Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Monday 3 October 2016**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

Items during which the Press and Public are welcome to attend. Members of the Public can ask questions with the Chairman's agreement.

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 4 July 2016 and of the special meeting held on 1 September 2016 (Pages 1 - 14)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. System Resilience - Report of NHS North East Commissioning Support, presented by Sue Jacques, Chief Executive of County Durham and Darlington NHS Foundation Trust (Pages 15 - 30)
8. Primary Care Strategy Update - Report of the Director of Primary Care, Partnerships and Engagement, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (Pages 31 - 118)
9. Oral Health Strategy - Report of Gill O'Neill, Interim Director of Public Health, County Durham, presented by Chris Woodcock, Public Health Portfolio lead (Pages 119 - 134)
10. CAS - Revenue and Capital Outturn 2015/16 and CAS Quarter 1 Forecast of Revenue and Capital Outturn 2016/17 - Report of Head of Finance (Financial Services), presented by Andrew Gilmore, Finance Manager (Pages 135 - 150)

11. 2016/17 Quarter 1 Performance Management Report - Report of the Director of Transformation and Partnerships, presented by Peter Appleton, Head of Quality and Service Strategy, Adults Services (Pages 151 - 162)

12. Proposed Review of Suicide Rates and Mental Health and Wellbeing in County Durham Scoping Report - Report of the Director of Transformation and Partnerships (Pages 163 - 174)

13. Better Health Programme Joint Health Scrutiny Committee Update - Report of the Director of Transformation and Partnerships (Pages 175 - 202)

14. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Colette Longbottom
Head of Legal and Democratic Services

County Hall
Durham
23 September 2016

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee:**

Councillor J Robinson (Chairman)
Councillor J Blakey (Vice-Chairman)

Councillors J Armstrong, R Bell, P Brookes, J Chaplow, P Crathorne, S Forster, K Hopper, E Huntington, P Lawton, H Liddle, J Lindsay, O Milburn, M Nicholls, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:

Mrs B Carr and Mrs R Hassoon

Co-opted Employees/Officers:

Dr L Murthy, Healthwatch

Contact: Jackie Graham **Tel: 03000 269704**

DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Monday 4 July 2016 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, J Blakey, J Chaplow, S Forster, K Hopper, E Huntington, H Liddle, J Lindsay, M Nicholls, L Pounder, P Stradling and O Temple

Also Present:
Councillor L Hovvels (Cabinet Portfolio Holder for Adult and Health Services)

1 Apologies

Apologies for absence were received from Councillor P Brookes and Mrs R Hassoon.

2 Substitute Members

There were no substitute Members in attendance.

3 Minutes

The minutes of the meeting held on 8 April 2016 and of the special meetings held on 27 April, 9 May and 24 May 2016 were agreed as a correct record and signed by the Chairman.

Matters arising:

Councillor R Bell referred to the minutes from 8 April 2016, and it was confirmed by the Principal Overview and Scrutiny Officer that an email had been sent on the same date to NEAS highlighting concerns regarding the issues raised at the meeting in respect of the availability of NEAS performance data. A response had been received by the Assistant Director of Communications and Engagement which contained an apology that the report had not been made available to the Rural Ambulance Monitoring Group and provided links to the NEAS website where all data, including the performance report was located.

Councillor R Bell reiterated his concerns regarding the performance of NEAS in Durham Dales, Easington and Sedgefield areas and the Chairman added that there were still outstanding concerns regarding North Durham. The Chairman suggested that NEAS performance monitoring be considered at the Special meeting on 1 September 2016 and any concerns could be directed to the Assistant Director of Communications and Engagement.

4 Declarations of Interest, if any

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

There were no items from Co-opted Members or interested Parties.

The Chairman welcomed Councillor Blakey as the new Vice-Chairman of the Committee and thanked Councillor Forster for her work as the former Vice-Chairman.

6 Media Issues

The Principal Overview and Scrutiny Officer provided the Committee with a presentation of the following press articles which related to the remit of the Adults, Wellbeing and Health Overview and Scrutiny Committee;

- **Twins will not be born at Darlington Hospital as interim measure following maternity services review – Northern Echo 14 June 2016**

  Expectant Mothers of twins would not be able to give birth at Darlington Memorial Hospital as an interim measure following a review of maternity services. An external review was commissioned following concerns and a series of serious incidents. This was the second review of maternity services at County Durham and Darlington Foundation Trust (CDDFT) since 2009, and explored the culture and provision of services in units at Darlington Memorial Hospital (DMH) and the University Hospital of North Durham (UHND).

- **What does the Better Health Programme mean for the region? Lead clinicians explain their approach to health service changes – Northern Echo 15 May 2016**

  Media reports had suggested that meetings had taken place between senior NHS officials to discuss the transfer of vital services from smaller hospitals to larger centres. The NHS in Darlington, Durham and the Tees Valley was in the process of holding public meetings about the Better Health Programme, which would shape how services were delivered across the North-East and Teesside.

- **True extent of the North East's diabetes epidemic is revealed – Evening Chronicle 13 June 2016**

  Figures had confirmed that thousands of people had been diagnosed with diabetes in the North East since 2013. Statistics showed that an extra 5,378 people in the region suffered from the condition. Newcastle University experts had revealed following research that people who reversed their diabetes, then keep their weight down, could stay clear of the condition. In addition, the team found that even patients who suffered from Type 2 diabetes for up to 10 years could reverse their diagnoses.

- **North-East 'fattest in the country', statistics reveal – Northern Echo 28 April 2016**

  There was a higher rate of hospital admissions in the North East, due to primary diagnosis of obesity than any other part of the country. Figures released by the Health and Social Care Information Centre (HSCIC) showed that in 2014/15 there were 1,829 admissions in total which equated to 70 admissions per 100,000 of population. Across England there were 17 admissions per 100,000 of population, 9,130 in total.

The Chairman welcomed to the meeting, Paul Frank, Associate Director of Operations (Family Health) and Joanna Crawford, Head of Midwifery and Gynaecology, and invited them to address the review of maternity Services within County Durham and Darlington NHS Foundation Trust (CDDFT).

The Associate Director of Operations (Family Health) confirmed that following the Morecambe Bay report of 2015 , CDDFT had commissioned and published a report in March 2016 regarding twin pregnancy pre and post birth care. As a result of the findings, the CDDFT had temporarily ceased this service at Darlington Memorial Hospital.

There was approximately 25 twin births per year at Darlington and there were ten women affected by the decision.. Nine had agreed to have their babies at South Tees Hospital (STH) and one at University Hospital North Durham. The arrangement was expected to be for a maximum of three months, however would be reviewed weekly.

Councillor Armstrong referred to the temporary closure of Bishop Auckland General Hospital Midwife-led Maternity Unit, which had been closed for two years, although at the time it was advised would be temporary. He queried whether the temporary arrangement would affect any other pregnancies and was advised by the Head of Midwifery and Gynaecology that with regards to multiple births, 60% delivered before 37 weeks which was considered a full term pregnancy. Anybody who went into labour before 37 weeks would be expected to be transferred to STH following delivery as there was an Intensive Care Baby Unit on site. All women affected had been contacted direct and were satisfied with the pathway changes.

Councillor R Bell referred to the Northern Echo article which claimed that as a result of the Better Health Programme, Accident and Emergency Care was being reorganised and would result in the closure of one unit across Durham and Teesside. He confirmed that many rural areas in County Durham could be affected, depending on which unit closed. The Chairman advised that the Better Health Service proposed changes to all services, not just casualty, and confirmed that a consultation was taking place prior to proposals regarding our future Health Service. Councillor Nicholls referred to a recent public consultation meeting which had been held, however none of the local residents were aware that it was taking place and therefore had a low turnout.

The Chairman advised that there was a series of events being held at the end of July and formal consultation was due to begin in November, details of which had been circulated to all Members by Councillor L Hovvels, who confirmed that the email would be resent to all Members.

The Principal Overview and Scrutiny Officer confirmed that Better Health Programme would undergo a number of phases before they would formulate options to consider during the formal consultation. There would be a number of pre-consultation engagement meetings before any key decisions would be made on how to provide future services. The formal consultation period would begin at the end of November, however consideration would be given by Adults, Wellbeing and Health Overview and Scrutiny Committee, Health and Wellbeing Board, Local Members, NHS providers, Communities, Physicians and in addition, the Regional Joint Health Scrutiny Committee, which was meeting on 7 July 2016.

Resolved:

That the content of the presentation be noted.

7 Care Quality Commission "Shaping the Future - CQC's strategy for 2016-2021"

Consideration was given to the report of Assistant Chief Executive, which provided Members with background information on the Care Quality Commission's (CQC) five year strategy (for copy see file of minutes).

A Stanford, Head of Inspection – North East and Cumbria, CQC, gave a presentation with an overview of the CQC's strategy for 2016-2021 (for copy see file of minutes).

The purpose of CQC was to monitor, inspect and regulate health and social care services to ensure they met fundamental standards of quality, ensuring people were provided with high-quality, safe, effective and compassionate care.

The NE and Cumbria CQC consisted of 7 Inspection Managers and 35 Inspectors. By 2021 the overall budget would reduce by £32m therefore to ensure the service remained sustainable, there had to be fewer resources going forward. Most services had undergone a full comprehensive assessment, therefore the focus would be on those with poor ratings that were not making the necessary improvements.

There were six themes which would develop the new model of regulation;

- Improving the use of data and information – inspections were time consuming due to the amount of data which had to be scrutinised, therefore existing data would be streamlined
- Implementing a single shared view of quality – patient experience was important for analysis therefore the Intelligence Team were working on a portal for patients to record their feedback
- Targeting and tailoring inspection activity
- Developing a more flexible approach to registration
- Assessing how well hospitals used resources
- Developing methods to assess quality for populations and across local areas

In response to a query from Councillor Forster, the Head of Inspection confirmed that anybody could contact the CQC via a contact centre. Listening events had been held prior to inspections, but they were more successful if there was an overall issue, for

example, there was a good turnout when Hartlepool was inspected, but that was due to the potential closure of A&E. One listening event in the deaf community had raised the issue of calling out names for appointments, with no alternative means for addressing deaf patients. There had been an event in the Jewish Community in Gateshead.

It tended to be older people that provided feedback to the CQC and there was a lot of feedback from relatives of patients with dementia or learning disabilities, however not all feedback was negative. Engagement with patients during an inspection was crucial and in-patients were interviewed when possible, however it was sometimes difficult due to their treatment plan.

Ms Stanford stressed that where issues of concern were detected during inspections, CQC reps met with NHS Trust Executive teams to discuss what action plans were proposed to address such issues.

Resolved:

That the report be noted.

8 Director of Public Health Annual Report 2015/16

Consideration was given to the report of the Director of Public Health (for copy see file of minutes).

The Chairman announced that Anna Lynch, Director of Public Health would be retiring and therefore he wished to formally acknowledge her work on behalf of the Committee and wish her luck for her future.

The Consultant in Public Health referred to the news headline that the North East was the fattest region in Great Britain and noted that it equated to ¾ of the County as overweight or obese. As well as the effect it was having on adults, it was also having on younger people, Type 2 Diabetes was being diagnosed in children. The solution was to eat less and exercise more although it was difficult when food was so readily available and cheap. He referred to the stop smoking campaign which had only seen success since the ban on advertising had been imposed and suggested a change in the way food was promoted may lead to a reduction in the figures.

Councillor H Liddle referred to the inconsistency in the Councils approach, here was the Committee considering how to reduce obesity, yet regulatory Committees such as planning and licensing were asked to approve permission for fast food takeaways, without consideration of the impact on health. She confirmed that there were nine takeaways in her village which only had a population of 5000. Councillor Huntington added that planning Committees could only consider legislation. The Consultant in Public Health agreed that like smoking, things might only improve if policies were reformed or primary legislation passed by Government as had been the case with the smoking ban. He referred to a recent headline with reference to a planning application for a fast food premises in Newcastle which had been refused due to it being near a school. A subsequent appeal was withdrawn by the applicant due which confirmed that it was possible to fend off organisations if they could be of detriment to children's health.

Councillor Temple confirmed that planning and licensing Committees were only able to judge an application with regards to the legislation that accompanied it. He referred to section 106 agreements can included the provision for outdoor playing space, however it did not specify that space had to be sufficient for activities such as cycling or walking. He referred the appendix included on all Committee reports which gave consideration to a number of implications including, equality and diversity, human rights, and disability, and suggested that the Committee could make a recommendation that health implications could be included on every report.

Councillor Forster referred to the contribution of sugar to diabetes and confirmed that food which was high in sugar was not identifiable for people who did not examine the food labelling. The Consultant in Public Health confirmed that a traffic light system had been developed by the Food Standards Agency, to identify the content of fat, saturated fats, sugar, and salt in foods, however some people may not interpret it the way it was intended.

Councillor Stradling added that an increase in sugar and a reduction in exercise had both contributed to the increase in obesity.

Resolved that:

(1) The Annual Report of the Director of Public Health be received and the recommendations therein noted;
(2) The Committee recommend to the Council's Monitoring Officer that the corporate reporting template include a section on Health Implications within Appendix 1.

9 2015/16 Quarter 4 Performance Management Report

Consideration was given to the report of the Assistant Chief Executive which presented progress against the councils corporate basket of performance indicators, Council Plan and service plan actions and other performance issues for the Altogether Healthier theme for the 2015/16 financial year (for copy see file of minutes).

The Head of Planning & Service Strategy presented the report and referred to the previous meeting where disappointment had been expressed regarding the number of health checks being below the national and regional performance. He confirmed that information regarding the role of GP's would be delivered at the meeting in October, in order for Members to consider. The Chairman confirmed that Members were still concerned considering successful drug and alcohol treatment had deteriorated further. The Head of Planning & Service Strategy confirmed that assurances had been sought by the current provider and they had been notified of Members concerns. They were being closely monitored and were aware that they would be considered as part of the Councils contract reviews.

Resolved:

That the report be received.

10 Council Plan 2016/2019

The Committee considered a report of the Assistant Chief Executive which inviteded Members to consider and agree an updated Work Programme for the Adults Wekllbeing and Health Overview and Scrutiny Committee for 2016-17 (for copy see file of minutes).
In considering topics for a piece of Review work, members agreed to include a Review of Suicide Rates and Mental Health and Wellbeing in County Durham.

Resolved:

That the proposed work programme for 2016-17 for the Adults Wellbeing and Health OSC be agreed and a Review into Suicide Rates and Mental Health and Wellbeing be included therein.

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DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Thursday 1 September 2016 at 9.30 am**

Present:

Councillor J Blakey in the Chair

Members of the Committee:
Councillors J Armstrong, R Bell, J Blakey, S Forster, J Lindsay, L Pounder, P Stradling and O Temple

Co-opted Members:
Mrs B Carr, Mrs R Hassoon and Murthy

1 Apologies

Apologies for absence were received from Councillors P Brookes, J Chaplow, P Crathorne, K Hopper, E Huntington, P Lawton, H Liddle, O Milburn, M Nicholls, J Robinson, A Savory and W Stelling

2 Substitute Members

There were no substitute Members in attendance.

3 Declarations of Interest, if any

There were no declarations of interest.

