care home provider and DC shows a response from a domiciliary care provider

## Recommendations

Based on the data presented in this report the following is a list of recommendations for the 2018/19 flu season. Please be aware that, in some cases, these are recommendations are based on a small number of responses and therefore may not be truly representative:

- The majority of care and domiciliary care providers used free NHS England funded vaccinations for their staff. This should continue to be encouraged to maintain and/or improve staff vaccination rates.

- Staff vaccination is lower in domiciliary care staff as compared with care home staff. Interventions to increase domiciliary care staff uptake should be encouraged.

- There are inconsistent messages from providers in relation to staff vaccination with some taking ownership and encouraging staff to be vaccinated and others leaving the choice to their staff. A consistent message from providers that vaccination is recommended to protect staff and service users is recommended, with potential for this to be emphasised in commissioner contracts or through business continuity plans.

- Encouragingly a large proportion of care home and domiciliary care providers make use of resources provided by NHS and Public Health England (PHE) to promote flu vaccination. These should continue to be produced and promoted (and possibly pre-printed before sending to providers – particularly posters and leaflets) with a recommendation to explore the development of a domiciliary care winter readiness pack.

- The main promotional methods used by care and domiciliary care providers were verbal via staff meetings and individual supervision and through the display of posters and distribution of leaflets. Some providers noted a general negative perception amongst staff regarding the side-effects of the vaccine and this could be an opportunity to dispel myths through future promotional material.

- Better accommodation for staff working hours and availability was sighted as barrier for vaccination. Most would prefer on-site vaccination as opposed to arranging via a GP or pharmacy. For the future there may be opportunities to combine service user vaccinations with staff vaccinations.

**Background Papers:**

- The National Flu Letter (flu letter: no 1) – see appendix 2
- NHS England gateway reference: 08188: Flu vaccinations for 2018 and planning clinics: https://www.england.nhs.uk/publication/flu-vaccinations-for-2018-and-planning-flu-clinics-letter-from-david-geddes/

- Post-season flu vaccination uptake in care home and domiciliary care. Devon, Plymouth and Torbay – see appendix 4
- CONFIDENTIAL TO THE PUBLIC: Draft Seasonal NHS Influenza Programme. Planning across South West 2018/19 – not included
- CONFIDENTIAL TO THE PUBLIC: DCIOS Health Protection Committee: Screening and Immunisation Quarterly Update – not included
- CONFIDENTIAL TO THE PUBLIC: Torbay flu telecom 11 April 2018 PowerPoint – not included

TORBAY Health & Wellbeing BOARD
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| | |
|---|---|
| **Title:** | **Adult Social Care Eligibility Policy and Guidance** |
| **Wards Affected:** | All |
| **To:** | Health and Wellbeing Board **On:** 6 September 2018 |
| **Contact:** | Joanna Williams, Deputy Director of Adult Social Services |
| **Telephone:** | 01803 547045 |
| **Email:** | Joannawilliams3@nhs.net |

## 1. What has been achieved in the past six months?

1.1 Following full consultation with the public, the ASC Eligibility Policy was agreed by Mayoral decision at PDG and via TSDFT's governance process and the PDG requested a review in 6 months via a report to the HWBB.

1.2 The Trust has focussed staff training on equipping our staff to use the Strengths Based Approach in all of our interventions with people. This policy is a central element of this social care change programme; focussing more on community interventions and less process/paperwork for staff. The programme will review the current operating model, in order to develop one which is coproduced with the Community and Voluntary Sector. This will offer people quick access to preventative services and free up statutory staff to work in the community to manage risk, cost and complexity.

1.3 A key component of the policy's implementation via the publication of a guidance document to underpin the policy. The Principal Social Worker has drafted this guidance, which is for inclusion in the wider change programme for social care.

1.4 This guidance is attached, as signed for decision by the DASS in consultation with the Exe Lead of Adults. Any final amendments will be aligned with the social care change process in the light of that programme and ratified internally by TSDFT, as further presented to DASS and Exe Lead for Adults..

## 2. What are the blockages?

2.1 Due to the impending change program, and the probability that process will slightly alter; it is prudent to delay the publication of the policy and guidance until the wider change programme is underway. This is to ensure that messages to the public, partners and staff are consistent and clear.

## 3. What is the planned activity for the next six months?

3.1 The Policy and Guidance will be published and implemented in October 2018.

## Appendices

## APPENDIX ONE - DRAFT - Care and Support Eligibility Policy - Operating Guidance

Torbay and South Devon NHS
NHS Foundation Trust

**Care and Support Eligibility Policy - Operating Guidance**

## Contents

## 1. INTRODUCTION

Under section 9 of the Care Act 2014, Torbay Council and their delegated provider, Torbay and South Devon NHS Foundation Trust (hereafter TSDFT), have a statutory duty to assess the needs of any adult or carer who appears to have needs for care and support and then to determine whether those needs are eligible for support or services from the trust.

Sections 1 and 2 of the Care Act place overarching duties on the Trust to promote an individual's 'wellbeing' and to provide preventative information and/or support that could delay or reduce any needs identified during the assessment process.

This guidance underpins the eligibility policy in place in TSDFT.

## 2. WELLBEING

The principle of wellbeing requires that the wellbeing of all people who appear to be in need of care and support is promoted, including during their assessment and the application of eligibility criteria.

The Act defines wellbeing for individuals as:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over their day-to-day life (including over care and support provided and the way they are provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of the individual's living accommodation
- the individual's contribution to society.

There is no hierarchy in the areas of wellbeing listed above – all are equally important. Wellbeing is a broad concept applying to several areas of life and there is no single definition of wellbeing. How it is interpreted will depend on the individual, their circumstances and their priorities. Therefore, using a holistic approach during the assessment process is vital to ensuring a clear understanding of the individual's views and defining what wellbeing means for them.

## 3. PREVENTION

There is a statutory duty to take action to prevent or delay the development of needs requiring care and support. This duty applies to both adults with needs and young and adult carers with needs.

Where the person may benefit from specific types of preventative support, steps should be taken to assist the person to access those services. Consideration should be given to what else, other than formal services, might support the person to meet the outcomes they want to achieve. This includes identifying strengths, capabilities and resources available within the individual's network that they could draw upon. It also includes small adaptations, equipment or reablement.

## 4. PERSONALISATION

A cornerstone of the Care Act is to empower individuals through personalised care and to develop care services that best fit around their lives. This in turn can help prevent, reduce or delay the person's need for statutory care services while supporting them to optimise their independence and sense of wellbeing.

TSDFT is committed to using Strengths Based Approach.

## 5. SAFEGUARDING ADULTS FROM ABUSE AND NEGLECT

Safeguarding and risk assessment have always been a key part of the assessment and support planning processes. The Trust has a duty to make enquiries and take appropriate action if there is reason to expect that abuse has occurred or is likely to occur. If a safeguarding issue is identified during the assessment process, the Multi-Agency Safeguarding Policy and Procedures must be followed.

## 6. ASSESSMENT

### 6.1 What is an assessment?

The Care Act makes it clear that an assessment is to be treated as an intervention in its own right. The purpose of an assessment is to identify what needs the person may have and what outcomes they are looking to achieve to maintain or improve their wellbeing. As such, it provides an opportunity to help people find ways to reduce or prevent needs from escalating, and to build upon their personal strengths, capabilities and support that might be available in their wider network or community to meet their needs.
The assessment provides a basis for:

- understanding the person's life, wishes and abilities as well as their needs
- providing information and advice to the individual and targeting prevention services
- supporting the person to find ways to meet identified needs
- determining eligibility for services or other types of support
- identifying and managing risks in line with the council's safeguarding responsibilities
- working in partnership with health and other organisations, including sharing information
- calculating the personal budget required to meet the person's eligible needs

During the assessment process, consideration must be given to ways to help the person meet the outcomes they want to achieve. The assessor must work with the person to explore their own strengths and capabilities and what support might be available from their wider support network or within the community that the person might draw upon. Formal interventions to provide care and support should only be considered after the potential to help the person to help themselves has been exhausted.

Potential support from family and friends should be considered in the light of its appropriateness and their willingness and ability to provide any additional support and the impact on them of doing so. During the assessment a 'whole family approach' must be adopted to consider the impact of the person's needs for care and support on family members or any other relevant person. This means the assessor must identify anyone who may be part of the person's wider network of care and support and consider whether they would benefit from the provision of information, advice or signposting to support services in the local community.

### 6.2 Who can have an assessment?

An assessment must be carried out for any adult or carer who appears to have any level of needs for care and support. This duty applies regardless of whether the person's needs are likely to be eligible for local authority-funded support or whether the person has the means to finance their own care.
The assessment process can be initiated by:

- an approach to the local authority or a delegated organisation by an individual or by a third party acting on their behalf
- a hospital discharge
- the local authority or a delegated organisation if it becomes aware that a person may be in need of care and support.
- 6.3 *Adults in need of care and support*
- In addition to the general duty to assess, there are specific circumstances where an assessment must be carried out:
- where an adult may need care and support before they can be safely discharged from hospital
- where an adult in a custodial setting may have care and support needs

### 6.4 Carers

All carers are entitled to an assessment of their needs, regardless of their financial status (or that of the person they care for); whether the cared for person has eligible needs or not or if the person is being assessed for or is in receipt of continuing healthcare support. A carer's assessment must establish not only the carer's needs for support but also the sustainability of the caring role in the short and longer term.
The carer's assessment must also consider the outcomes that the carer wants to achieve in their daily life, their activities beyond caring and the impact of caring on these activities. This

includes the carer's desire and ability to work and partake in education, training or recreational activities, including having time to themselves. Carers should not be encouraged to give up existing paid employment.

### 6.5 Young Carers

If a child is involved in providing care for an adult, the adult must be offered a needs assessment and consideration given to whether the child should be referred for a young carer's assessment under section 63 of the Care Act, or a needs assessment under the Children Act 1989. Adult and Children's social care services should work together to ensure that the family's needs are assessed effectively as a whole.
When assessing an adult or carer, if it appears that a child is involved in providing care, consideration must be given to the impact of the person's needs on the young carer's wellbeing, welfare, education and development. The assessment should also take into account the parenting responsibilities of the adult. A young carer becomes vulnerable if their caring role leads to regular absences from school, affects their learning, prevents them from building friendships and relationships or undermines their wellbeing.

The question of whether the child is undertaking any caring tasks that are inappropriate must also be considered. The test of what is inappropriate will be different for each child but may include heavy lifting, emotional support, maintaining the family budget, administering medication or personal care. The assessor should take the child's own view into account when considering the appropriateness of any caring tasks.

### 6.6 Young People (Transitions

The Care Act introduces new entitlements to transition assessment for young people and their carers. There is a duty to carry out a transition assessment for a young person or carer if they are likely to have needs once they (or the child they care for) turn 18. There are three groups who have a right to a transition assessment:

- young people under 18 with care and support needs who are approaching transition to adulthood
- young carers under 18 who are preparing for adulthood
- adult carers of a young person who is preparing for adulthood

The young person does not have to be receiving support from children's services to be eligible for an assessment. Under the Care Act 2014 there is a duty to conduct a transition assessment when it will be of 'significant benefit' to the person to do so. Significant benefit relates to the timing of when the young person is ready to have an assessment and will get the most out of the assessment process.

Under the Children and Families Act 2014, the Education, Health and Care Plan requirements for preparation for adulthood begins at 14. Adult Social Care must work with Children's Social Care to ensure young people experience a seamless transition.

### 6.7 Moving to Torbay and continuity of Care

There will be times where adults who are already receiving care and support in another local authority will want to move to TSDFT. In these circumstances it will be the responsibility of those acting on TSDFT behalf to confirm if the person has a genuine intention to move and if this is the case will become responsible for undertaking a new assessment of the person's needs. This responsibility also extends to carers if it is established that they will continue to care for the adult after the move.

Both assessments can take place before the adult moves to TSDFT, to help ensure that the right care and support is in place when they arrive. If the adult's assessment has not been completed the "continuity duty" is triggered which require TSDFT to meet any of the needs that were being met by the previous authority, from the day that the person arrives in the new area. (This also applies to the needs of any carer who will continue to care for the adult after the move).

The continuity duty will continue until those acting on TSDFT's behalf have carried out an assessment and put in place all necessary care and support the person requires on the basis of that assessment.

There are some exceptions where the assessment responsibility for an adult will usually remain with the Local Authority from where the person will be moving. These exceptions may include:

- Where the adult has requested or may require a move to supported accommodation/extra care/a shared lives scheme in TSDFT.

- Where the adult has been identified by another Local Authority as needing Local Authority funded residential or nursing care but the person has requested to move into a residential setting in TSDFT, the original authority remains responsible for both the funding and reviewing of their care and support needs.

### 6.8 Refusal of Assessment

Under section 11 of the Care Act, there is no requirement to carry out an assessment if the person (if they have capacity to refuse the assessment) does not feel they need care or does not want support provided by the local authority.
If someone who refuses an assessment appears to lack the capacity to do this or to request an assessment or to express their needs, then a mental capacity assessment should be carried out in line with best practice and the requirements of the Mental Capacity Act 2005 – hereafter referred to as the MCA.

If the person is found to lack capacity to refuse the assessment, and it is determined that a needs assessment would be in their best interests, there is a requirement to carry out the assessment. The same applies if the person is experiencing or is at risk of abuse or neglect.

It is good practice to maintain contact with the person, support them to consider the implications of their choice and to understand other choices open to them. If the person continues to choose not to have an assessment, they should be provided with details of who to contact to request an assessment should their circumstances change.

Where there is reason to believe that a person may lack capacity to refuse a needs assessment, and it has not been possible to engage them in a mental capacity assessment, and there is reasonable belief that they may be at risk from self-neglect or abuse – then a safeguarding alert should be made by the responsible organisation.