4 Any Items from Co-opted Members or Interested Parties

There were no items from Co-opted Members or interested Parties.

5 Durham Dales, Easington and Sedgefield Clinical Commissioning Group - Review of Urgent Care Services

The Committee considered a Joint Report of the Director of Transformation and Partnerships, Durham County Council and the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that provided details of the consultation feedback received from the public consultation exercise undertaken in respect of the three proposed options for Urgent Care Services in Durham Dales, Easington and Sedgefield (DDES) from April 2017 (for copy see file of Minutes).

Members received a presentation from Sarah Burns, Director of Commissioning, and Joseph Chandy, Director of Primary Care, Partnerships and Engagement, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that highlighted the following:-

- Why Change – a refresh of why the services needed to change
- The consultation process – a good section of the population was reached with 2771 responses received
- How they consulted – public meetings, roadshows, radio and video campaign and social media.
- Thematic Analysis
- The Outcome – ranking the options
- Estates – up to 3 hubs in each of the three localities
- Key Challenges & how they would be addressed
- Communication & engagement – 3 phased approach
- Key messages –
    - GP First
    - NHS 111
    - A&E or 999 only if life threatening
- Enhancement of the 111 Service – ability to speak to a GP, nurse or clinician. Importance of keeping directory up to date.
- Workforce – important to have sustainable care. A number of initiatives had been developed including Pharmacists working in general practice and GP career start to increase the number of GPs for DDES.
- Primary Care Access – working group set up to look at what is good access to general practice. Current demand would be measured and appointment availability.
- Making Good Access Happen
- Practice Sign up – support from GP practices and making the best use of the clinical staff available. The PRG had played a vital role and were thanked for their input.
- Measuring Success – with health issues being resolved on 1st contact with easier access and fairer to the whole population.
- To support change
- Milestones

The Chairman thanked the officers for their detailed presentation.

Councillor R Bell referred to GP practices receiving payment for providing urgent care, and asked if they would receive this regardless of how many patients they assessed. He further referred to GP practices signing up to good access and acknowledged that there needed to be a private place to talk to the receptionist if required. He said that he would like to see posters in GP practices explaining what you should do if you have an urgent care need – i.e. what to do and who to contact out of hours. He explained that there was nothing in his surgery at present to advise about urgent care and no facilities to discuss issues in private. He also asked for clarification on what option was being proposed to take forward.

The Director of Commissioning advised that option 3 was being put forward as the preferred option. The Director of Primary Care, Partnerships and Engagement advised that a task group had been set up over the summer to look at how people can make an appointment and all GP practices had been asked to sign up to producing a leaflet giving details about appointments and urgent care. He further explained that in future urgent

care would be available at GP practices during the day and there would be no supplication of costs being paid. GP practices would receive payment for the patient for the whole year.

The Director of Commissioning went to explain that GP practices had been involved in detailed discussions over the last 18 months and an understanding of resources at each practice had been reached. Some practices consume more resources than others and budgets were based on deprivation. With hub proposals there would be a fairer spread of resources and costs would be monitored.

Councillor S Forster agreed with the majority of the proposals but expressed her concerns with the NHS 111 Service. She felt that training was required and that it was not always better for people to talk to clinicians. She felt that training on how to end a call was also required and had personal experience of the telephone being slammed down when the call had ended. Referring to GP surgeries she said that in her surgery there was access to a confidential room and that there were posters in the waiting room regarding urgent care. She also mentioned that at her surgery a doctor would call you back within 2 hours to assess what care you needed.

The Director of Commissioning advised that the NHS 111 service was a nationally defined service and with more clinicians available to speak directly to patients would help to improve the outcomes and the service. She went to explain that GP services would be available from 8.30 a.m. to 8 p.m. and with the new role of an NHS 111 Relationship Manager it would allow the monitoring and would highlight any issues, such as if patients were directed to the wrong service.

Councillor J Armstrong suggested that Members should look at the changes and monitor the progress once the hubs were in place and the new systems had been implemented. He asked that a report come back to Committee to show if the new way of doing things was working, including improvements to the 111 service. He said that the public would need to be convinced that the changes were working.

Referring to Primary Care, Mrs Hassoon said that some patient reference groups had not met for over a year and therefore felt that the input was sporadic and dysfunctional. The Director of Primary Care, Partnerships and Engagement explained that the CCG cannot demand that practices run a patient reference group but that work was ongoing with those practices that did not have a group to help firm up their feedback on services. He advised that the Dales PRG had helped develop an information leaflet that would be used as a model for other groups. He further explained that the CQC do prefer to see how practices work with patients whether that be through meetings or feedback information.

Mrs Hassoon was informed that patients will have access to the practice manager should there be any concerns and was advised that all practices complete a MORI poll included questions about access. The data from this was published nationally and can be used to measure practices against patient satisfaction.

Referring to the 111 service Dr Murthy felt that the proposals were too good to be true. He felt that there was no joined up thinking and asked for a guarantee that patients would not have to repeat their stories several times. He referred to a case whereby the patient had repeated their story 6 times in a 3 hour period. He referred to the new role of

relationship manager and hoped that it would improve good co-ordination of care but felt that it was a case of too many cooks. Dr Murthy went on to ask if there would be any certainty of filling the shortage of GPs and asked if there would be a clinical audit to check that standards were being met.

The Director of Commissioning advised that a clinical audit would be carried out that would allow the measurement of how effective the pathway was. She informed the Committee that there was event held on Primary Care Pilot that discussed primary care from budgets to health care services. A speaker at the event had stated that perhaps we did have enough GPs and that some patients did not really need to see their GP. The Director of Commissioning said that the changes were to ensure that it was not just about access to a GP but about getting access to services first time. She went to explain that the relationship manager for the 111 service would provide the key to the success of the service by liaising with staff, clinicians and patients to ensure patients had access to GP appointments and out of hours contacts. The directory of service was an important part of this role and having someone in place on hand to react to situation was important. She did feel that the North East were lucky to have the Vanguard Service that gave more clinicians resulting in better services.

Councillor O Temple asked how people would know to go to see their GP rather than visit an urgent care centre and asked if people would not be allowed to visit an urgent care centre. He struggled to see why the urgent care centres would remain and asked about the interface between urgent care and GPs.

The Director of Commissioning said that it would be a behavioural change and would not be an easy task to discourage people from presenting at urgent care. Patients would still be triaged but would only receiving treatment if they presented with a minor injury. If presenting with an illness the patient would be diverted to their GP practice. It was hoped that appointment would be able to be made directly with the GP practice and that the next time the patient is feeling unwell they would use their GP first.

Councillor Bell was informed that there would be a re-branding of the service so that people knew where to go, further to a question about the changes.

Sue Jacques, Chief Executive of County Durham and Darlington NHS Foundation Trust commented that the health services need to work together and confirmed that the Foundation Trust had been involved in the development of the changes to Urgent Care within DDES CCG process. She advised that they supported option 3 and that work would continue to ensure that services were the best that they could be. She said that the changes would be kept under review and would be monitored regularly to ensure that there was no significant increase in the numbers presenting to A&E.

The Principal Overview and Scrutiny Officer explained that the Committee views in terms of the consultation process and the results of the consultation exercise were sought. He added that option 3 was the preferred option that would go forward to DDES CCG governing body for approval.

He asked Members if they agreed that consultation process had met its statutory obligations. He reminded Members that they had expressed a number of views throughout the process on how the model would work and advised that there were three

issues remaining and confirmation during implementation phase would be sought - GP capacity and accessibility, the 111 service and how people would be informed as to how the new model would operate. He suggested that the Committee could recommend that it receive a report post implementation to show how the changes have been implemented and how effective the new Urgent Care service had been in addressing those issues identified within the case for change.

Councillor Armstrong felt that the consultation exercise had been comprehensive and deep and that everything the Committee had requested had been taken into consideration. He said that it was an exercise that the CCGH should be proud of.

The Director of Commissioning thanked the Committee for their continued support throughout the process.

Resolved:

(i) That the report be received;

(ii) The Committee is satisfied that DDES CCG has met its statutory obligations and commends it's approach regarding public consultation in respect of its proposed changes to Urgent Care services within the DDES CCG locality

(iii) That the remaining concerns highlighted by the Committee in respect of GP capacity and accessibility; the NHS 111 Service and the communications plan associated with the implementation of the new Urgent Care model be relayed to DDES CCG and that the Committee agree support for the proposed option 3.

6 Health and Wellbeing Board Annual Report 2015/16

The Committee received a joint report of the Interim Corporate Director of Adult and Health Services and the Interim Director of Public Health County Durham that presented the Health and Wellbeing Annual report for 2015-16 (for copy see file of Minutes).

The Strategic Manager, Policy, Planning and Partnerships, CAS presented the third Annual report and highlighted the functions of the Board, the relationships with this Committee, the achievements during 2015/16 and the commitments made. Members were advised of the forthcoming Health and Wellbeing Board big tent event on 5 October 2016 and members participation in the event was welcomed.

Resolved:

(i) That the report be received; and

(ii) That the work undertaken by the Health and Wellbeing Board during 2015/16, be noted.

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Adults Wellbeing and Health OSC

03 October 2016

System Resilience Update

Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust

1. Purpose of the Report

1.1 The purpose of the report is to give an update on the transformation of System Resilience Groups (SRGs) to Local A&E Delivery Boards.

1.2 The report provides an overview of the 2015/16 funded resilience schemes undertaken by County Durham and Darlington Foundation Trust (CDDFT) and other providers, and the outcomes of these schemes following evaluation. It also sets out the process for resilience planning in 2016/17 and summarises the Local A&E Delivery Boards financial position in terms of resilience funding at the end of 2015/16 and going into 2016/17.

1.3 The report also refers to the plan for improving A&E waiting time performance and plans for the recovery of national and local performance to 95% by the end of 2016/17.

2. Background

2.1 Until recently the County Durham and Darlington System Resilience Group (SRG) had overall responsibility for the capacity planning and operational delivery of urgent and emergency care across the health and social care system.

2.2 On 26 July 2016 a letter from NHS England, NHS Improvement and ADASS (Directors of Adult Social Services) was received by CCG Accountable Officers and CEOs from Foundation Trusts, Ambulance Services and Local Authorities to outline plans for improving A&E waiting time performance for the recovery of England's performance to 95% by the end of 2016/17.

2.3 The letter set out performance against the 95% standard in the Northern Region over 6 months to May 2016:

	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16
North Region	90.7%	88.2%	88.0%	87.5%	91.3%	91.0%

2.4 A review of current arrangements for SRGs identified the need for local leadership structures to focus specifically on Urgent and Emergency Care and to be attended at the Executive level by member organisations. Therefore SRGs were transformed to Local A&E Delivery Boards on 1 September 2016, with Chair responsibility from a local acute Foundation Trust.

2.5 A response from County Durham and Darlington was submitted to NHS England in August 2016 to address the following actions:

- The agreed local leader who will chair the Local A&E Delivery Board
- Confirmation that the footprint of the Delivery Board had been reviewed and any appropriate mergers had been made as felt necessary
- Confirmation of the individual member organisations within the Local A&E Delivery Board and their named Executive lead and title
- Alignment of the Terms of Reference within the context of the North East Urgent and Emergency Care Network given the governance structure that had been established

2.6 The County Durham and Darlington Local A&E Delivery Board will comprise Darlington; Durham Dales, Easington and Sedgefield and North Durham Clinical Commissioning Groups (CCGs) and its focus will be on County Durham and Darlington Foundation Trust. The Chair will be Sue Jacques, Chief Executive of CDDFT, and Vice-Chair will be Stewart Findlay, Chief Clinical Officer from Durham Dales Easington and Sedgefield (DDES) Clinical Commissioning Group.

3. 2015/16 SRG Resilience Funding

3.1 In 2015/16, for the first time, CCGs received resilience monies from within their baseline funding allocation to facilitate 2016/17 funding being in place to manage year round surges in activity. This was a move away from previous years when resilience funding had been identified by NHS England later in the year.

3.2 In 2015/16 the available resilience funding, totalling £4,681,000, was split on a fair shares basis. CDDFT received the highest amount of resilience monies totalling £1,714,000. The Trust proposed six winter schemes they would use this funding for. CDDFT also received an additional £147,920 from SRG contingency monies for two further initiatives (Brokerage Scheme and A&E Ambulance Handover Nurse Scheme) at a later stage in the year.

3.3 In April 2016 providers were requested to evaluate their resilience funded schemes. They were asked to complete a standardised document which would provide specific detail to enable the SRG to determine the effectiveness of individual schemes and the impact they had on achieving the eight high impact interventions (appendix 2).

3.4 The SRG agreed that schemes considered not having had a positive impact and not contributing to the delivery of the eight high impact interventions would be stopped and not re-funded in 2016/17. The schemes that demonstrated a positive impact following evaluation would be rolled over in 2016/17. A summary of all provider schemes and the outcomes post-evaluation are listed in appendix 3.

4. 2016/17 Local A&E Delivery Board Resilience Funding

4.1 Following the recent transformation of SRGs, 2016/17 resilience funds will be deployed by the Local A&E Delivery Board. The funding allocation for winter resilience in 2016/17 is £4,708,000. Detail of how this is split by CCG is as follows:

CCG	Resilience monies (£,000s)	Mental Health resilience monies (£,000s)	Total resilience funding (£000's)
DDES	1,994	242	2,236
North Durham	1,531	197	1,728
Darlington	663	81	744
TOTAL	**4,188**	**520**	**4,708**

4.2 There are five mandated improvement initiatives which have been developed by experts in the field of emergency care. The initiatives that relate to streaming, flow and discharge represent actions that have already been adopted by the most successful systems. Local A&E Delivery Boards will coordinate and oversee these five actions of the A&E Plan:

- Streaming at the front door – to ambulatory and primary care
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – DoD and code review pilots; HEE increasing workforce
- Improved flow – 'must do's' that each Trust should implement to enhance patient flow
- Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models

4.3 The County Durham and Darlington Local A&E Delivery Board will also continue to support CDDFT and other providers with the delivery of the eight High Impact Interventions in 2016/17.

4.4 Providers have been invited to submit revised templates for schemes that will roll over in 2016/17 and proposals for new resilience schemes (i.e. those that won't continue in 2016/17) that are expected to achieve the five mandated improvement initiatives and the eight High Impact Interventions.

4.5 One provider member of the former SRG was opposed to decisions made following the outcome of 2015/16 resilience scheme evaluations. The provider failed to

submit evaluations for their 2015/16 winter schemes by the extended deadline. Brief evaluations of the schemes were received at a later date however these did not offer any substantive evidence that the schemes had a positive impact. The decision was made not to refund the schemes and not to allocate any 2016/17 resilience monies to the provider. This was formally communicated to the provider in August 2016. The provider has since appealed this decision and has requested a meeting with the former SRG Chair which is currently being arranged.

5. Winter planning and improvement assurance

5.1 Recent communication from NHS England acknowledged that performance this summer had not improved in line with expectations, and set out actions for Local A&E Delivery Boards in terms of winter planning as well as plans being put in place for the five mandated initiatives of the A&E plan.

5.2 As part of preparation for winter 2016/17 and assurance of the A&E plan NHS England has requested all Local A&E Delivery Boards to submit two plans by 30th September:

- A winter 2016/17 plan
- A plan for implementation of the five mandated improvement initiatives (and detailed recovery plans where appropriate).

To allow for variation of these plans at local level, no standardised templates have been developed to support this process.

5.3 To guide content of these plans, some basic principles to cover in winter planning have been provided from NHS England as follows:

A&E Improvement Plan	Plan for Winter 2016/17
· Plans/demonstration of new governance arrangements	· Plans for flexible capacity that can be increased in the event of winter surge, across the acute, community, residential/home care sectors and packages of care. This should include the agreed multi agency triggers for extending and withdrawing this extra capacity
· Plans for delivering ED streaming (against criteria set out in RIG)	· Plans for how Primary Care will work with the rest of the system to support the management of flow, particularly on Bank Holidays and out of hours
· Plans for delivering increase in NHS 111 calls being handled by clinicians (against criteria set out in RIG)	· Robust plans for ambulance services and NHS 111 providers to deal with known activity peaks in demand across the winter period
· Plans for delivering ambulance response programme initiative (against criteria set out in RIG)	· A comprehensive local flu strategy with a mechanism to monitor and performance manage provider and community uptake of vaccination. · An adverse weather plan which includes the clinical impact of cold weather and snow and also the impact on business continuity. · Plans for cascading advance warnings and briefings

A&E Improvement Plan	Plan for Winter 2016/17
	with a focus on admissions prevention amongst high risk groups
· Plans to implement measures to improve flow through the system (against criteria set out in RIG)	· System wide escalation plans in line with the new national framework with agreed local multi agency triggers. These triggers should include both escalation and de-escalation · Plans/processes for system- wide operational sitrep/ early warning & escalation reporting
· Plans for implementing best practice measures to improve discharge processes (against criteria set out in RIG)	· Collaborative operational planning with social services and mental health services
· Any other improvement actions being taken to get back to delivery of trajectory (if off track) and when this will be achieved · This will include any actions agreed as part of ECIP, CQC, special measures etc, to ensure there is one overarching system improvement plan	· CCG, Provider and Local Authority on-call arrangements to include an executive level.
	· Managed outbreak plans to avoid (and contain) any D&V/norovirus impact
	· A multi-agency proactive and reactive communications plan to promote appropriate use of local services. · Focus on high risk groups and admissions avoidance best practice.
	· A mechanism to test these arrangements ahead of the winter period.

6. Emergency Care Improvement Programme (ECIP) Facilitated Workshop

6.1 An ECIP Facilitated Workshop with a focus on ambulance handovers and Delayed Transfers of Care (DTOC) was held on the 4 August 2016. The workshop comprised representation from CCGs and Foundation Trusts from each North East region and the North of England Commissioning Support Unit (NECS).

Regional Concordat for Ambulance Handovers

6.2 Following the event a regional concordat for A&E ambulance handovers has been agreed, with specific actions for each Local A&E Delivery Board across the North East. Representatives from CDDFT, CCGs and NECS agreed three priority actions for County Durham and Darlington to be implemented within 120 days. These are summarised in the table below:

Priority actions for County Durham and Darlington					
	Objective	**Action**	**CCG Area**	**Led by**	**Timescale**
1	Directory of services (DoS)	• A review of end dispositions to include Social Care**	DDES, Darlington and North Durham	Helen Stoker (NECS)	<60 days
2	Activity review	• Develop a wider system involvement in the evaluation of unnecessary ambulance usage in particular GP's (perfect week in primary care)	DDES, Darlington and North Durham	Helen Stoker (NECS) on behalf of Local A&E Delivery Board	<60 days
3	Improve flow	• Develop further the SAFER bundle improving flow	DDES, Darlington and North Durham	Paul Peter (CDDFT)	< 60 days

****Note**: Work to develop the DoS is ongoing and is led by NECS. It has already been suggested that to support integration with Social Care links to LOCATE (a Directory of Services for Local Authority and Voluntary services) could be implemented.

Delayed Transfers of Care

6.3 In addition, an action plan on Delayed Transfers of Care for each Local A&E Delivery Board has also been drafted as a result of the workshop:

Regional action plan to reduce number of patients experiencing delayed transfer of care				
	Objective	**Action**	**CCG Area**	**Timescale**
1	Reduce number of patients experiencing delayed transfer of care	• Progress Discharge to Assess - 2 or 3 patients per day by 1 October 2016	DDES, Darlington and North Durham	<60 days
2	Reduce number of patients experiencing delayed transfer of care	• Implement Home First for 1 patient from next week	Sunderland	<60 days
3	Reduce number of patients experiencing delayed transfer of care	• Implement Home First for 1 patient within 2 weeks	South Tyneside	<60 days
4	Reduce number of patients experiencing delayed transfer of care	• Programme Model Ward – SAFER+ Implemented in 3 streams from 1st August 2016. Consider the requirements needed to undertake this fully and include external agencies	South Tees	<60 days

5	Reduce number of patients experiencing delayed transfer of care	• DTA pathway to be reviewed on 5th August 2016 across 10 patients. Aiming for implementation by September / October 2016	Hartlepool and Stockton	<60 days
6	Reduce number of patients experiencing delayed transfer of care	• DTA and Trusted Assessor – implementing over next couple of weeks • Implementing EDD / Red and Green days by September 2016. Need support for implementing Trusted Assessor across the region	Gateshead Newcastle	< 60days

7. Recommendations

7.1 The Adults Wellbeing and Health OSC is recommended to:

- Accept this report for information
- Note the developments, achievements and targets set for new schemes

Contact: Helen Stoker, Commissioning Manager,
North of England Commissioning Support Unit
Tel: 0191 374 2763

Background papers: None

Appendix 1: Implications

Finance – Clinical Commissioning Groups will receive resilience monies from within their baseline funding allocation to facilitate 2016/17 funding being in place to manage year round surges in activity. This happened for the first time in 2015/16 which was a move away from previous years when resilience funding had been identified by NHS England later in the year.

Staffing – Providers in receipt of Local A&E Delivery Board funding to support resilience schemes in 2016/17 will be expected to ensure appropriate safe staffing arrangements are in place to support each of their projects.

Risk – Contract variations will be put in place to ensure contractual accountability for appropriate use of the allocated Local A&E Delivery Board funding.

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation - None

Procurement - None

Disability Issues - None

Legal Implications - None

APPENDIX 2 – Eight High Impact Interventions for Urgent and Emergency Care

No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

APPENDIX 3 - SRG winter monies 2015/16, evaluation outcomes at a glance

Scheme	Provider	High Impact Areas delivered Y/N/P	KPIs Y/N/P	Comments	Recommendations Roll Forward New Proposal	R/A/G
Additional A&E staff to support rapid assessment and see and treat	County Durham & Darlington FT	**N**	**N**	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
Additional A & E staff to support majors practitioners care stream	County Durham & Darlington FT	**P**	**P**	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
Additional Medical staff in ED	County Durham & Darlington FT	**P**	**P**	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
Additional Physician of the Day capacity	County Durham & Darlington FT	**P**	N	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
Discharge Management & Facilities	County Durham & Darlington FT	**N**	**N**	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
Extended Access to Diagnostics	County Durham & Darlington FT	**N**	**N**	Didn't achieve the desired expected outcomes feedback given	New proposal To do something different to address the gaps identified in the evaluation	R
						£1,714,000
Front of House staffing	City Hospitals Sunderland FT	**Y**	**Y**	Achieved scheme objectives. Good case studies. Good evaluation	Roll Forward 16/17	G
7 day therapies and diagnostics	City Hospitals Sunderland FT	**Y**	**Y**	Achieved scheme objectives. Good case studies. Some text was repeated. Could therapists be based in A&E next time (would this improve the impact)?	Roll Forward 16/17	G

7 day pharmacy	City Hospitals Sunderland FT	**Y**	**Y**	Achieved scheme objectives. Good case studies. Good evaluation	Roll Forward 16/17	G
7 day discharge nursing team including specific front of house discharge team	City Hospitals Sunderland FT	**Y**	**Y**	Achieved scheme objectives however data limited	Roll Forward 16/17	G
Speciality Ambulatory care	City Hospitals Sunderland FT	**P**	**Y**	Achieved scheme objectives Good evaluation	Roll Forward 16/17	G
						£185,000
Resilience Beds including estates	North Tees & Hartlepool FT	**NO EVALUATIONS RECEIVED BY EXTENDED DEADLINE** **Fedback through contract lead that funding for NTHFT will not be an SRG priority in 2016/17.**				
Front Loading elective activity	North Tees & Hartlepool FT					
Therapy led discharge team	North Tees & Hartlepool FT					
Expansion of CIAT	North Tees & Hartlepool FT					
Pharmacy Support	North Tees & Hartlepool FT					
Ambulatory Overnight	North Tees & Hartlepool FT					
Day Case Unit Overnight	North Tees & Hartlepool FT					
Manager On-call payments	North Tees & Hartlepool FT					
GPs in A&E (full year)	North Tees & Hartlepool FT					
						£165,000
Funding for additional MH nurses	Tees, Esk & Wear Valley FT	**Y**	**Y**	Achieved scheme objectives Good evaluation - fedback through contract lead	Roll Forward 16/17 with tweaked/revised elements	G
						£503,000
Saturday Clinics	Darlington CCG	**Y**	**Y**	Achieved scheme objectives. Good evaluation	Roll Forward 16/17	G

Evening Telephone Advice Service	Darlington CCG	**Y**	**Y**	Achieved scheme objectives; expensive service for the low activity; potentially this duplicates current urgent care service, so recommend this is further discussed before rolling forward as other options maybe available	To discuss further for confirmed outcome	A
Sunday MDT	Darlington CCG	**Y**	**Y**	Achieved scheme objectives. Good evaluation	Roll Forward 16/17	G
Flu Vacs	Darlington CCG		**Y**		Roll Forward 16/17	G
						£172,514
Vulnerable Adults Weekend Scheme	North Durham CCG	**Y**	**Y**	Achieved scheme objectives. Good evaluation, scheme does not seem to be value for money	Potentially roll forward 16/17 but requires follow up discussion	G
GP Practice Weekend Opening	North Durham CCG			Achieved scheme objectives. Good evaluation	Roll Forward 16/17	G
						£497,000
SDHCIC ANP Team Sunday Morning	DDES CCG	**Y**	**Y**	Achieved scheme objectives. Needs increased evidence	Roll Forward 16/17	G
SDHCIC ANP team Weekdays 6pm - 8pm	DDES CCG	**Y**	**Y**	Achieved scheme objectives. Needs increased evidence	Roll Forward 16/17	G
SDHCIC Tackling Social Isolation COPD continuation	DDES CCG	**Y**	**Y**	Achieved scheme objectives.	Roll Forward 16/17	G
SDHCIC Suicide Prevention expansion - Spennymoor	DDES CCG	**P**	**Y**	Further evidence to demonstrate success of scheme was received post evaluation	*Evidence demonstrated that the scheme was successful and has informed a plan for a new link service which is now rolling out (CPN will be aligned to practices to carry out this work). For this reason the scheme will not be rolled forward in 2016/17. Invitation for new proposal.	R* (see comments in previous column)

SDHCIC Christmas 2015/New year 2016 additional capacity weekend opening	DDES CCG	**Y**	**P**	Achieved scheme objectives. Needs increased evidence	Roll Forward 16/17	G
SDHCIC Admissions reduction with additional locum cover / practice pharmacists to Frail Elderly	DDES CCG	**P**	**P**	Unsure whether this scheme has been successful or not based on evaluation	Potentially roll forward 16/17 but requires follow up discussion	**A**
SDHCIC Screening >5yrs non-attenders >50 yrs	DDES CCG	**SCHEME DID NOT START AS PLANNED – Will commence in July 2016** SDHCIC planned to commence the scheme in Spring 2016 but it was delayed. Expressions of interest have been sought from practices and the scheme is ready to go. Agreed that scheme will commence in July 2016 with last years funding. The scheme will be evaluated in October 2016 to inform the decision as to whether the scheme will run again in 2016/17. SRG will protect the 2016/17 funding (£61,833) until then.				**A**
						£378,497
Intrahealth Federation - Frail Elderly Additional Support	DDES CCG	**Y**	**Y**	Achieved scheme objectives. Good Evaluation	Roll Forward 16/17	G
						61,000
DDHF SRF	DDES CCG	**P**	**P**	Achieved scheme objectives.	Roll Forward 16/17	G
						£203,735
Social worker to support the DTOC pilot	Durham County Council	**Y**	**Y**	Achieved scheme objectives. Qualitative evidence is good, there are some conflictions with CDDFT evaluation conclusions, could explore further.	Roll Forward 16/17	G
						£158,000
Additional Assessment staff	Darlington Borough Council	**Y**	**Y**	Achieved scheme objectives.	Roll Forward 16/17	G

Rapid response Domiciliary and Overnight Support Service	Darlington Borough Council	**Y**	**Y**	Achieved scheme objectives.	Roll Forward 16/17	G
OT Equipment / Adaptations	Darlington Borough Council	**Y**	**Y**	Achieved scheme objectives.	Roll Forward 16/17	G
Additional Reablement	Darlington Borough Council	**Y**	**Y**	Achieved scheme objectives.	Roll Forward 16/17	G
						£57,000
Paramedic Rapid response	Police Authority	**Y**	**Y**	Achieved scheme objectives, small nos. However scheme was for 1 month	Roll Forward 16/17	G
Paramedic Support	Police Authority	**Y**	**Y**	Achieved scheme objectives, small nos. However scheme was for 1 month	Roll Forward 16/17	G
Dedicated Police Support in A&E	Police Authority	**Y**	**Y**	Achieved scheme objectives, small nos. However scheme was for 1 month	Roll Forward 16/17	G
						£20,716

Y = Yes

N = No

P = Partial

R	**Scheme will not roll forward in 2016/17. New schemes to be proposed**
A	**More information required. Scheme will roll forward in 2016/17 on receipt of additional information**
G	**Scheme will roll forward in 2016/17**

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Adults, Wellbeing and Health Overview and Scrutiny Committee

13 September 2016

Primary Care Strategies – Durham Dales, Easington and Sedgefield CCG and North Durham CCG

Joseph Chandy, Director of Primary Care, Partnerships and Engagement, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups

Purpose of the Report

1 The purpose of this report is to present the Adults, Wellbeing and Health Overview and Scrutiny Committee with the Durham Dales, Easington and Sedgefield CCG Primary Care Strategy (Appendix 2) and the North Durham CCG Primary Care Strategy (Appendix 3) for comment.

Background

2 Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is a member practice organisation made up of 40 GP practices with 14 branch surgeries. North Durham Clinical Commissioning Group is an organisation made up of 31 GP practices with 15 branch surgeries.

3 Both organisations commission services from three main acute care providers, two mental health providers, independent and voluntary providers as well as commissioning additional primary care services from member general practices by way of core contract and Enhanced Services. Since April 2015 the CCG's undertook new responsibilities for commissioning Primary Care which was previously commissioned by NHS England. Commissioning Secondary, Primary and Community Care allows the CCG to develop services around the patient journey.