### 6.9 Proportionate Assessments

The Care Act also requires an assessment to be carried out in a manner which is appropriate and proportionate to the needs and circumstances of the person to whom it relates. The assessment should be in proportion to the severity of need and the complexity of the situation, and should reflect the wishes of the person being assessed and address any communication needs the person may have. To ensure the assessment is proportionate, regard must be given to:

- the person's wishes and preferences and desired outcomes
- the severity and overall extent of the person's needs
- the potential fluctuation of needs

### 6.10 Initial Contact

Information gathered about the person at the initial point of contact may take the form of a 'strengths based conversation; and may form part of a Care Act assessment. Therefore, contact staff must make clear to the person that the information gathered may be passed to the organisation responsible for undertaking their assessment (Please also see Confidentiality and Consent to Share Information Section below).

Contact staff must have appropriate information gathering skills and be able to access people with expertise to whom they can refer issues that go beyond their knowledge. They should have the support of professional social workers, occupational therapists and other relevant experts to support the identification of underlying conditions and/or to ensure that complex needs are identified early and that people are signposted appropriately.

At the point of initial contact, it must be also considered whether the person would have difficulty being involved in an assessment and whether an advocate may be required (see Advocacy section below).

### 6.11 Pausing the assessment

Early or targeted interventions, such as universal services, a period of reablement or provision of equipment or minor household adaptations, can delay an adult's needs from progressing. If such interventions are put in place after the first contact, the assessment

process can be paused. This is to allow the intervention to take place and then to evaluate the effect on the person's needs.

### 6.12 Urgent needs

There is a power to meet urgent needs for care and support before completing an assessment. Urgent needs may also be met regardless of the person's ordinary residence. This initial response to meet urgent needs should be followed by a more detailed needs assessment and any relevant referrals.

### 6. 13 Format of assessment

The assessment may take different forms according to the person's circumstances and preferences.

| | |
|---|---|
| **Face to face** | A face-to-face assessment between the person and an assessor, whose professional role and qualifications may vary depending on the circumstances, but who must always be appropriately trained and have the right skills and knowledge. |
| **Supported self-assessment** | A supported self-assessment should use the same assessment materials as a face-to-face assessment but the person will complete the assessment themselves. The organisation responsible for the assessment must be sure that it is an accurate reflection of the person's needs. |
| **Telephone or online** | A proportionate way of assessing less complex needs or where the person is already known to the organisation responsible for the assessment. The responsible organisation must assure itself that the assessment is an accurate reflection of the person's needs. |
| **Combined assessment** | An adult's assessment may be completed alongside a carer's assessment and/or an assessment relating to a child so that interrelated needs are properly captured and the process is as efficient as possible. Those being assessed must consent to the assessments being combined; otherwise they must be carried out separately. |

| | |
|---|---|
| **Joint assessment** | This refers to an assessment where relevant agencies work together to ensure that the person's needs are fully understood and to avoid the person undergoing multiple assessments. This includes assessments in a prison.<br>Where a person has both health and care support needs, the assessor should work with health professionals to ensure the person's health and care services are aligned. |

### 6.14 Supported self-assessment

A supported self-assessment is an assessment carried out jointly by the adult or carer with care and support needs and the organisation responsible for the assessment. It places the individual in control of the process to the point where they themselves complete the assessment form. The assessing organisation remains responsible for assessing the person's needs and ensuring that the assessment is accurate and complete.

The person must be offered the choice of a supported self-assessment if they have the capacity to take part in this process and wish to do so. If the person does not wish to self-assess, the organisation responsible for the assessment must undertake it. The person should be asked to complete the same assessment questionnaire that the responsible organisation uses for a needs or carer's assessment.

In order to support the person in carrying out a supported self-assessment, the organisation responsible for the assessment must give them any relevant information it has either about the person themselves or, for a carer's self-assessment, about the individual they care for. This is so that the person completing the assessment has a full picture of their care and support history and is equipped with the same information an assessor would have when undertaking an assessment. Before sharing any information, the person's consent must be obtained. If the person lacks capacity to make this decision, information must only be shared if doing so would be in the person's best interests (Please also see Confidentiality and Consent to Share Information Section).
If the carer is a young carer, the council must consider whether the information is appropriate to be shared with the child.

If a person who would otherwise receive a specialised assessment chooses to self-assess, the assessment process must involve a person who has specific training and expertise when assuring itself that the assessment accurately reflects the person's needs.

The organisation responsible for the assessment must assure itself that the self-assessment is an accurate and complete reflection of the person's needs and must then make an eligibility determination. The person must be informed of the decision and the reasons for it. If the person disagrees with the decision, they have the right to appeal.

### 6.15 Who can carry out an assessment?

Assessments can be carried out by a range of professionals, including registered social workers, occupational therapists, rehabilitation officers, HSCC's (health and care coordinators), support service coordinators, and adult transition workers. Anyone carrying out an assessment must have the required skills, knowledge and competence.

When assessing particularly complex or multiple needs, an assessor may require the support of an expert to carry out the assessment. Consideration should be given to whether additional expertise is required on a case-by-case basis, taking into account the needs of the individual and the skills of the assessor.

Where the assessor does not have the necessary knowledge of a particular condition or circumstance, they must consult someone who has. This means someone who - through training or experience - has acquired knowledge or skill of the particular condition or circumstance.

There are some specific groups of people that the Department of Health consider require specialised assessment:

| | |
|---|---|
| Autism | In accordance with statutory guidance, the assessor must have specialised training in autism to assess an adult with autism. |
| Deafblind | A trained expert must be involved in the assessment of adults who are deafblind. This includes where an adult who is deafblind is carrying out a supported self-assessment. |

### 6.16 Supporting the Person to be involved in the assessment

The assessment must involve the person being assessed and any carer or any other person the adult wants to involve. This means that the assessor should help the person to understand how they can be involved, how they can contribute and take part and wherever possible lead or direct the process.

From their very first contact, the person must be given as much information as possible about the assessment process to ensure a personalised approach to their assessment. This information should include details about what questions will be asked in the assessment, timescales, complaints processes and access to independent advocacy, if required. The information must also be provided in an accessible format for the person so that the person's involvement in the assessment process is maximised.

From the first point of contact, consideration must also be given to whether the person, would have difficulty being involved in the assessment. If so, it must be established whether the person could be supported to be involved through changes to the assessment process. Under the Equality Act (2010), there is a duty to make reasonable adjustments to meet the needs of people with particular accessibility requirements.

**7. ADVOCACY**

If the person would have substantial difficulty in being involved in their assessment, and adaptations to the process would be insufficient to overcome this, it must be ensured that there is an appropriate individual, such as a friend or relative, that can facilitate their involvement. If there is no-one who can fulfil this role, an independent advocate must be arranged to support and represent the person in the assessment process.

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If the person does not have the mental capacity to decide upon an appropriate individual or advocate, then the responsible organisation must make a best interest decision as to who would be the most appropriate person to facilitate the person's involvement in their assessment.