4 Good Primary Care has to be modern, accessible, patient centred General Practice and the strategies describe the way in which the CCGs aim to achieve that vision through a range of objectives. The objectives have also been aligned to the vision of the Adults, Wellbeing and Health Overview and Scrutiny Committee along with the key messages from the Joint Strategic Needs Assessment.

5 In May 2016 NHS England published the General Practice Forward View. The CCGs have mapped their local primary care strategies against the national strategy and revised the delivery plans to reflect specific areas for development within the scope of their primary care strategic objectives.

Strategy Development

6 DDES and North Durham have developed their primary care strategies in different ways.

DDES developed a strategy with its key stakeholders.On 24th September 2015, The Council of Members agreed the vision and objectives which formed the basis of the strategy development. Feedback was sought from the Council of members on the initial draft of the strategy during October 2015.

The CCG also felt that it was vital to receive feedback from a range of different stakeholders and this was engagement exercise was therefore undertaken in November 2015. These stakeholders included members of the public, member practices, secondary care NHS Foundation Trusts, Public Health, Health and Wellbeing Board and Adults, Wellbeing and Health Overview and Scrutiny Committee. A standardised proforma was developed to ensure that feedback was received in a consistent format. Following the release of the General Practice Forward View an exercise was undertaken to ensure that the strategy was aligned to the key areas highlighted within the document.

This feedback has been incorporated into the final strategy which was initially taken to the Executive Committee meeting on 26th January 2016, approved following further minor amendments at the Executive Committee on 3rd May and ratified at the Primary Care Commissioning Committee on 10th May 2016.

North Durham's strategy has been refreshed in line with the 5YFV. The first draft is going to Adults, Wellbeing and Health Overview and Scrutiny Committee before going out to consultation. This is the list of stakeholders it will be going out to:

- Health and Wellbeing Board
- LMC
- Adults, Wellbeing and Health Overview and Scrutiny Committee
- County Durham and Darlington Foundation Trust
- Gateshead Foundation Trust
- Tees Esk and Wear Valley Foundation Trust
- Sunderland Foundation Trust
- Local Authorities
- NEAS
- Federations
- Health Networks
- Lay Governing Body Members
- PRG members
- Practices

Recommendations

7 The Adults, Wellbeing and Health Overview and Scrutiny Committee is recommended to:

a. Provide comments on the Durham Dales, Easington and Sedgefield CCG Primary Care Strategy (Appendix 2) and the North Durham CCG Primary Care Strategy (Appendix 3).

Contact: Gail Linstead, Head of Primary Care Development and Engagement, DDES CCG
Tel: 0191 371 3232

Appendix 1: Implications

Finance – Expansion of GP Career Start programme to include both CCGs and potential development of Specialist Practice Managers

Staffing – As above

Risk – Highlights issues of recruitment/workforce within member practice

Equality and Diversity / Public Sector Equality Duty – Equality and diversity has been given due consideration during the production of this report.

Accommodation – Premises and Estates are included within the strategies

Crime and Disorder – N/A

Human Rights – Have been given due consideration

Consultation - Consultations have been carried out through Patient Reference Groups, Area Action Partnerships, Council of Members, DDES Wide Meeting, Public Health Away Day alongside opportunity for email feedback from all those named previously plus other stakeholders such as secondary care Foundation Trusts and the Health and Wellbeing Board and Adults, Wellbeing and Health Overview and Scrutiny Committee.

Procurement – N/A

Disability Issues – N/A

Legal Implications – N/A

NHS

Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

A Refreshed Primary Care Strategy for DDES

2016-2018

Joseph Chandy

May 2016

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Introduction

Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is a member practice organisation made up of 40 GP practices with 14 branch surgeries. For the purpose of this Strategy, the term *Primary Care* refers to General Practice, although technically, it covers Pharmacy, Optometry and General Dental Services as well. We commission services from three main acute care providers, two mental health providers as well as commissioning additional primary care services from member general practices by way of core contract and Enhanced Services.

The NHS Five Year Forward View (5YFV) was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around the new models of care. This was published by the NHS Chief Executive Simon Stevens. We are working towards implementation of the 5YFV through the development of this strategy to move as much care as possible out of hospital into the community. Consequently, general practice will grow and change as will other services such as community hospitals as we implement multi-specialty community provision.

Since April 2015 the CCG has new responsibilities for commissioning Primary Care which was previously commissioned by NHS England. Commissioning Secondary, Primary and Community Care allows the CCG to develop services around the patient journey. When the NHS was founded in 1948, 48 per cent of the population died before the age of 65; that figure has now fallen to 14 per cent. Life expectancy at 65 is now 21 years for women and 19 years for men, and the number of people over 85 has doubled in the past three decades. DDES CCG also has some of the most deprived areas in England and premature mortality rates (under 75) for the biggest killers (heart disease, cancer, stroke) across County Durham are higher than the rest of England.

Given current pressures, commissioners must strive, wherever possible, to shift the curve of care from high cost, reactive and bed-based to preventative, proactive care, based closer to home and focus as much on wellness as on responding to illness.

Our current model of General Practice is the envy of the world. However, due to rising demand on the NHS, rising expectations regarding greater accessibility over seven days and the NHS financial challenge we have to explore new ways of delivering Primary Care in future. The General Practice Forward View has been published in April 2016 and sets out over the next 5 years the responsibilities and investment to undertake this transformation https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

The model of GP Practice created with the NHS in 1948 is by and large the same model. However, this is not sustainable for the future, with workforce, financial

challenges and our ambition to reduce health inequality, it needs to move forwards with radical models of change.

General Practice services look after the health and wellbeing of people in their local community who are on their registered list. Their core contract requires them to provide services for those who have or believe themselves to:

- Be ill with something from which recovery is generally expected
- Have a long term condition
- Be terminally ill'

General practice is organised into individual surgeries, some of whom have 'branch' surgeries. These are all of varying sizes depending on the size of the population they serve. Many branch surgeries are small, part time services but allow GPs to deliver some services at the heart of smaller, more isolated communities and to increase patient choice by offering more than one practice in a village. Core opening hours for general practice are 8-6, however; the CCG has commissioned additional opening hours, both during the week and on Saturday mornings, to offer flexibility and to accommodate patient need. Sunday morning surgeries were commissioned in line with central strategic direction initially but the demand for this was so low that the CCG re-invested the money where the demand was highest. This includes the ability for the NHS 111 service to book patients who ring when their practice is open directly into their practice, which helps patients receive the most appropriate care first time.

General practice is central to primary health care services in the UK. Primary health care services also include pharmacies and ophthalmologists plus a range of community services provided by Foundation Trusts.

The key attributes of primary care are:

- First point of contact for most health care needs.
- Continuity of care over a lifetime and, in many cases, across generations.
- Comprehensive service that ensures either the provision of general services, or referral on to specialist services.

Practices also offer a range of other services commissioned by the CCG and Public Health (Durham County Council) which reflect the needs of their local community. For example;

- Smoking cessation
- Near patient testing
- Sexual health
- Health Checks

General Practice core contracts are detailed at the link in Appendix A.

There is a huge opportunity for Primary Care in DDES to provide additional services that meet our patients' needs and reduce the reliance on hospital care.

The CCGs primary care strategy reflects the development of good primary care as the hub of wider health system that co-ordinates patients within a continuum of prevention, self-care, diagnostics, treatment, disease management, acute care and end of life. It is also aligned to the DDES Vision of "working together for excellent health for the local communities", and the CCG objectives which are to close the health and wellbeing gap and drive transformation to close the care and quality gap.

To meet these challenges, we will build on our strengths and maximise our opportunities to develop *a modern, accessible, patient centred General Practice in DDES.*

Dr Stewart Findlay

Chief Clinical Officer

Executive Summary

What is the CCG Vision

Working together for excellent health for the local communities

The Primary Care Strategy aligns with the three overarching priorities for the CCG:

- To drive up the quality of commissioned services
- To ensure full engagement and participation of patients, clinicians and stakeholders
- To deliver our five key aims within the CCG's allocated budget

What is the CCG Vision for Primary Care?

A modern, accessible, patient centred General Practice in DDES

How will this strategy achieve this? – Our four objectives:

- Developing 7 day services that meet the needs of our vulnerable population
- Sustainable Care closer to Home and out of Hospital
- Focusing on Population Health
- Wrapping services around General Practice

Our programmes of work to deliver these objectives will form part of our Operating Model and implementation plan:

1. Developing 7 day services that meet the needs of our vulnerable population

1.1 We will develop Primary Care services from 8am-8pm weekdays from April 2017.

1.2 We will build upon the CCG's successful GP Practice Weekend working pilot for Saturdays and expand over the weekend for vulnerable patients. The means that

support is available for vulnerable patients outside of normal GP Practice Core Hours

1.3 Workforce is essential to deliver 7 day services. We will continue our initiative for attracting GPs in the form of Career Start Scheme, extend the Nursing Career Start Scheme and develop Pharmacists in General Practice.

1.4 Driving up Quality will underpin our approach to strengthening Primary Care.

1.5 Ensuring that all Practices have robust Business Continuity plans so that service continuity is assured.

2. Sustainable Care Closer to Home and out of Hospital

2.1 We are piloting a disease specific pathway for integration of services and budgets developed in line with the 5YFV new models. Diabetes has been chosen and will require a pooling of health and Local Authority budgets and creating centres of excellence in primary care that will increase prevention and management in the community.

2.2 In 2014 the CCG created a new set of Local Enhanced Services. From 2016, we will evaluate the use of Direct and Local Enhanced Services and the Quality and Outcomes Framework (QOF) to improve patient outcomes and reduce duplication of services and targets.

2.3 CCG will develop Practice Based Budgets and support a Demand Management programme to align clinical and financial responsibility and optimise our use of secondary care.

2.4 The CCG will create a programme for Supporting Struggling Practices and develop a Federation approach.

3. Focusing on Population Health using new models of delivery

3.1 We will use a robust evidence base to demonstrate The Case for Change for population health and reducing health inequalities.

3.2 Build upon the current development of Federations to develop at scale models outlined in the 5 Year Vision and develop the concept of Primary Care Home

3.3 Ensure that our primary care premises and community hospitals are optimally utilised to benefit services grouped around local populations.

3.4 The CCG will continue to develop learning opportunities for Primary Care staff and develop learning sets as part of the organisation culture to becoming a learning organisation.

4. Wrapping services around the patient

4.1 Progress the development of the Integration of Primary and Community Care Nurses to wrap around practice and patients to avoid duplication.

4.2 We will ensure that the Primary Care Information technology structure supports patient care and greater accessibility by healthcare professionals and patients alike.

This plan sets out our approach to future Primary Care delivery aligned to our priority health outcomes within NHS Durham Dales, Easington and Sedgefield CCG.

'Delivering the Forward View' sets out steps to help local organisations to develop plans which will enable them to deliver a sustainable, transformed health service and to improve quality of care and wellbeing. This includes a new, dedicated Sustainability and Transformation Fund (STP) worth £2.1 billion in 2016/17 and rising to £3.4 billion in 2020/21. Within the STP there are nine 'must do' targets for 2016/17. These are:-

1. Develop a high quality and agreed Sustainability and Transformation plans.

2. Return the system to aggregate financial balance.

3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.

4. Get back on track with access standards for A&E and ambulance waits.

5. Improvement against, and maintenance of, the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

6. Deliver the NHS Constitution 62-day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two-week and 31-day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain two new mental health access standards [and] continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with learning disabilities.

9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures

Where the 'must do's impact on Primary Care we will strive to ensure that this strategy encompasses the CCG's ability to achieve these targets and to also answer the questions posed in the NHS Forward View Guidance 2016/17 (hyperlink - https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

Joseph Chandy

Director of Primary Care, Partnerships and Engagement

How does this fit with CCG and Health and Well Being Priorities?

The Health and Wellbeing Board vision is:

Improve the health and wellbeing of the people of County Durham and reduce health inequalities'

The key aims/programmes of work for DDES CCG are aligned to the Health and Well Being Board Priorities/Strategic Objectives which are:-

1. Children and young people make healthy choices and have the best start in life
2. Reduce health inequalities and early deaths
3. Improve the quality of life
4. Long term conditions independence and care and support for people with
5. Improve the mental and physical wellbeing of the population
6. Protect vulnerable people from harm
7. Support people to die in the place of their choice with the care and support that they need

Joint Strategic Needs Assessment (JSNA)
The Joint Strategic Needs Assessment (JSNA) provides a detailed overview of the current and future health and wellbeing needs of the people of County Durham. The data and key messages from this document provide the evidence base for the development of the Joint Health and Wellbeing Strategy 2016/19, the Children, Young People and Families Plan 2016/19 and Clinical Commissioning Group Commissioning Intentions.

The Key messages are focussed around the demographics of the population of County Durham alongside their Health and Social Care. For more detail on the JSNA's key messages please visit (hyperlink)

http://www.durham.gov.uk/media/9140/JSNA-2015-key-messages/pdf/CountyDurhamJSNAKeyMessages2015.pdf)

Many of the initiatives in the primary care strategy address these key messages. In particular smoking cessation, NHS Health checks, aligning mental health workers to general practice and integration of services.

Engagement and feedback on the Strategy Refresh

Before commencing this strategy refresh we had discussions with key stakeholders. In November 2015 we have consulted specifically with the following groups;

- Member Practices
- Council of members
- Patient Reference Groups
- Area Action Partnerships
- Local Medical Committee

The engagement proforma document relating to this process is available at Appendix B.

All members of the above committees have been given a pro-forma to complete the feedback. On this pro-forma we asked if the vision and objectives need to change and if so for some suggestions or ideas as to what they should change too. We also asked if respondents agreed with the way forward and for any additional comments or ideas. The comments we have had include;

- Doctors should come out at night and over the weekend
- The vision and objectives would be achievable with proper resources but may not be deliverable in the current climate.
- Proper and effective engagement is the number one objective (both with patients and with partners). Engagement has been undertaken before and ignored.
- We have lost the experience in management to effectively deliver primary care.
- Primary care is failing in a number of areas;
    - 7 day week not resourced
    - Shortage of doctors
    - Failing services in rural areas
    - Demise of volunteer support services
    - No proper emergency cover by consultants at weekends
- Need to demonstrate you are listening to communities and value their input.

Member Practice Engagement
We have also sought feedback specifically on this strategy refresh and received the following comments;

The draft Strategy refresh was discussed at the Council of Members and at the DDES-wide and Locality Group meetings prior to being circulated to all practice staff to seek their views. The main themes from the Council of Members were;

- GP workforce
    - Concerns about the aging profile of the current GP workforce
    - Desire to increase the skill mix and include wider skill base in this
    - Concerns about the increasing demands on primary care
- Premises
    - Use of void space across the health economy
    - Need to make use of the void space in secondary care premises too
- General Practice at scale
    - Continue support for Federations
    - Ensure increased work in Primary Care is appropriately funded
    - Concerns that 8-8 and 7 day working are not deliverable due to workforce issues

There was general consensus that the vision, objectives and way forward were correct although there was some individual disagreement.