The advocacy duty in the Care Act applies equally to people whose needs are being jointly assessed by the NHS (including Continuing Health Care) and (or on behalf of) the local authority. In these circumstances the local authority or the organisation acting on its behalf retains responsibility for arranging an independent advocate.

In determining whether a person has a substantial difficulty in being involved with the assessment, the following four criteria must be considered, in any one of which substantial difficulty may be found:

- whether the individual understands relevant information
- whether the individual is able to retain information
- whether the individual is able to weigh up information in order to fully participate
- fully and express preferences for or choose options (for example, the
- advantages and disadvantages of moving into a care home)

- the individual's ability to communicate their views, wishes and feelings

If it is determined that the person would have substantial difficulty being involved in their assessment, consideration should be given in the first instance to whether there is an appropriate individual who can facilitate a person's involvement in the assessment. This includes four specific considerations an appropriate individual cannot be:

- already providing care or treatment to the person in a professional capacity or on a paid basis
- someone the person does not want to support them
- someone who is unlikely to be able to, or available to, adequately support the person's involvement
- someone implicated in an enquiry into abuse or neglect or who has been adjudged during safeguarding procedures to have failed to prevent abuse or neglect

Sometimes it will not be known at an early stage of the assessment whether there is someone appropriate to assist the person in engaging. As a result, an independent advocate may be appointed only for it to be discovered later that there is an appropriate person available. The appointed advocate can at that stage hand over to the appropriate individual. Alternatively, an agreement may be reached with the appropriate individual and the advocate that it would be beneficial for the advocate to continue their role, although this is not a specific requirement under the Care Act.

On the other hand, it is possible that a person may be considered someone appropriate and who may then turn out to have difficulties in supporting the person to be involved in the process or who is later considered to be inappropriate to support the person. At that point arrangements for an independent advocate must be made.

Frequently a person will be entitled to an advocate under the Care Act and then, as the assessment process proceeds, it will become clear that there is a duty to provide an Independent Mental Capacity Advocate (IMCA) under the MCA. This will occur, for example, when, during the process, a decision needs to be taken about the person's long-term accommodation. It would be unhelpful to the individual and to the assessment process for a new advocate to be appointed at that stage. It would therefore be better that, if possible, the advocate who is appointed in the first instance is qualified to act both under the MCA (as an IMCA) and the Care Act and that commissioning arrangements enable this to occur.

There are times when an independent advocate should be provided for a person who has substantial difficultly even though they have an appropriate individual (family member, carer or friend) to support them. These are:

- where there is a disagreement between the local authority and the appropriate person whose role it would be to facilitate the individual's involvement, and the local

authority and the appropriate person agree that the involvement of an independent advocate would be beneficial to the individual.

- where a placement is being considered in NHS-funded provision in either a hospital (for a period exceeding four weeks) or in a care home (for a period of eight weeks or more), and the local authority believes that it would be in the best interests of the individual to arrange an advocate.

**8. MENTAL CAPACITY**

In carrying out an assessment, the assessor must always consider whether they need to conduct an assessment of the person's capacity to consent to any actions that may need to be taken to meet their needs. This is essential in order to ensure that any actions taken by care professionals under a subsequent support plan are protected from liability under section 5 of the MCA.

The MCA applies to anyone over 16 who is unable to make some or all decisions for themselves. Particular attention must be paid to the five statutory principles of the MCA when working with anyone who may lack capacity:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- Any decision or action made on behalf of a person who lacks capacity must be done in their best interests.
- Anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

Individuals can appoint people to make decisions on their behalf in the event that they become unable to make their own decisions, under a Lasting Power of Attorney arrangement (LPA). The person must be over 18 and must have mental capacity to make an LPA at the time they make one.

If the person does not have capacity, the Court of Protection may appoint a Deputy to make decisions on their behalf. The Deputy may be a close friend, relative, a professional, or the local authority.

There are two types of LPA and Deputy:

- Health & Welfare

This covers decisions about day-to-day care, medical care, where to live, assessments, and the provision of community care. It can only be used when the person is unable to make a particular decision themselves.

- Property & Financial Affairs
  This covers decisions about paying bills, bank accounts, collecting benefits, property transactions, and so on. It can be used to receive and manage a Personal Budget in the form of a direct payment on a person's behalf.

Adults who lack capacity may find it harder to communicate their needs and aspirations and may require additional support during assessment, such as the use of alternative forms of communication and information as well as access to an independent advocate.

If an adult is believed to lack the capacity to engage in decisions about how their needs will be met, the MCA guidance must be followed.

## 9. DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

There is a particular need to consider the person's mental capacity when either the council (or an organisation acting on behalf of the council) or an NHS body is proposing to arrange accommodation in hospital for longer than 28 days or in a care home for more than eight weeks.

If arrangements proposed for the care or treatment of someone who lacks capacity would amount to a deprivation of liberty, this must be authorised in accordance with MCA or Mental Health Act requirements. A deprivation of liberty arises if the person will be under continuous supervision and control, is not free to leave and lacks capacity to consent to these arrangements. This includes domestic settings, such as a supported living placement, if the local authority or those acting on its behalf have facilitated the arrangement. The purpose of the placement or the person's compliance or lack of objection to it are not relevant to whether there is a deprivation of liberty requiring authorisation.

If it appears that a DoLS application may be required, this should be done without delay.

## 10. CONFIDENTIALITY AND CONSENT TO SHARE INFORMATION

In May 2018, the General Data Protection Regulation came into force, with the requirements that data is:

- Processed fairly, lawfully and in a transparent manner.
- Collected for specified, explicit, and legitimate purposes and not further processed for other purposes, incompatibly with the original purpose.
- Adequate, relevant and limited to what is necessary in relation to the purposes.

- Accurate and kept up to date.
- Kept in a form that permits identification no longer than is necessary.
- Processed in a way that ensures appropriate security of that personal data

From the point of initial contact the individual must be made aware of how the information they provide will be shared and their consent obtained. The person has the right to refuse to consent or to withdraw consent at any time. If they lack capacity, information may only be shared in their best interests in accordance with the requirements of the MCA. However, if the individual's safety or the safety of others is at risk, professionals have a duty to share confidential information in line with the Safeguarding Adults Information Sharing Policy

## 11. CONTINUING HEALTH CARE

This is available for people who need ongoing health care and meet the eligibility criteria specified in the National Framework for Continuing Health Care. The key criteria are that the person must be assessed as having a 'primary health need' and have a complex medical condition and substantial and ongoing care needs.

Continuing Health Care can be provided in any setting, including a care home, hospice or the person's home. If a person in a care home is eligible for NHS Continuing Health Care, the NHS will fund their care home fees, including the cost of accommodation, personal care and health care. If Continuing Health Care is provided to a person in their own home, the NHS will fund the costs of personal care and health care

If it appears that the person may be eligible for NHS Continuing Health Care during the assessment process, the responsible organisation must notify the Continuing Health Care Team.

## 12. ELIGIBILITY

### 12.1 Adults in need of care and support

After completing the assessment of the adult's needs it must be determine whether any of those needs are eligible for support from the council. The Care Act has established a national eligibility threshold whereby an adult's needs will meet the criteria if **all three** of the following conditions are met:

- The adult's needs arise from or are related to a physical or mental impairment or illness
- As a result of the adult's needs they are unable to achieve two or more of the specified outcomes below
- As a consequence there is, or is likely to be, a significant impact on the adult's wellbeing

**FIRST CONDITION - Physical or mental impairment or illness**

The first condition is that an adult's needs arise from a physical or mental impairment or illness. Consideration must therefore be given whether the adult has a condition as a result of physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuses or brain injury.

**SECOND CONDITION - Specified Outcomes**

The second condition is that consideration must be given to whether the adult is 'unable to achieve' two or more of the following outcomes:

- managing and maintaining nutrition
- maintaining personal hygiene
- managing toilet needs
- being appropriately clothed
- being able to make use of the adult's home safely
- maintaining a habitable home environment
- developing and maintaining family or other personal relationships
- accessing and engaging in work, training, education or volunteering
- making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
- carrying out any caring responsibilities the adult has for a child

An adult will be deemed unable to achieve an outcome when they are:

- unable to achieve it without assistance
- able to achieve it without assistance, but achieving it causes the adult significant pain, distress or anxiety
- able to achieve it without assistance, but achieving it endangers or is likely to endanger the health or safety of the adult or of others
- able to achieve it without assistance, but achieving it takes significantly longer than would normally be expected

**THIRD CONDITION - Significant impact on wellbeing**

The third condition is that as a result of the adult's needs and being unable to achieve two or more of the above outcomes, there is, or is likely to be a **significant** impact on the adult's wellbeing.

The term significant is not defined in the Care Act Regulations but the subsequent Care Act Guidance states that the term must be understood to have its everyday meaning. The term

significant impact should be considered as being an “important, consequential effect on a person’s daily life, their independence and their wellbeing”.

A significant impact on the person’s wellbeing could be a consequence of a single effect or of a cumulative effect. For example the person may be unable to achieve two or more of the eligibility outcomes and this affects at least one of the area of their wellbeing in a significant way. Alternatively, the person may have eligible needs across several of the eligibility outcomes, perhaps at a relatively low level, but as these needs affect the individual in various areas of their life, the overall impact on the person’s wellbeing is significant.

How wellbeing is interpreted will depend on the individual, their circumstances and their priorities. Wellbeing is a broad concept applying to several areas of life, and needs affect people in different ways. Therefore, needs that affect one person significantly may not have a significant impact on another. Assessments and the application of eligibility criteria must therefore be individual to the person’s presenting needs and circumstances.

### 12.2 Needs met by carers

The eligibility determination will be based solely on an adult’s needs and how these impact on their wellbeing. Where the adult has a carer, information on the care they are providing should be captured during the assessment but cannot be used to influence the eligibility determination. This is to ensure that an appropriate response can be provided at the right time to meet the level of needs, whether or not the carer is able to continue providing care.

### 12.3 Carers

Carers can be eligible for support in their own right, and their eligibility does not depend on whether the person they care for has eligible needs. The Care Act has established a national eligibility threshold whereby a carer’s needs will meet the eligibility criteria if **all three** of the following conditions are met:

- The needs arise as a consequence of providing **necessary** care for an adult
- The carer’s physical or mental health is deteriorating or is at risk of doing so or the carer is unable to achieve any of the outcomes specified below
- As a consequence there is, or is likely to be, a significant impact on the carer's wellbeing.

**FIRST CONDITION - Needs arising as a consequence of providing necessary care for an adult**

The first condition that must be satisfied is that the carer’s needs arise as a consequence of providing ‘necessary’ care for an adult. If the adult is capable of meeting such care and support needs themselves, the carer may not be providing 'necessary' care and support.

**SECOND CONDITION -Needs arising because of deteriorating physical or mental health or the inability to achieve specified outcomes**

The second condition that must be satisfied is that the carer's physical or mental health is deteriorating or is at risk of doing so, or the carer is unable to achieve any of the following outcomes:

- Carrying out any caring responsibilities the carer has for a child
- Providing care to other persons for whom the carer provides care
- Maintaining a habitable home environment in the carer's home (whether or not this is also the home of the adult needing care)
- Managing and maintaining nutrition
- Developing and maintaining family or other personal relationships
- Engaging in work, training, education or volunteering
- Making use of necessary facilities or services in the local community, including recreational facilities or services
- Engaging in recreational activities

A carer will be deemed unable to achieve an outcome when they are:

- unable to achieve it without assistance
- able to achieve it without assistance but achieving it causes the carer significant pain, distress or anxiety
- Is able to achieve it without assistance but achieving it endangers or is likely to endanger the health or safety of the carer or of others

**THIRD CONDITION - Significant impact on wellbeing**

The third condition that must be satisfied is that there is or is likely to be a significant impact on the carer's wellbeing as a consequence of needs arising due to provision of necessary care for an adult and either the carer's physical or mental health is or is at risk of deteriorating, or the carer is unable to achieve any of the outcomes above.

### 12.4 Fluctuating needs

Adults and carers may have fluctuating needs which are not always apparent at the time of their assessment but may have arisen in the past and are likely to arise again in the future. In these circumstances the responsible organisation will consider the persons needs over an appropriate period of time to ensure that all their needs have been accounted for when eligibility is being determined.

### 12.5 Power to meet needs that are not eligible

There may be circumstances where an individual does not meet the eligibility criteria (i.e. they only have one outcome that is having a significant impact on their wellbeing). In these cases the severity of the impact on the person must be considered. If the person is deemed

to be at significant risk of harm if a service is were not to be provided then the case should be sent to the relevant council commissioner for consideration.

## 13. ORDINARY RESIDENCE

### 13.1 Determining ordinary residence

Following the eligibility decision the responsible organisation should establish whether the person meets the ordinary residence requirement and has, as a consequence, an ongoing duty to meet the person's assessed eligible needs.
In broad terms, where an adult is living in TSDFT voluntarily, and for settled purposes, whether for short or long duration, he or she will be ordinarily resident in TSDFT. For carers, the person they care for must be ordinary resident in TSDFT.
Ordinary residence also extends to residential care and nursing home placements, shared lives schemes and in some circumstances supported living/ extra care housing arrangements, when funded by TSDFT outside of the area. Where a person lacks capacity to decide where to live, a best interest decision about their accommodation should be made under the Mental Capacity Act 2005.

The determination of ordinary residence must not delay the process of meeting needs. In cases where ordinary residence is not certain, the responsible organisation should meet the individual's needs in the first instance, and then resolve the question of residence subsequently. This is particularly the case where there may be a dispute between two or more local authorities.

### 13.2 Continuing Healthcare

Where a person is placed in a care home (or other accommodation funded by the NHS) for the purpose of receiving NHS continuing health care, they continue to be ordinarily resident in the local authority area where they were ordinarily resident before entering the NHS accommodation. Where a person ceases to be eligible for Continuing Health Care, but still needs to remain in their care home, or to be provided with accommodation elsewhere, the local authority where the person was ordinarily resident immediately before being provided with NHS accommodation will be responsible for arranging care and support to meet the person's eligible needs, subject to any financial assessment.