Other issues were also discussed, but the above are the main themes which were raised. These other issues included whether 7 day working was required as Sunday opening has been tried in the CCG and was not utilised by patients. Practices could trial a step process to GP access whereby patients are seen by other members of the clinical team initially before being referred to a GP only when necessary. There could also be a 'home visit squad' who undertake all home visit requests for a group of practices or perhaps for a federation.

Stakeholder feedback
Finally feedback was also requested on this strategy refresh for our colleagues and partners in the local Acute and Mental Health Secondary Care Foundation Trusts and Primary Care beyond the Council of Members. The main themes from these stakeholders were:-

- To see a further focus on the 9 musts do's from the Sustainability and Transformation Plans and where primary care fits into this process
- Detail on the efficiencies to deliver admission avoidance and timely discharge from the acute sector
- The role of Pharmacy as part of the whole systems approach
- Welcomed the alignment and inclusion to the Health and Well Being Board Objectives
- Links required to the Joint Strategic Needs Assessment
- Reference to multi-disciplinary and integrated working
- To identify vacant space and utilisation of space within primary care premises
- GP workforce specifically relating to recruitment issues and the ability to build capacity to ensure it can cope with the increasing volume of work.
- The future size of GP practices/hub arrangements.

What does this Strategy build on?

This Primary Care Strategy builds upon the 2013-15 strategy. This has, in the main, been delivered. The strategic vision and objectives for the 2013-15 strategy were:

- **Strategic vision;**
  - Investing in General Practice for a modern, patient centred integrated service
  - Sustainable care closer to home and out of hospital where appropriate
  - Accessible General Practice with personalisation and continuity of care
  - Reducing inequality improving health focusing on outcomes and best evidence
- **Strategic Objectives**
  - To have a high quality core service supporting 7 day working with the additional capacity to support an out of hospital strategy
  - To have a service that strengthens prevention, management of long term conditions and ambulatory care sensitive conditions
  - To have a service that co-ordinates care for the elderly

What did this Strategy achieve?
In two years there has been significant transformation of Primary Care. This has been achieved even before becoming direct commissioners of Primary Care through:-

- The development of access to healthcare services seven days a week (we are doing this by improving the availability of patient appointments) and wrapping services around the patient; The CCG commissioned a scheme to enable practices to offer extended opening hours every Saturday. Originally introduced in November 2013, the scheme improved access to GP appointments and was extended by the CCG until the end of March 2015. The scheme was extremely successful and saw thousands of patients every weekend in primary care. From June 2015 the scheme has been given greater flexibilities and appointments can be booked via 11, the impact can be seen in the table below. The information below includes 25% of interventions/contacts from the VAWAS nurses. These nurses look after our vulnerable patients and prevent them from being admitted to hospital.

- Total interventions seen in Primary Care to from June 2015 – March 2016:

Federation	**Target patient contact**	**Actual Interventions**
Intrahealth	1755	3799
DDHF	3926	5104
SDH	9200	15792
Total	**14881**	**24695**

- Improving services for frail and vulnerable patients, being visited by an appropriate professional from a common care plan which may reduce multiple visits by multiple professionals. In DDES CCG all 41 practices signed up to the Unplanned Admissions Direct Enhanced Service (DES) (14/15) to identify a minimum of 2% of registered adult patients (18 years and over) at risk of unplanned admission to hospital. The percentage figure is agreed with NHS England across the country as being the most optimal population for effective intervention. The DDES CCG Vulnerable Adults Wrap Around Service (VAWAS) specification is a further enhancement to the DES. This cohort of patients were those who the VAWAS service initially focused on, however additional services must also wrap around those patients as identified in the specification/contract. Having identified the patient list practices developed care plans for patients as part of proactive case management working with this additional resource of nurses.

- Encouraging GP practices to work together. GPs have traditionally worked separately yet there is a growing realisation that general practice has to work at a larger scale to extend access beyond core hours and compete for community based services as they move out of hospital. In 2013 the practices grouped together to form three Federations i.e. Practices coming together in a separate commercial entity to provide services at scale for a greater population and to compete in the healthcare market. These Federations have made massive strides already despite being new organisations. Two of our Federations provide Anti-coagulation services and are part of a new national pilot for employing pharmacies in General Practice. All three Federations provide weekend working, Advanced Nurse Practitioner and wrap around nurse schemes are in place to ensure extra services for patients and increase capacity in Primary and Community Care. One of our Federations also provides Rapid Testing status for a new model of Primary Care delivery called Primary Care Home.

- Our member GP practices were facing GP recruitment and retention issues. Many GPs are taking early retirement and new GPs are choosing to become agency locums as an alternative career/lifestyle choice. In addition, DDES is a very deprived population with high levels of morbidity that increases the work burden on General Practice. Geographically the area does not offer the same economic or lifestyle choices that other parts of the North East offer a GP and their family when making a life commitment to a workplace. With the support of Health Education England we committed to reverse this downward spiral by launching 'Career Start'. By offering newly qualified GPs the opportunity of guaranteed continuing education and a minimum guarantee of salary we have recruited seven new GPs. 15 Practices highlighted vacancies and this programme has begun to make inroads.

- The CCG committed to investing in General Practice and have more services delivered out of hospital. There was a legacy of some additional or enhanced services commissioned by predecessor commissioning organisations. However, this was different in each locality and this causes inequity of access for patients and inequity of funding for practices. For 2014-16 the CCG successfully reviewed and re-launched 5 new enhanced services which focused on Gynaecology Minor Injuries, Dressings, Near Patient Testing and Shared care treatment.

- The CCGs has a statutory role in driving up quality in Primary Care. Since 2013, the CCG has commissioned a quality incentive scheme. This requires General Practice to look at consolidating some of their existing good practice by additional audits which allows them to learn from current patient experience and improve outcomes. This scheme also assisted the CCG in pump priming the development of Federations.

- The CCG works with our Local Authority partners to deliver on our Health and Well Being priorities. Screening, smoking cessation and Health Checks are the main services commissioned from General Practice. The CCG has worked with the Local Authority to move practices to the new programme for Health Checks called 'Checks for Life'.

- In conjunction with our Information Technology Strategy, all Practices in the CCG have been moved to a new system that stores patient data in warehouses as opposed to being in the individual practice computer. This web based system has now enabled patients to access their records at many more points of care than just their General Practice. However, this requires patient consent.

The following is a summary of the main aims and objectives from that strategy and how we have delivered on them;

2013-15 strategy	**Delivery**
Workforce – GP Career start scheme	7 GPs on the career start scheme with a further 3 coming on board
7 day working and weekend opening	GP services open on Saturdays across DDES
Frail Elderly – Vulnerable Adults Wrap Around Service (VAWAS)	VAWAS services operating 7 days a week
Quality Incentive Scheme (QIS)	QIS in place in practices
Investment – Enhanced Services	Enhanced Services Commissioned from General Practice and investment increased
Primary Care at Scale – Federation development	3 fully operational Federations with pump priming for three years
Information – Migration to web based systems	Migration complete
Premises – condition and utilisation of void space	6 facet survey and utilisation survey undertaken.
Prevention – Change for Life	Change for Life roll out underway
Research and Innovation – R&I collaborative	CCG actively involved in developing a research network of practices
Patient Engagement	Developments are being undertaken with our locality Patient Reference Groups to align patient champions to provide objective advice on key transformation areas such as Diabetes, Urgent Care etc.

1 Developing 7 day services that meet the needs of our vulnerable population

1.1 We will develop in Primary Care services from 8am-8pm weekdays from April 2017.

There are many routes available to patients for accessing Primary Care routine and urgent care during the day. In addition to General Practice there are also Urgent Care Centres and Accident and Emergency. These different centres are often used inappropriately in place of General Practice and sometimes accessed all together causing a duplication of services despite supporting patient choice. Currently General Practice closes at 6pm in DDES CCG.

There is a region wide Urgent Care Strategy covering Durham and Darlington. The Urgent Care Strategy identifies eight high impact interventions which were developed by NHS England following the Keogh review of urgent and emergency care in 2014. The main one pertaining to this Primary Care Strategy is that;

No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

The Out of Hospital strategy developed across Durham, Darlington and Tees as part of the Better Health Programme also requires a responsive General Practice as one of its standards to prevent unnecessary admissions and emergency attendances. This standard was recommended in March 2016.

These interventions are parallel to the direction of travel within Primary Care to ensure patients are seen in the right place first time and to develop services and capacity in primary care by moving as much as is safely possible out of hospital.

Last year the Prime Minister created a Challenge Fund to allow General Practice to explore widening access. An independent evaluation on the first wave of the Prime Minister's GP Access Fund (formerly Challenge Fund) pilots has now been published.

The first report on the national evaluation of the programme looks at how the first twenty pilots have delivered on their key objectives to provide more GP appointments, expand the types of patient appointments and improve patient and staff satisfaction in GP access.

The wave one pilots will use the results of the evaluation to work with their local CCGs and assess how the most successful aspects of their local pilot can be incorporated into future services. A second evaluation report will be published in the coming months which will present data over a longer period of time compared to the first wave of the pilot.

What is the CCG doing?
Currently we have created slots with 111 for them to book directly into General Practice during the day. This offers an alternative to sending all patients to Urgent Care.

Direct Enhanced Services (DES) for extended hours access
The intended outcome of the Direct Extended Hours Access Scheme (DES) is an increase in patients' access to primary medical services, though face to face appointments with a health care professional at times outside practices' current core contracted hours, in line with any known patient preferences, and utilised at an acceptable rate. Appointments may be booked ahead or booked at the last minute.

As we develop 7 day services in DDES we need to look at the current take up of this DES which is not universal and how this investment can support access for vulnerable patients till 8pm weekdays across the CCG.

Key deliverables

- Commence a consultation on day time urgent care as part of the DDES wide urgent care strategy development
- Explore pilots for 6-8pm opening for vulnerable patients
- Review the DES for extended hours
- Negotiate for pathology and diagnostics to be more accessible between 6-8pm.
- Explore current ease of access for urgent and routine appointments in General Practice and whether capacity is meeting demand.

1.2 We will build upon the CCG successful GP Practice Weekend working pilot for Saturdays and expand over the weekend for vulnerable patients

The CCG commissioned a scheme to enable practices to offer extended opening hours every Saturday. Originally introduced in November 2013, the scheme improves access to GP appointments and was extended by the CCG until the end of March 2015. A number of practices ran the scheme together, giving patients a choice of:

- pre-bookable Saturday appointments;
- urgent appointments booked on Saturdays via NHS 111;
- urgent walk in appointments on Saturdays.

The scheme was extremely successful and saw thousands of patients every weekend in primary care. Due to the introduction of this service Urgent Care activity has dropped by 8% in Seaham, Peterlee and Bishop Auckland, whereas a 23% reduction has been reported from the Walk in Centre at the Healthworks, Easington.

The introduction of the CCG extended opening in primary care offers choice and alternatives for patients who might otherwise attend A&E, Urgent Care Centres and Walk in Centres.

Extending opening for GPs also supports the interaction with other services working outside of normal hours for example District Nursing, Intermediate Care plus and VAWAS services and much needed support to our care homes. This all contributes to the reduction of unnecessary admissions and provides care for patients closer to home.

From 1st June 2015 the new extended opening service now offers the following;

- GP extended opening on Saturday mornings for same day appointments/111 diverts and walk ins and telephone advice;
- GP priority appointments and advice to care homes/residential homes/ ANPs/111 and support triage on a Saturday morning;
- ANP advice to care homes/residential homes/ 111 and support triage on a Saturday and Sunday;
- Extend the current VAWAS model to offer home visits for house bound and care homes over the weekend;

The scheme aims to reduce the pressure on hospital accident and emergency departments, allowing them to concentrate on more urgent cases, and evaluation of this will inform future commissioning of extended opening.

Urgent and Community Care Networks
The North East Urgent Care Network has been successful in its bid to be a Vanguard site in the development of a model of care across the North East to address system pressures and improve quality of care and patient safety. Urgent care will be delivered, not just in hospitals, but also by GPs, pharmacists, community teams, ambulance services, NHS 111, social care and others, and through patients being given support and education to manage their own conditions. Another aim is to break down boundaries between physical and mental health to improve the quality of care and experience for all.

The Urgent Care Strategy puts GP practices at the heart of the Urgent Care System, recognising their role in providing access to responsive primary and community care services 7 days a week.

Key deliverables

- Evaluate the use of VAWAS nurses until 8pm weekdays and weekends
- Extent GP Practices opening Sundays, appointments are required alongside out of hours arrangements

1.3 Workforce is essential to deliver 7 day services. We will continue our initiative for attracting GPs in the form of Career Start, extend the Nursing Career Start and develop Pharmacists in General Practice.

NHS England, Health Education England, RCGP and the BMA GP Committee are working together to ensure that we have a skilled, trained and motivated workforce in general practice.

All four organisations have jointly developed a new GP workforce action Action plan which sets out a range of initiatives to expand the general practice workforce. The broad themes are:

- **recruit newly trained doctors into general practice**
- **to retain GPs**
- **to encourage doctors to return to general practice**

There is a critical workforce problem given the relative shortage of new GPs who want to work in the North of England. As a CCG we have locally developed an initiative to recruit newly trained GPs in to the area with our Career Start scheme.

Building capacity in general practice

GP Career start
The GP Career start scheme (which was initiated through the previous Primary Care Strategy) was considered as a one-off scheme. By attracting seven new GPs into the DDES CCG area, which will improve chances of retaining these individuals in the longer-term, the scheme has proved to be a success. These GPs have formed a CCG-based peer set. When the occasion presents, we are taking this peer set to Durham University Queens Campus Stockton and extending the training to ST3 students. These are students in their last year of GP training and at the end of their training they will be looking for permanent jobs. In order to develop this scheme into a regular recruitment campaign we are widening the peer set to include ST3s who will pay per session to attend. Immediately we will be selling our area with a strong learning culture.

Pharmacy Pilot
By testing new ways of working across professional boundaries, we are taking another step forward to relieving some of the pressure that GPs are clearly under and ensuring that patients see the health professional that best suits their needs. In 2015, the government announced a pilot with funding of £15m to incentivise general practice to employ pharmacists. Two of our Federations have been successful in this bid for this pilot which will see 10 practices locally employing pharmacists alongside their clinical staff.

Recruitment and retention of the clinical and medical workforce has been one of the major themes in the feedback received. The main concern is that there is a huge

expectation in terms of primary care development in coming years. This expectation will not be achieved with the current workforce and more needs to be done to try to recruit not only GPs, but also nurses and Health Care Assistants alongside developing the skill mix with the wider workforce such as Pharmacists, Advanced Nurse Practitioners and Allied Health Professionals.