### 13.3 Section 117 Aftercare

The duty on local authorities to commission or provide mental health after-care under section 117 of the Mental Health Act 1983, usually rests with the local authority for the area in which the person was ordinarily resident immediately before they were detained under the 1983 Mental Health Act, even if the person becomes ordinarily resident in another area after leaving hospital.

For example, if a person is ordinarily resident in local authority area (A) immediately before detention under the 1983 Act, and moves on discharge to local authority area (B) and moves

again to local authority area (C), local authority (A) will remain responsible for providing or commissioning their after-care. However, if the patient is subsequently detained in hospital for treatment again, the local authority in whose area the person was ordinarily resident immediately before their subsequent admission (local authority (B) or (C) will be responsible for their after-care when they are discharged from hospital.

### 13.4 Transitions

Following a Supreme Court Judgement on 8th July 2015 (Case ID UKSC 2014/0092) it has been determined that once a Council has responsibility for accommodating a child this responsibility is likely to continue into adulthood should they remain mentally incapable of making their own accommodation decisions no matter where they are geographically accommodated.

### 13.5 Further Guidance

The full provisions in the Care Act 2014 in regards to ordinary residence are detailed and as such are outside the scope of this policy. Further guidance can also be taken from the Care and Support Statutory Guidance: Chapter 19: Ordinary Residence.
If the ordinary residence of the person remains uncertain then all related information to the person's residency and care and support needs should be sent to the relevant council commissioner for a decision.

## 14. INFORMING THE PERSON

### 14.1 Providing a copy of the assessment

Following the assessment, the person must be given a copy of their assessment and eligibility outcomes, which must include their views. A copy must also be shared with anybody else that the person asks for it to be shared it with.

### 14.2 Unmet eligible needs

If the person has been assessed as having unmet eligible needs, the assessor must:

- Agree with the person which of their eligible unmet needs they would like the council to meet. The adult may choose to arrange alternative services themselves to meet some needs or may not want a service from the council or organisations acting on its behalf. A person who has savings above the local authority financial threshold has the right to request that services (but not residential care) are arranged by the council or organisations acting on its behalf.

- If the person wants support that might be funded the council, consider how to meet those needs and if a chargeable service is involved, initiate a financial assessment.

- Establish whether the person meets the ordinary residence requirement.

An adult must be ordinarily resident in TSDFT. In the case of a carer, the person they care for must be ordinarily resident in TSDFT.

Where the person has unmet eligible needs and support planning is to proceed, the person should be provided with an "Indicative" Personal Budget. The indicative amount is to be recorded on the person's assessment documentation.

### 14.3 Met eligible needs

If the person has been assessed as having eligible needs but these needs are being fully met the assessor must:

- Record on the assessment documentation how the person's needs are being met.
- Agree with the person (and if relevant their carer) how the responsible organisation can keep under review its duty to meet any unmet eligible needs (for example, if a carer can no longer meet some or all of the person's eligible needs, or if alternative services cease or do not adequately meet the person's eligible needs).
- Record this decision on the assessment documentation.

### 14.4 When there are no eligible needs

Where none of the person's needs meet the eligibility criteria, the organisation responsible for the assessment must give them written advice and information about what can be done to meet or reduce the needs or what can be done to prevent or delay the development of needs for care and support in future.

People who have needs that fall below the eligibility criteria may qualify for help from a range of other services, including health, housing, benefits, education, training, employment, transport and leisure. Local voluntary services, community groups and networks may also be able to help people. People must be given information about alternative sources of support, and advice about how to access them.
If a person's condition is likely to deteriorate without support so that their needs will increase, the assessor should consider whether the person would benefit from preventative interventions or services. This may involve referring the individual to another service or providing advice or giving assistance to access support.

## 15 COMPLAINTS AND APPEALS

All reasonable steps to limit appeals or disputes through effective assessment practice and transparency in decision-making should be taken. In addition, people should be kept informed of the timescales that are likely to be involved in different stages of the process. Anyone who remains dissatisfied with a decision made should be informed that they can complain via the Feedback and Engagement Team (tsdft.feedback@nhs.net; telephone 0800 0282037)

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

| | | | |
|---|---|---|---|
| **Title:** | Promoting Active Ageing | | |
| **Wards Affected:** | All | | |
| **To:** | Health and Wellbeing Board | **On:** | 6 September 2018 |
| **Contact:** | Sue McDermott | | |
| **Telephone:** | 07735415674 | | |
| **Email:** | suemcdermott@torbaycdt.org.uk | | |

## 1. What has been achieved in the past twelve months?

### 1.1 'Food for Thought' and Innovation Fund Commissioning work

Our 'Food For Thought' and Innovation Fund Commissioning reflected a genuine process of empowerment, moving towards real participation and an exchange of power. The process started with consultation through the Food for Thought sessions which enabled us to collect the views of older people. The issues raised by older people were then written as outcomes into AWT Innovation Fund Commissioning plan and the fund was launched for local commissions up to £25k – around three different outcomes (increased activities, overcoming the barriers to social connection, IT and intergenerational working). A panel of seven local older people were trained by Hall Aitken to assess over 30 tenders and in total, almost £170k was allocated to eight local projects which included:

**Wellswood Wheels**

Providing a 'Door to door' bookable minibus service, for people over 50 including support from an assistant driver and the driver, to walk or be wheeled to the bus, get on the bus, and be helped off the bus safely. The contract commenced on 1st December 2017.

**Hear & Now - Sound Communities**

The project will run over 2 years and bring together younger and older people in local history groups, care homes and communities to record, produce, broadcast and archive local stories and memories across Torbay.

**Digital Inclusion - Torbay Healthwatch**

Project to bridge the 'digital divide' for those unable to use online services and effectively excluded from health and social care resources and services. Offering one-to-one support in the community or at home.

**Ellacombe Café - Ellacombe Community Partnership**

Project to provide a new community internet café with opportunities for older people to expand their existing skills set, socialise and feel valued. The café opened in April 2018.

**Karing**

Trialling different activities for older people including Sunday Tea Dances, and new craft classes, social trips and garden parties.

**Daybreak Peer Support – Step One**

This project has created new mental health peer support networks for people over 50, to reduce anxiety, depression and low self-esteem, by providing groups, outreach and engagement sessions.

**So-Fly**

Garden Project to bridge the Inter-generational gap – and help to build mutual understanding and communication through peer-led groups and also one-to-one matched mentoring.

**Riviera FM**

Project offering people over 50 the chance to have media training on all aspects of running a radio station including developing content, presenting programmes, outside broadcasting and developing social media campaigns.