Key Deliverables

- Continued development of the Career start GP scheme built upon Phase I of the scheme which now has seven new GPs in post. Phase II will be the development of GPs with additional interests, by providing access and support to development/courses in areas of interest. These are recognised as being key development areas, especially for delivery of care in an out of hospital setting. For example, care of the elderly, which has been highlighted as an area of interest and priority to provide enhanced care for the frail elderly in their own homes and dealing with multi-morbidity. We are currently working with HENE and our local acute trusts to develop this.
- Promote the career start scheme as an employment route for aspirant/trainee GPs who are in their final stages (ST3).
- Explore portfolio opportunities with other providers as part of the GP career start development.
- HENE is developing schemes for return to practice and near retirement GPs.
- Expand a career start programme for practice nurses. This will help the transition of nurses working in the secondary care setting who wish to work in primary care. This expansion will include Sedgefield for the first time and therefore benefit all localities.
- Access to clinical leadership programmes for GPs. This will include building on the existing clinical leadership programmes, where these are appropriate. However, it may also require access to additional training. Two of our GPs (Dr Satinder Sanghera and Dr Jonathan Smith) have previously attended the North East Leadership Academy (NELA) Clinical Fellowship Programme.
- Developing the pharmacy workforce by working with the HENE Pharmacy Sub Group to ensure appropriate development of the pharmacy workforce in primary care. This will be in addition to the national pilot for expanding the pharmacy workforce in primary care.
- Work actively with NHS England to introduce a capping of locum costs.

Driving up Quality will underpin our approach to strengthening primary care
We will use local and national frameworks to assist us. Local schemes include the CCG Quality Incentive Scheme and Prescribing Incentive Scheme. National Performance frameworks include the Friends and Family test, Care Quality Commission and the Primary Care Web tool.

CCG approach to quality
A comprehensive programme of quality improvement activity has been introduced across the CCG member practices supported by the locality quality leads.

The activity includes a focus on improving the processes for safeguarding children, improving diagnosis rates for Dementia, improving the diagnosis of Cancer, reporting of incidents and improving the care for those who are on the end of life / palliative care registers.

Locality Prescribing Groups now have their own designated GP Prescribing Lead and there is a clinical champion and locality representation on the CCG Research and Innovation Group.

DDES CCG is also involved in contributing to the development of the NHS England approach to Clinical Quality Review, helping to oversee provider quality in secondary care and supporting the development of how primary care services will be monitored in the future.

Quality Incentive Scheme and Prescribing Incentive Scheme
The CCG has, since 2012, worked with practices on evidence-based improvements for patients that would be an enhanced over their day to day work. The aim of these schemes is to reduce health inequality and ensure that the quality of care and prescribing patients currently receive is delivered to an even higher standard.

Patient Experience (FFT)
The Friends and Family Test (FFT) was introduced in England in April 2013 and initially established in all NHS inpatient and A&E departments. In December 2014, it was rolled out across Primary Care organisations. The FFT is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. For example, it asks people if they would recommend the NHS services they have used. The FFT provides a mechanism to highlight both good and poor patient experience (NHS England, 2014).

DDES CCG is working with NHS England to analyse the submissions from the FFT in order to identify areas of improvement within primary care based on patient experience. We are also working with our Patient Reference Groups to analyse the responses. Patient Reference Groups are made up representatives from each GP practice Patient Participation Group and they meet monthly, by locality supported by the CCG.

Constitutional Indicators
The CCG also has responsibilities set out in the NHS constitution which are delivered in Primary care; namely cancer diagnosis and end of life care.

Cancer Diagnosis
To address improved survival, evidence strongly advocates for earlier diagnosis, and timely access to treatment (Foot and Harrison, 2011). GPs have been suggested as pivotal in this arena, and survival rates have been highlighted as a key index of the effectiveness of Primary Care in cancer management locally (Abdel-Rahman et al, 2009).

Looking to the future, the overall picture for cancer survival is positive. However, in the short term, inequalities still exist. In 2015 DDES CCG introduced a Quality Incentive Scheme (QIS) which included an element that specifically looked to address issues with cancer diagnosis. In the scheme GP Practices are asked to:-

- Complete an audit on' Improving diagnosis of cancer'
- Evaluate the effectiveness of action plans in place following a previous audit
- Develop a second action plan where issues are still apparent

These actions will be monitored via the QIS process.

End of Life Care

The first national End of Life Care Strategy (2008) generated significant momentum to reverse the upward trend of people dying in hospital. However, there is still much to build on.

The Quality Standard for End of Life Care (NICE, 2011) provides a comprehensive picture of what high quality end of life care should look like. Taking into account the current needs of the population and the changing health and social care landscape, NHS England (2014) has developed a 5 year vision for end of life care beyond 2015. This strategy focuses on 'dying well', wherever it occurs, with Primary Care being identified as a key stakeholder.

As with Cancer the DDES QIS included an element that specifically looked to address issues with End of Life Care. Within the scheme GP Practices are asked to:-

- Identify a practice End of Life Care Lead
- Engage with the CCG Cancer/End of Life Care Lead and hold regular Multi-Disciplinary Team Meetings
- Demonstrate continued improvements in End of Life and Palliative Care using the Gold Standards Framework
- Increase the number of patients on the End of Life/Palliative Care registers

Learning Disabilities

CCGs need to give particular consideration to commissioning services for people with learning disabilities because they experience poorer health than the general population. These differences are to a large extent avoidable and thus represent health inequalities. Some health inequalities relate to barriers people with learning disabilities face in access health care and health screening.

People with learning disabilities often have difficulty in recognising illness, communicating their needs and using health services. Research shows that regular health checks for people with learning disabilities often uncovers treatable health conditions. Most of these are simple to treat while sometimes serious illness such as cancer is found at an early stage when they can be treated. The Annual Health check is also a chance for the person to get used to their GP practice, which reduces their fear of going at other times.

In order to drive up the quality of services for people with a learning disability and to aim to reduce the inequalities specific measures have been added to the 2016/17 Quality Incentive Scheme. These measures will include GP practices:-

- Increasing flu and pneumo vaccinations including those in care homes
- Increasing health checks (including eye checks), including those in care homes
- Supporting practices to carry out death reviews for people with a learning disability

Key Deliverables:

- We will continue in 2016 with a QIS and Prescribing Incentive Scheme (PIS)
- Constitutional indicators will be included in the QIS scheme so that General Practices are able to support achievement.
- A Primary Care Macmillan service is commissioned to support practices improve screening rates and support newly diagnosed patients.
- We will develop a dashboard to monitor practice achievement against Friends and Family test, Care Quality Commission inspections, QOF and the Primary Care Web tool. We will also use the developing trigger tool within RAIDR that draws upon practice data to identify untreated patients.
- The QIS will include new targets for improving Learning Disability health

1.4 Ensuring that all Practices have robust Business Continuity plans so that service continuity is assured.

Primary care is an essential service that is relied on by the community. Planning ahead for how to continue to provide services during any circumstance is essential; whether it be a disruption to a single practice (such as a fire) or a wider-scale event that impacts on a whole region (such as an earthquake).

In addition, primary care may experience an increased demand for their services during emergency events, and find they are faced with providing services beyond their 'business as usual'.

From 2015 our responsibility as a level 3 Commissioner of Primary Care means that we require assurance that all practices have these plans in place. An example of a business continuity plan is included in our Operating Framework.

Additionally, the CCG as commissioner has to be able foresee any bottle necks or problems around the corner that may result in individual practices moving to a challenging position. This is covered under section 2.4.

In line with managing day time urgent care a six level escalation plan within the North East Escalation Plan (NEEP) framework has been adopted by General Practice through the Federations. For the first time this allows us to have an up to date position on practice capability at any given time.

Key Deliverables

- Practices to lodge business continuity plans with the CCG by March 2016.
- The CCG to create an escalation flow chart for incidents that affect business continuity and require escalation outside the practice.
- CCG continues to monitor the NEEP framework to establish patterns of service challenge.

2 Sustainable Care Closer to Home and Not in Hospital

2.1 We are piloting disease specific pathways for integration of services and budgets developed in line with the 5 year Forward View new models

The above objective demonstrates how the CCG is moving in the same direction of travel as set out by Simon Stevens in the 5 Year Forward View which was published in October 2014. This sets out the direction of travel for the NHS over the subsequent five year period up to 2019. The document argues that in order to ensure the sustainability of the NHS in the longer term a radical upgrade in prevention and public health in required as part of a radical over hall in the structure of how NHS services are delivered to patients.

Better Health Services
Commissioners and clinicians are three years into a programme of work that considers the future needs of patients and the health services they will need in Darlington, Durham and Tees.

Phase 1 was known as the 'Acute Service Quality Legacy project' which focused on how we deliver clinically agreed standards of care for best patient outcomes and then addressing how finance and workforce constraints impact on this. During this phase clinicians agreed clinical standard aspirations for:

- Acute Paediatrics, Maternity and Neonatology
- Acute medicine, surgery and intensive care, and
- End of life

Phase 2 was Securing Quality in Health commissioned external experts to analyse the feasibility of implementing the recommendations.

The current phase is known as the 'Better Health Programme' and is focussing on the pre-engagement, public consultation and implementation of the agreed standards. Implementation is due to take place between April 2017 and March 2020.

One element of the Better Health programme is 'Not in Hospital' Care. To date the standards that have been developed have been embedded in the 'In-Hospital' services and therefore a similar approach needs to be used for the 'Not in Hospital' element. 'Not in Hospital' Care can be delivered from the following groups:-

- Primary Care
- Health Services
- Social Care
- Community services
- Voluntary and Third sectors organisations

The aim of this element of the Better Health Programme is to ensure that patients only go to hospitals for appropriate care, and on other occasions are treated closer to home.

New Models of Care
This CCG is committed to developing new models of care for the following areas;

- Diabetes,
- Mental health,
- Community nursing

Diabetes
The current model is not financially sustainable for County Durham and Darlington (CD&D) as Diabetes prevalence rises. If we 'Do Nothing' it will require finding an **additional £7-9m per year** by 2025 to fund Diabetes care in County Durham and Darlington. In DDES this is an extra £1.7 million by 2019/20. Depending on the level of CCG investment there will be a shift in management of patients from secondary care to primary care, by upskilling GP practices and supporting patients to take more control of their condition.

Future diabetes services in County Durham and Darlington will see primary care and secondary care working together with commissioners to develop new ways of working, and indeed commissioning – with the introduction of a programme budget and an outcome based service. The new model of care has three underpinning principles:

- Patient centred care
- An integrated service
- Financially sustainable

We have developed an alternative model of delivery for diabetes services following clinical consensus between primary and secondary care that services needed to change. We are creating a pooled budget for diabetes care with clinicians across primary and secondary care plus the Local Authority focussed on transforming care using an outcome based commissioning approach. We are working with NHS England to explore the potential to pool/align their related budgets into this model to develop a truly system wide approach to diabetes care. We plan to expand this approach to other chronic diseases over the next three years.

The vision of the new integrated community based model of care for diabetes in County Durham and Darlington is to provide a seamless service for adult patients living with type 1 and type 2 diabetes, with a strong focus on prevention and education. This will include implementation of the National Diabetes Prevention Programme

The current service is financially unsustainable in the face of rising prevalence and increased costs of treating diabetes. The service is fragmented, particularly between primary and secondary care, there is significant variation across County Durham and Darlington, and health outcomes are at best, average, and in some cases worse than the UK average.

Clinicians in County Durham and Darlington (CD&D) have developed a model that will see clinicians from secondary care and primary care working together in diabetes groups with shared responsibility for health and system outcomes. The system will be supported by overarching enablers including a joint governance model, aligned incentives, information sharing and organisational development.

The new model will be flexible to accommodate the needs of each local group, with improved access for patients, who will receive the majority of their care from their local GP practice or community clinics. Practices will be supported by specialists in secondary care, providing education and continued professional development so primary care clinicians feel confident and able to manage more complex cases outside of a hospital setting.

The aim is:

- to reduce the prevalence of diabetes by identifying people most at risk of developing Type 2 diabetes and referring them into evidence-based lifestyle interventions
- to reduce the incidence of avoidable complications in patients with existing diabetes, by assertive management of glycaemic control
- to assist patients to self-manage their condition, by providing education, support and encouragement through individualised care plans that reflect the patient's personal circumstances
- to see a reduction in unnecessary hospital admissions, particularly for avoidable complications such as amputations, renal failure and retinopathy, and continued reductions in outpatient appointments
- to achieve a financially sustainable model of care. If we do nothing it will cost Durham Dales, Easington and Sedgefield CCG at least a further £1.76m per year by 2020.

'Diabetes Groups' will be formed where clinicians from primary and secondary care share responsibility for health and system outcomes for a defined cohort of patients. The new model will achieve high quality care through a new focus on enabling patient self-management via longer *individualised care planning* conversations in primary care. Every patient with diabetes will receive a jointly agreed individual care plan, as well as the core care processes (i.e. Urinary Albumin, Eye Screening, Foot Exam, Smoking Review, Body Mass Index (BMI), Cholesterol, Blood Creatinine, HbA1c and Blood Pressure). More patients will be managed in primary care or in the community, reducing the need for referrals into secondary care. As the model matures there will be a phased discharge of patients from secondary care and Tier 2 into primary care.

Community nursing

Our current approach to ensure effective care for both the general population and the frail elderly means services are delivered in both primary and community care by multiple providers. Therefore the patient can have their care delivered by a number

of practitioners in the same day and quite often, in an emergency, there is no co-ordination which often results in an emergency admission to hospital. Community services and primary care are natural partners; the opportunity exists through a new model to combine the wide range of primary and community care professionals, generalists and specialists, aiming to play to the strengths of each, while feeling like a single service from the patient perspective. This collaborative working, based around populations on GPs registered lists, is at the heart of the emerging multispecialty community provider, primary and acute care system models. DDES CCG is currently developing this model under the 'Primary and Community Nursing' Model.

Mental Health

Mental Health is a high priority for DDES CCG. There are a large number of services provided by Tees Esk and Wear Valley Foundation Trust (TEWV), Voluntary and Community Sector Organisations plus some private providers. It is therefore difficult when a patient presents at General Practice for the practitioner to have knowledge of all available and services and this results in some patients not being referred into the most appropriate service for their needs first time.

To aim to address this issue DDES CCG has proposed working with TEWV and the DDES GP Federations to develop a service model that would see Primary Care Mental Health Nurses aligned to work in and alongside General Practice. Theses nurse will sit alongside GP's and undertake sessional work and take on a case load pf patients within a Primary Care setting as well as ensuring that onwards referrals are being directed to the right place first time. To ensure the smooth running of this proposal a Partnership Agreement has been developed which proposes a joint working arrangement between TEWV and the DDES GP Federations.

The CCG is also committed to continuing to work to deliver the actions associated with the Crisis Care Concordat, of which it is a signatory, and to work with the Mental Health Partnership Board to improve joint working with partners in the delivery of mental health services.

Multispecialty community providers

The 5YFV sets out an ambition for new models of delivery. One of these models is Multi-speciality Community Providers. The principles of this model are forming the basis of our disease area transformations. We are not being prescriptive with our providers on the shape of this model.

2.2 In 2014 the CCG created a new set of Local Enhanced Services. From 2016, we will evaluate the use of Direct and Local Enhanced services and the QOF to improve patient outcomes and reduce duplication of services and targets.

Local Enhanced Services
The CCG commissions a number of Enhanced Services from practices which are detailed in the operating model. This is the contracting vehicle we use to move care out of hospitals into the primary care setting.

The aim of Enhanced Services is to meet the needs of the local population, recognising and addressing gaps in the core services in order to reduce the necessity for admission to secondary care. In the past, these services have been commissioned via an add-on (enhancement) service to the GP contract. However, increasingly this is done via a tendering process which means GPs have a contract for the treatment of their registered list and the old Enhanced Services are now commissioned under a standard NHS contract. These services are also key to the implementation of other CCG Strategies, such as the Urgent Care Strategy.