**1.2 NEW COMMISSIONS**

**Financial Advice Information and Resilience (FAIR) - January 2018 – December 2020 - £175K**

The FAIR service was commissioned in Autumn 2017 following open collaboration workshops which were held across Torbay, and co-design workshops with older people who had told us they wanted more accessible and low level advice services, and to also be involved in providing information and support to their peers. The partnership of agencies involved in providing the new service includes Visualeyes, Mencap, Citizens Advice Torbay, Age UK Torbay, Homemaker Southwest, Youth Enquiry Service and Brixham Does Care.

**Wellbeing Co-ordination June 2018 – March 2021 £270K**

The social prescription model works with people currently in the health system and remove the barriers from achieving their personal aspirations and taking part in their community. The WBC project was due to finish at the end of June 2018, however:

- The Neighbourhoods' and WBC teams over the last 2 years have worked increasingly closely together and both teams have said it would be difficult to continue making an impact without the presence of the other.

- Before the WBC team came on board, it was difficult for community builders to progress with stimulating activities as they became bogged down in individual support and there was a concern that if the WBCs go, this will leave a gap they will be called on to fill.

- The WBC and Neighbourhoods team were designed to be a systemic approach and they are forming an integral part of the programme.

Consequently there was unanimous support from the AWT programme board to jointly fund with the ICO, the continuation of this project into years 4,5, and 6 (from June 2018 – March 2021).

## 3. What is the planned activity for the next six months?

### 2.1 NEW COMMISION 'Staying Put – Peer Support Commission' £250K

During our 'Food for Thought' sessions, many people over 50 identified themselves as being an 'untapped resource' and more able to support their peers (with low level DIY, gardening, shopping, household chores, neighbourly driving) to live inter-dependently.

However they recognised that there were barriers to helping or providing this natural support, such as the potential suspicion people fear their offers of support will be met with, and the possible need for CRB checks and/or insurance.

Ageing Well Torbay is committed to supporting local organisations to innovate, collaborate and develop high quality projects and tender submissions. In order to support this, the AWT programme office team have been facilitating collaboration between organisations and also supporting tenderers to come together with people over 50, and utilise 'Service Design thinking and principles' to co-design an innovative 'Staying Put – Peer Support' project.

Final ITT to be sent out in September 2018.

**NEW COMMISSIONS – Mental Health Peer Support & IT support September 2018**

**Appendices**

**Background Papers:**
The following documents/files were used to compile this report:

Positive Ageing Strategy & Older Persons' Assembly development

# Development of an Older Persons' Assembly

The development of a new Older People's Assembly was envisaged as a means of lobbying for better people-centred services so that older people would be supported to co-design new services, strategies and policies.

The working party for the Older Persons' Assembly has met several times and consists of up to ten local older people as members. Meetings have been facilitated by Sue/Jess from TCDT but led by the members who have focussed on agreeing the functions of the assembly and developing a structure to facilitate the functions.

## AIMS OF THE OLDER PERSONS' ASSEMBLY

- To portray ageing and older people in a positive light;
- Celebrate Positive Ageing;
- Support Torbay achieving Age Friendly Status

## FUNCTIONS OF THE OLDER PERSONS' ASSEMBLY

1. To influence and steer decisions regarding services, strategies and policies, with the local authority, statutory and voluntary agencies, through the Assembly having seats on the HWB and potentially attending statutory board meetings.

2. To support the local authority, statutory, voluntary and private organisations to deliver the outcomes of the "Positive Ageing Strategy" and where necessary hold them to account.

3. To ensure that local older people have a role and the opportunity to share their knowledge and experience to improve current services.

4. To be the voice of local Older People, by ensuring that local concerns, needs, as well as suggestions and solutions are collated on a grass-roots community level, and used to identify themes for either further investigation or escalation by the Assembly or their focus groups.

5. To create and maintain clear channels of communication, which enable timely feedback on the impact of strategies and services or the escalation of concerns, and the dissemination of decisions and strategies to local people in accessible formats (including hard copies, on-line and audio).

6. To support and drive the local authority, statutory, voluntary and private organisations to achieve and maintain Age Friendly Status.

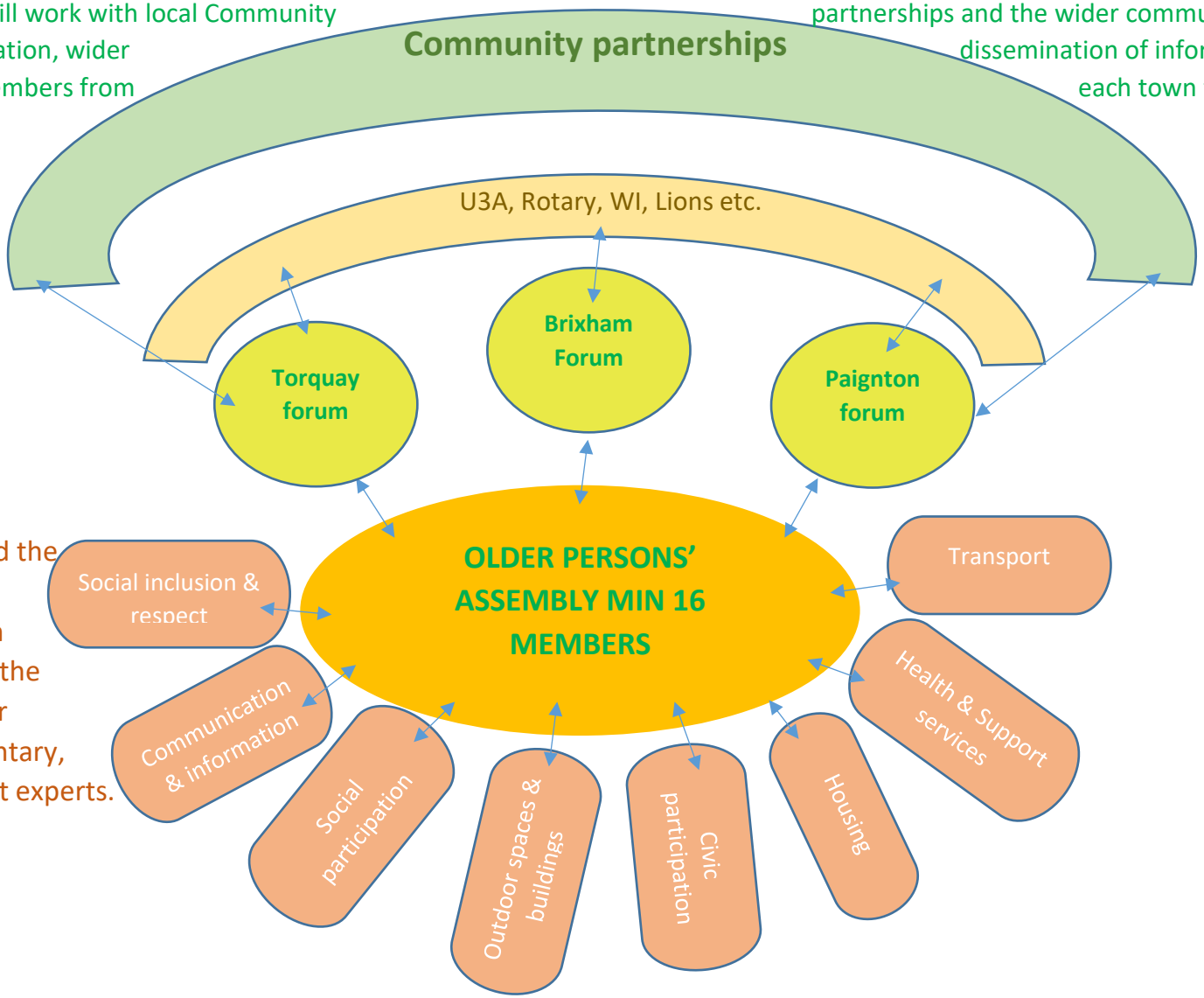
7. To be inclusive and represent the diversity of all older people across 'Bay.

## POTENTIAL STRUCTURE OF THE OLDER PERSONS' ASSEMBLY

Three town Forums will be set up to feed into the Assembly which will meet quarterly. The forums will work with local Community partnerships and the wider community of 50 plus to ensure there is optimum representation, communication of information and less duplication. The structure is still being finalised and visits to other Older People's forums has been arranged for September.

## SCEMATIC REPRESENTATION OF THE OLDER PERSONS' ASSEMBLY

The three town Forums will work with local Community partnerships and the wider community of 50 plus to ensure there is better communication, wider dissemination of information and less duplication. At least 4 members from each town forum will sit on the assembly.




Focus groups are around the Eight domains for Age Friendly status and each has two members from the Assembly, and wherever possible statutory, voluntary, business or independent experts.

## Development a Positive Ageing Vision/Strategy

At the 'Big Vision Event' on 24th January 2018, there was overwhelming support to develop the Positive Ageing Vision/Strategy for Torbay, and for us to work together on this.

AWT's role has only been to facilitate a working group to finalise the Positive Ageing Vision, not to write the strategy or lead the work. The strategy working party group consists of at least 5 professionals from Public Health, Torbay Council and ICO, and 5 citizens and it has now met several times and began focussing on the development of a Positive Ageing Charter (as opposed to a strategy, which might sit on a shelf and not be actioned), as a first step towards Torbay becoming 'Age friendly'.

## POSITIVE AGEING CHARTER

The Charter has gone through several iterations and this is the latest draft. The consensus was that finalisation should not happen without further involvement of the HWB, and that signing up to the Charter would mean a genuine commitment to the aspirations and the consequent responsibilities. In addition to the Charter, there are implied commitments and integral values.

## Aspirations of the Positive Ageing Charter include:

1. **Challenging Ageism** through actively identifying Ageism in work practices, strategies or services and making the required changes **so that people are not excluded or discriminated against by virtue of their age.**

2. **Engaging Older People in the co-production of a better future through involvement of the Assembly with service/strategy development**, including initial consultations, service/strategy planning, review and re-design.

3. **Listening to older people** (i.e. through engaging with the assembly or Forums), **and including (the "voices" of older people) in decision-making processes** for all business, services and groups who serve over 50's in Torbay.

4. **Actively working with the Older Person's Assembly**, and relevant partners and evidencing a commitment **towards achieving 'Age Friendly Status' for Torbay by 2022**, and a commitment to maintaining the status once achieved.

5. **Commitment to improving communication,** by the timely sharing of information in plain English, and in accessible formats, **and welcoming the feedback or challenge from the Assembly** and using it to inform decision making.

6. **Demonstrating commitment to** services and practices which will **reduce the number of older people who are lonely or socially isolated, and/or in financial poverty.**

7. **Commitment to supporting and valuing the Older Persons' Assembly after Ageing Well Torbay ceases in April 2021.**

## Positive Ageing Charter Key Commitments:

### People are part of the Solution

- People don't just have issues and concerns they have knowledge, skills and life experiences.

### Removing Barriers

- Giving the Assembly or the "voices" of older people a place and a role in decision making processes, for all business, services and groups who serve over 50's in Torbay
- Treating people as equal partners or stakeholders' whether they are older citizens, or from private, voluntary, or statutory sector and working together to co-produce and co-design.

### Accountability

- All involved are accountable to each other and need to demonstrate a commitment to working together and resolving conflict.
- Businesses, statutory, third sector, community groups and individuals recognise an accountability to older people in Torbay through the Assembly.

### Communication

- Communication is timely and information is shared in plain English, without jargon in accessible formats.
- Organisations make a commitment to listening to older people and keeping them updated and involved on everything which affects them, and demonstrate this commitment.

### Age Friendly Status

- Achieving Age Friendly Status for Torbay is the central objective and commitment of the Positive Ageing Charter. The expectations around the 8 key areas of an Age Friendly Development plan will eventually be shared with organisations, business and groups who sign up to the Charter, so that they can identify the key areas in which their service or business could have a positive impact, and also let the assembly know how their activities, aims and outcomes contribute to those key areas.

## Positive Ageing Charter - Values:

- **Openness and honesty regarding level of participation and power of the assembly voice** in planning, changes to services, and what resources exist and what's available.
- **Commitment to use all resources effectively and efficiently** and to avoid duplication as much as possible.
- **Creating a shift in culture** – more enabling and removing barriers so that individuals and across sectors and departments are able to help each other or work more collaboratively
- **Challenging current commissioning and moving towards collaborative commissioning**, reducing competition, creating opportunities, and flexibility.
- **Focus is strengths-based and positive.**
- **Voluntary, Charity and business sector need to step-up.** Statutory agencies are not the only ones who can 'bring something to the table'.
- **Inclusivity** – give everyone the opportunity to have a place to get involved.

## What are the requests to the Health & Wellbeing Board?

1. For the HWB Board to recognise that the 'Positive Ageing Strategy' is a necessary step towards Age Friendly status.

2. For the HWB Board to strongly encourage each constituent agency member to put forward a Senior Responsible Person or non-Exec officer, to work on finalising the 'Positive Ageing Charter', including developing the 'how' and agreeing actions during the next 2 months.

3. For the HWB Board to ratify, and endorse the finalised 'Positive Ageing Charter', and to mandate individuals, departments and organisations to sign up to the Charter for the benefit of our residents.

4. For the HWB Board to give the Older Persons Assembly two seats on the HWB, demonstrating a commitment to Older People in the 'Bay, having an opportunity to influence and be involved in decisions regarding services, strategies and policies.

5. For the Assembly to be recognised by the HWB and its constituent members as a valued resource and mechanism to either inform the development of new services or policies or the review of existing services and strategies, within a realistic timeline.

6. The HWB agrees to hold constituent members to account in terms of the finalised 'Positive Ageing Charter' and to the Assembly.

7. For the HWB to agree to begin working in earnest with the Assembly and other partners towards Age Friendly Status.

8. For the HWB to encourage and support its constituent agencies to open their governing committees and boards, and provide at least one seat to an Assembly representative.

9. To support the development of an 'Age Friendly' kite mark which will endorse services and organisations that adopt the 'Positive Ageing Charter' values and guidelines.