- DDES CCG currently has 5 locally agreed Enhanced Services in place which began in 2014. These are:-
    - Community Gynaecology Services
    - Near Patient Testing and Shared Care
    - Minor Injuries
    - Innovation and Transformation
    - Basket of Services

- Each service comes with its own aims and objectives. The Community Gynaecology specification is paid for on activity relating to the number of Vaginal Ring Pessary's fitted, monitoring, checking and removal of LNG-IUSs as appropriate in the management of menorrhagia within primary care. The other services were paid for on a block basis from the practices raw lists size on the 1st April 2015.

Direct Enhanced Services (DES) for extended hours access
The intended outcome of the Extended Hours Access Scheme DES is an increase in patients' access to primary medical services, though face to face appointments with a health care professional at times outside practices' current core contracted hours, in line with any known patient preferences, and utilised at an acceptable rate. Appointments may be booked ahead or booked at the last minute.

As we develop 7 days services in DDES we need to look at the current take up of this DES which is not universal and how this investment can support access to vulnerable patients till 8pm weekdays across the CCG.

Quality and Outcomes framework
Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results.

It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services.

It is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. The indicators for the QOF change annually, with new measures and indicators being retired. The QOF awards practices' achievement points for:

- managing some of the most common chronic diseases, e.g. asthma, diabetes
- managing major public health concerns, e.g. smoking, obesity
- implementing preventative measures, e.g. regular blood pressure checks

In 2016, the CCG clinical champions, who are local GPs with special disease interests that advise the CCG, will look at the QOF and whether the measures are appropriate for us to achieve our desired local outcomes. This will be particularly relevant with Chronic Obstructive Pulmonary Disease (COPD) and Diabetes where we are working with Primary, Community and Acute care to improve outcomes for patients with an integrated pathway closer to home.

Practice Based Community Contracts

- Individual GP practices also provide a range of Community Contracts, details as follows:
    - Anti-Coagulation
    - Deep Vein Thrombosis
    - Minor Skin Surgery
    - Physiotherapy
    - Vasectomy

Key Deliverables

- The CCG will evaluate local enhanced services before re-commissioning in 2016
- The Clinical Champions group will review QOF indicators in line with our Out of Hospital Strategy
- The CCG will review the DES for extended opening in line with the Urgent care Strategy.

2.3 The CCG will develop Practice Based Budgets and support a Demand Management programme to align clinical and financial responsibility and optimise our use of secondary care.

The government announced a forecast position of NHS nationally (£30bn pressure by 2020) during its public consultation 'A Call to Action'. Against this backdrop we expect minimal financial growth locally. Extra services in Primary Care must be funded from existing funds. Increasing activity and costs in secondary care will use up all available funds unless current trends are slowed/reversed. GP practices have a key role to play as significant expenditure committed at the point of the GP's decision to refer into a secondary care setting. If the CCG does not achieve financial balance then funding for additional services in Primary Care will not be available. We wish General Practices to take control of budgets from April 2016 and have agreement from our member practices on an apportionment methodology of our entire budget.

To support future budget monitoring and variation we will support General Practice with our Demand Management Programme. This is the analysis and discussion of how, where and when patients are referred from their GP to secondary care. GPs, with the support of specialists within the CCG, look at this data analysis to ensure that patients are referred at the right time within their care pathway to the right place in order to optimise treatment outcomes.

Primary Care Federations are involved in our demand management programme and play a key role in management of referrals and peer comparison across practices to understand variation in referral rates. This is part of the CCG's wider approach to demand management.

The main monitoring tool is the referrals dashboard, which is produced every two months by Business Intelligence. The dashboards allow practices to see how their current referral levels for the top 3 referred to specialties compare to the same period last year, minus the 1% referral target. In effect it shows what level of action is required to achieve the 1% reduction target.

Key Deliverables

In 2016:

- We will give member practices their delegated budgets and create rules for re-investment of efficiency saving into improving patient services.
- We will continue to support practices with their demand/variation management

2.4 The CCG will create a programme for Supporting Struggling Practices and develop a Federation approach.

Support for struggling GP practices
The vision presented by the 5YFV is about releasing the potential of general practice in primary care.

There are many positive examples of general practice redesigning their services and programmes of work are being aligned to support improvement and change management to deliver primary care at scale envisaged under the 5YFV.

However, we are increasingly concerned about the resilience of a number of GP practices to respond to current pressures on general practice, let alone begin a journey of change around new ways of working that will improve services for their patients. These pressures are well known (if not fully articulated) and relate to:

- Increasing and more complex workload
- Recruitment problems and understaffing
- Complexity of annual contractual requirements.

Much focus has been placed on the individual needs of GPs, such as risk of burn out and stress which clearly relate to, and impact on, practice resilience. Options for individual occupational health support are being considered separately by NHS England.

GP practices as independent contractors are responsible for, and control the running of, their business including the planning and allocation of resources to meet service demands and pressures. Under the new Primary Medical Services (PMS) the impact of a move to equitable funding can present as pressure if practices fail to plan even with a pace of change and respond accordingly to local changes or if external factors (such as GP recruitment) impact on the cost of delivery.

There is increasing anecdotal evidence nationally that the number of practices that are struggling and are vulnerable are on the increase, presenting as practice closures or as adverse impact on patient services.

More worryingly around 150,000 patients across England were displaced as a result of 58 practice closures between April 2013 and April 2015 (Source: Pulse report based on Freedom of Information returns from our regional teams). Practices can also seek to unilaterally close their practice lists temporarily to new patients.
CQC ratings are currently finding 4% of inspected practices inadequate and 12% as requiring improvement. However the standard of Primary Care in DDES is high and we do not expect this. We are aiming not to have any practices rated as inadequate.

Locally two practices are in discussion with the CCG regarding closing their list to stop any further new patient registrations. The introduction of the CQC inspection

regime has highlighted a number of practices in difficulty nationally and the importance of practices being well-led. However, with the nature of general practice operating as small independent units, there is a risk that even high performing practices can quickly fall into difficulty e.g. with the loss of one or two critical personnel. We have seen this happen in DDES CCG.

DDES CCG will create local capacity to support struggling practices by investing in Specialist Practice Managers who will be available at least one day per week to be placed in practices who are identified as requiring support.

We want to support all general practices to realise their potential and that means ensuring struggling and vulnerable practices are supported too. Commissioners must have due regard for procurement principles and ensure providers and potential providers are not unfairly treated.

The Secretary of State for Health confirmed in his 'new deal' speech that NHS England had identified funds of £10m from the 2015/16 Primary Care Infrastructure Fund (PCIF) to develop a support programme for struggling practices. A submission is currently being prepared on future PCIF investment plans for the next three years and proposes this investment for struggling practices should continue to 2018/19. The beneficiaries of the 'turnaround' fund – pledged as part of health secretary Jeremy Hunt's 'new deal' - will have to be identified by January 28 2016.

This flexibility will prioritise practices with a high ratio of patients to GPs, but it will also give funding to practices with higher than average referral and prescribing rates.

Any practices receiving funds will have to match any investment 50:50, and the specification that will come out states that it must align with "CCG plans for primary care locally".

Key deliverables

1. Support access to the Royal College of General Practitioners peer support pilot programme for practices in CQC special measures using the Vulnerable Practices fund. NHS England will fund 50% and the Practice will match fund.

2. Key elements of support services to struggling practices include:

    - Offer of diagnostics – development of action plan
    - Targeted approach – time limited interventions
    - 'Whole practice 360 appraisal'
    - Specialist advice and guidance – e.g. HR, IT, Management, Finance
    - Support for merging / federations
    - Coaching / supervision / mentorship
    - Short term clinical or practice management capacity
    - Intensive support from a specialist manager

3. Create Specialist Practice Managers who will work in practices identified requiring support. This will be done in conjunction with Federations.

4. Create a risk register which aligns practices highlighted as having quality or workforce issues.

5. Work with partners to develop a suite of offerings to practices that extend their options at an identified time of vulnerability to support recruitment, premises or financial viability.

3. Focusing on Population Health using new models of delivery

3.1 We will use a robust evidence base to demonstrate the Case for Change for population health and reducing health inequalities.

The case for change
We know that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently; actions need to be universal but with a scale and intensity that is proportionate to the level of disadvantage. Evidence based lifestyle activities and mental wellbeing programmes can achieve as much health gain as medical interventions if delivered through quality assured programmes. By working in partnership with public health to ensure commissioning of a range of self-management programmes for people at risk of CVD, low level anxiety and depression as well as more specialised lifestyle interventions, such as exercise referral, the health of the population can be improved and preventable hospital admissions reduced.

Commissioning for Health Prevention

Primary care and population health
The aim of this section of the primary care strategy is to stimulate greater engagement of general practice with improving the health of the population and reducing the gap in health inequalities.

This is not something that general practice can do alone. GPs have a unique and essential contribution to make in collaboration with public health, clinical commissioners and the community.

This is not something new. Population health has always been an important element of primary care. However, there has always been the tension in general practice between treating those who are unwell, managing patients who are at a high risk of becoming unwell and giving sufficient attention to the general population to improve their health and well-being to prevent them becoming unwell.

“The profession has a minority of doctors who seek to conserve health in populations rather than restore it in sick individuals; but they are at the periphery, and have never been encouraged to combine the functions of prevention and cure.” (Tudor Hart, 1981, p.871)

There is a growing consensus around the view that general practice could, and probably should, do more to improve health and well-being in its population. Following a review of the quality of general practice, the King's Fund concluded that:

"General practice is regarded as uniquely well placed not just to provide medical care, but also to promote the health and well-being of the practice population and to address health inequalities."

In general, practices in more deprived areas are under greater pressure to deal with a rising demand for the management of people with long-term conditions leaving little time for prevention programmes. To ensure parity of esteem it is also essential that we look to improve and maintain good mental health within our population and aim to prevent mental ill health. This will contribute to a widening of health inequalities.

Key Deliverables

1. All practices should invite a sufficient number of eligible patients for an NHS Health Check to ensure coverage of 20% of the eligible practice population using the check for life programme. Any practices not wishing to provide this will consider this being done by another provider or Federation.
2. Every practice should provide level 2 stop smoking services based on the recommendations in the guidance document, brief interventions and referral for smoking cessation in primary care and other settings. (NICE, 2006a)
3. Practices should routinely use the general practitioner physical activity questionnaire (GPPAQ), to identify inactive individuals and act on the recommendations in the guidance document. Commonly used methods to increase physical activity are: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling.(NICE, 2006b)
4. Practices should agree to include alcohol brief interventions as an intervention based on the guidance document; Alcohol- use disorders: preventing harmful drinking, (NICE, 2010) when offered in next year's public health agreement.
5. Every practice remains part of a Federation and supports our commissioner approach to wrapping services around groups of populations. We will be encouraging practices to work closely together so that those who have demonstrated successful delivery of services (such as smoking cessation) can share their learning and best practice with others.
6. improving the uptake of vaccinations, immunisations and screening. This includes childhood immunisations, influenza and pneumococcal uptake and cancer screening including cervical, breast and bowel and non cancer screening including Triple A screening and diabetic retinopathy screening

3.2 Build upon the current development of Federations to develop at scale models outlined in the 5 year Vision and develop the concept of Primary Care Home

GP Federations
We introduced a quality improvement scheme that incentivised the setting up of GP Federations (GP practices coming together in collaborative models). From this, three federations have evolved - South Durham Health, Intrahealth and Durham Dales Health. These organisations have clinical leaders in place and have now been commissioned to deliver new services to support patient care.

- The benefits to patients:
  - Services closer to home - every patient has access to a local, flexible and enhanced service that is delivered by their own GP Practice or a group of practices from a hub.

- For practices
  - Allows them to deliver primary care services at scale and creates an opportunity for practices to share staff skills and other back office functions.
  - Allows their patients to access services even if they are unable to provide them at the practice level.

Our population of 280,000 is currently served three established Federations.

The Federations are as follows:

Durham Dales Health	12	104,052
South Durham Health	24	169,670
Intrahealth Ltd	4	27,470

Primary Care Federated Service Delivery
Since supporting the development of Federations they now deliver the following services:

July 2014 – Primary Care (PC) federations started delivering weekend opening services for the entire DDES population. In July 2015 this service was modified to ensure that there was a focus on the frail elderly population including those in care homes by providing additional support throughout the weekend.

Urgent care attendances have decreased by 12% on a Saturday morning following the introduction of PC Federated weekend opening.

July 2014 – Primary Care Federations started delivering pro actives support in the form of wrap around services for frail elderly patients

June 2014 – Primary Care Federations started delivering emergency admission avoidance services (reactive services) to prevent admission to hospital

In July 2015 these services were merged in recognition of the fact that the two services often supported the same cohort of patients, just at different times in their care pathway

DDES CCG now has three fully operational GP federations. They have been working with the CCG to develop their capabilities as providers. The CCG hold monthly meetings with each Federation Management team individually to discuss progress with each service and to develop improvement plans where these may be required. The CCG will continue to support Federations and their development for the duration of this strategy. We are unable to offer a longer commitment than this due to the constantly changing political landscape within which the NHS functions. The CCG would encourage Federations to support practices in any way they can, for example, bulk purchasing consumables in order to achieve cost reductions could be one way the Federation is able to support General Practice where the CCG cannot. Federations are also in a position to be able to co-ordinate the delivery of care across specific areas without the need for all practices to offer every service.

What is the Primary Care Home (PCH) model?
The PCH is a form of multispecialty community provider (MCP) model. Its key features are:

- provision of care to a defined, registered population of between 30,000 and 50,000;
- aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and
- a combined focus on personalisation of care with improvements in population health outcomes.

What is unique about the PCH model?
The PCH and MCP model share some of the same goals, such as better outcomes for patients, at lower cost, based on greater integration between primary and secondary care. However, the PCH model, in particular, focuses efforts on the 'make or buy' decisions within care provision through the accountability of independently managing a capitated budget for a registered population of between 30,000 and 50,000. It can strengthen organisational relationships, with multi-disciplinary clinical and social care teams working collectively through networked arrangements. The PCH model will be based within modernised community healthcare premises, with access to diagnostics on site and fully integrated IT systems.

What are the benefits of the PCH model for patients?
The key benefits for patients are a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals. Working at

this scale ensures everyone within the team knows everyone else and the patient has a more consistent experience of care, similar to having a named GP.

What is the PCH workforce model?
The PCH model enables primary care, community health and social care professionals to work in partnership with specialists to provide out of hospital care. The workforce model should reflect the size and needs of the registered population, which may result in exploring opportunities to design and develop the roles of nursing, pharmacy and allied health professionals. The scale of the population for the PCH model is intended to drive a workforce model that ensures patients have a consistent and personalised experience of care.

What next?
The South Durham Federation has been successful in its bid with the National Association of Primary Care (NAPC) to be a rapid test site. DDES CCG in parallel will ask Federations to identify further groups of practices who wish to pioneer a population based approach to Primary Care. There are two pieces of work that fit with these sites will be well positioned if organised to consider the new contract that is being offered in April 2016 based on this approach.

Key Deliverables

1. Practices to remain in a Federation.
2. Federations and other providers work with the CCG to develop new models piloting Primary Care Home and disease specific models in line with the FYFV.
3. Federations play a more active role to support struggling practices or practices who are not meeting quality indicators on enhanced services.
4. Federations work with the CCG to integrate General Practice teams with community staff wrapped around the patient.

3.3 Ensure that our primary care premises and community hospitals are optimally utilised to benefit services grouped around local populations.

We are carrying out a review of premises and estates across DDES to ensure best use of clinical space. We have a number of minor elective procedures that could be carried out in a community setting to provide alternative options hospital and care closer to home. The review includes potential space in GP practices and Primary Care Centres across the CCG patch. As Primary Care Commissioners, we now have responsibility for primary care estate and, as such, need to work with General Practice to ensure that all premises are fit for purpose and utilised to maximum capacity. This includes utilising some estate beyond office hours to accommodate 8-8 opening hours and 7 day working.

Future primary care premises strategy has to align to:

- The CCG vision for Primary Care
- "Local Estates Strategies - A Framework for Commissioners" ;DH June 2015
- What key criteria we might want to use for making premises investment decisions (recognising national tools need to be adapted to local circumstances)
- Key strategic locations and how we maximise utilisation of these sites and drive out efficiencies
- Horizon scanning / current hot spots
- Condition survey work and CQC/Statutory / regulatory issues
- Opportunities for partnership / joint developments working across communities / public sector

NHS guidance states that to be considered for development, practices have to identify that they meet two of the four criteria to for new premises:

1. That there is a known current or future geographical gap in primary medical care service provision.
2. That any of the GP Contractor's practice premises are currently 50% undersized (utilising the size criteria contained in the Principles of Best Practice).
3. That the surgery is unsatisfactory in terms of functionality and/or condition.
4. There is a need to respond to an emergency situation e.g. fire; flood which requires a temporary solution.

Additional sources of investment will need to be sought to support the development of Primary Care estate. The next phase of NHS England's £1billion **Primary Care Transformation Fund** promises to deliver GP premises fit for the future so patients can access more services out of hospital and in their local communities.

Proposed schemes can now span more than one year. This means bigger, more ambitious projects will be possible that will help address rising demand on GP services that account for 90% of all patient contact with the NHS.

The first year of the four year investment made £250m available to help GP practices to make much needed improvements in premises and technology. The fund will now also be able to support more ambitious longer term plans to improve out-of-hospital health services, helping ensure general practice remains at the heart of NHS care as services adapt to meet future challenges.

From 2016/17 we plan and fund the majority of local health services and will lead proposals for how funding will be invested, working with GPs locally. This will ensure investment supports long-term plans for delivering the best, joined-up services for patients in their local communities, while reducing reliance on hospitals.

CCGs will work with GP practices to identify opportunities for developing existing premises, relocating services to new or existing buildings to provide a wider range of services and better use of existing premises.

The recommendations will need to demonstrate that they meet one or more of the criteria set out below:

- increased capacity for primary care services out of hospital;
- commitment to a wider range of services as set out in the CCG commissioning intentions to reduce unplanned admissions to hospital;
- improving seven day access to effective care;
- increased training capacity;
- Commitment to utilise community hospitals for services such as IC+

Key Deliverables

1. We will invite new bids and re-appraise previous premises bids with approval in principle to re-apply to the Challenge fund if they meet the criteria set out above.
2. We will continue to encourage practices to meet the statutory and regulatory frameworks for GP premises and offer NHS England Improvement grant scheme.
3. We will explore with General Practice how empty sessional space already covered by notional rent can be optimised.
4. Work with practices to ensure that their current sites are fit for purpose and that services are sustainable based on future workforce requirements and clinical good practice.

3.4 The CCG will continue to develop learning opportunities for Primary Care staff and develop learning sets as part of the organisation culture to becoming a learning organisation

Developing a Learning Culture amongst GPs
People learn in different ways. Currently, the CCG operates Time-In and Time-Out sessions regularly throughout the year where external trainers are invited to run sessions for GPs to attend to update their skills in both mandatory and voluntary training. This does not take account of different people's individuals training needs. The Time-In and Time-Out model will continue but we will develop action learning sets of specific groups of GPs who could support each other and offer peer support.

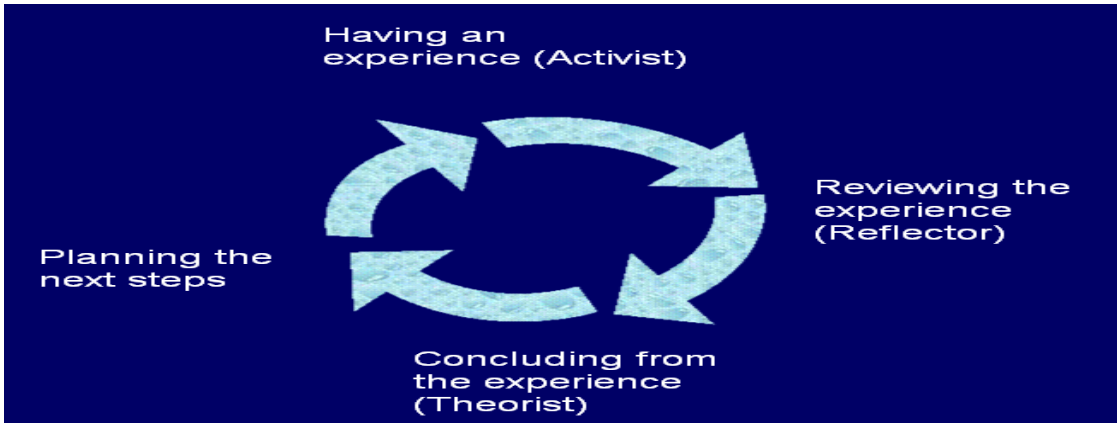
Our current example of learning sets has been with our Career Start GPs. These are GPs who completed the Vocational Training Scheme and took jobs in GP Practices in DDES. Twice a month the GPs meet with Dr Martin Jones as their group facilitator to share experiences, learning and to provide support to each other. We now wish to extend this concept with other primary care professionals.

Why action learning sets?
Principles of Adult Education - Traditional teaching methods in medicine are gradually being replaced by those based on principles of good practice and effectiveness in the wider world of adult education. Brookfield (1986) and Knowles (1975) described some of the fundamental principles of adult education.

Adults learn best when they:

- Are helped reflect on their practice
- Identify strengths and weaknesses
- Resolve conflict between educational wants and needs
- Negotiate their learning objectives
- Articulate learning outcomes for themselves
- Analyse how they have learned
- Agree plans for further development.

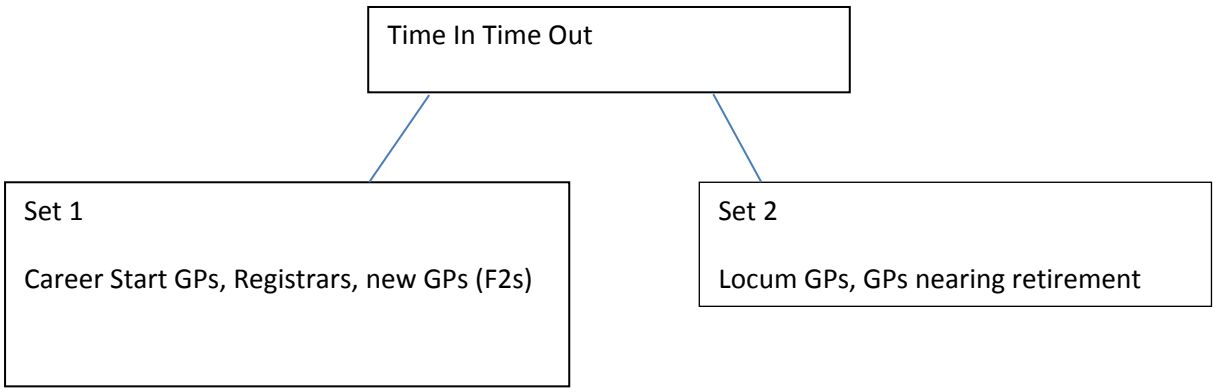
Self-directed learning can be defined as
A process that involves taking the initiative with or without the help of others in diagnosing learning needs, identifying resources for learning, choosing and implementing appropriate learning strategies, and evaluating learning outcomes. The process of learning can be illustrated as a cycle:



The CCG will create a support network, led by a DDES GP Tutor. It will focus on the educational needs identified by the GPs in this group and develop as an action learning set. Between the action learning meetings the GPs will continue self-directed learning in line with their PDP and approach to appraisal and revalidation.

Set 1 would consist of GPs at the start of their practicing career and the aim of the group would be to attract new GPs into the CCG area. Set 2 will be aimed at GPs who do not practice here regularly or who are nearing retirement (this latter group would be self-selecting) as these two groups are often identified as struggling to keep abreast of the frequent changes made to pathways, referral methods and other regularly changing aspects of practice.

Diagrammatically, it would look like this;



These groups will meet twice a year as a minimum but could meet more regularly as required by members.

Key Deliverables

1. Expand Career start learning sessions to include and sponsor Medical School GP trainees (ST3s) periodically
2. Work with a GP Tutor to develop the Peer sets for locum GPs and GPs nearing retirement
3. The CCG to build on the Time-In/Time-outs

4. Wrapping services around the patient

4.1 Progress the development of the Integration of Primary and Community Care Nurses to wrap around practice and patients to avoid duplication.

Following successful delivery of services by Primary Care Federations we have looked to strengthen collaboration between providers. Three of the key delivery projects for 15/16 are:

To develop coordinated of care services to include our district nursing, practice nursing, Advanced Nurse Practitioners and Vulnerable Adults Wrap Around Service resources into an aligned provision in phase 1. These services will be based around general practice, improve communication, reduce duplication (which will also avoid the potential of patients falling through the gap) and support a seamless patient centred journey.

Once the first stage of this work is competed we will be working to integrate with other services such as the Specialist Nurses, Intermediate Care service, Macmillan services etc.

We are developing a service model with TEWVFT and PC Federations with Community Psychiatric Nurses (CPN's) aligned to and working in an integrated way with primary care services. The aim is to ensure a coordinated pathway of care is in place, with the aim of ensuring patients are referred to the most appropriate service first in order to meet their needs effectively. The service will also provide care closer to home and improve access for hard to reach patients.

Key Deliverables

- Reduce in hours and out of hours avoidable admissions by 3.5% from 01/09/14 to 31/08/16 and all other targets within line with the Better Care Fund plan.
- Upskill and work in partnership with Federations and Care homes to reduce avoidable admissions.
- Ensure that the Vulnerable Adults Wrap Around Service team integrates with Primary and Community Nursing. Every Practice to know their named nurses in the community and operate regular multi-disciplinary meetings looking at the top 2% vulnerable adults in their practice.

4.2 We will ensure that the Primary Care Information technology structure supports patient care and greater accessibility by healthcare professionals and patients alike.

To enable this, we align our Five Year Informatics Strategy to delivering the needs of the FYFV and Personalised Health and Care 2020. These drivers for change ensure that we look at how our citizens are traveling through care pathways and we will review and implement, at pace, change for the better.

We will use information and Informatics solutions to enhance patient experience and drive a step change towards patients being informed prior to any consultation, enabling patients and carers to participate as partners in their own healthcare.

We will use technology to deliver the paper free agenda, pushing forward with the 2020 vision of having fully interoperable electronic health records in place, so that patients' records are paperless at the point of care. The paper-free agenda is supported further through the delivery of projects such as electronic prescribing, this enables prescriptions to be sent electronically to the pharmacy of choice; this not only reduces paper flow but gives further flexibility for patients.

Building on providing further flexibility for patients we are providing extended hours of access to primary care services, this will ensure that patients have greater choice and accessibility in seeing health care professionals.

Key Deliverables

- Working with ICT and Information Governance colleagues we will provide safe and secure access to solutions as e-consultation, WIFI and patient online access, which gives improved access to services, ensuring the patient is at the centre of their own care.
- We will continue to ensure that all providers of care in the vulnerable patient pathway are able to access the patient record with permission of the patient
- We will work towards a standardised care template for key clinical data for vulnerable patients so that the record is able to be shared.
- We will continue to build on the success of national solutions such as patient online, which gives patients direct online interaction with their GP enabling them to book appointments, book repeat prescriptions and view their own medical record reducing the need to travel to the practice
- Intra-Practice and CCG communication will continue through our intranet product GP TeamNet. This is also our platform for sharing and disseminating clinical guidelines via the Clinical Support Information module.

Appendices

Appendix A - General Practice Core Contracts

https://www.england.nhs.uk/commissioning/gp-contract/

Appendix B – Engagement Documentation

Please see next page.

Appendix C – GP Forward View

https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Contributors

Durham Dales, Easington and Sedgefield Clinical Commissioning Group would like to take this opportunity to thank everyone who has contributed to the development of this Primary Care Strategy. This would include:-

- DDES CCG Council of Members and 40 DDES GP Practices
- Patient Reference Groups
- Health Networks
- Area Actions Partnerships
- Durham County Council Public Health
- Health and Well Being Board
- Tees, Esk and Wear Valley NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

Appendix B – Engagement Documentation

Primary Care Strategy: 2016 – 2018 Refresh

What should Primary Care should look like in the future?

Primary Care Strategy

Following the formation of Durham Dales, Easington and Sedgefield CCG in April 2012 work was undertaken to develop a Primary Care Strategy and Implementation Plan. The 2013 – 2015 Primary Care strategy set out a vision to develop Primary Care in readiness for the ambitions in the Call to Action supporting a total transformation of the NHS to meet the burgeoning demands of patients and the reality that this was unsustainable with a £20 million gap by 2020

In October 2015 the FYFV was published which set out how the values of the NHS have not changed, however the world has. In order to meet these new challenges we are required to take a longer view and, therefore, it is an appropriate time to refresh the Primary Care strategy to ensure that it supports this vision.

We would like your views.

The presentation that you have heard outlines the vision and objectives that the CCG has for Primary Care in 2016 – 2018. However, we would like to hear from you on the following points:-

- Are the Vision and Objectives still current?
- Do you agree with the aspirations in relation to Primary Care?

How can I respond?

If you would like to forward us your views then please complete the attached proforma and return it via email or post to:

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Sharon Gooch
Personal Assistant

Joseph Chandy, Director of Primary Care, Partnerships and Engagement
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Primary Care Strategy: 2016 – 2018 Refresh

Engagement Proforma

1. Do you think the vision and objectives need to change? If so what suggestion/ideas do you have?

2. Do you agree with the way forward? Please include any additional suggestions or alternative ideas you may like us to include.

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NHS
North Durham
Clinical Commissioning Group

North Durham Primary Care Strategy Refresh

Refreshed July 2016

Contents

Our vision for primary care

General Practice as partners leading healthcare for the people of North Durham

Introduction

NHS North Durham Clinical Commissioning Group (CCG) was authorised as a statutory body with effect from 01 April 2013. North Durham CCG is a member practice organisation, made up of 31 GP practices and serves a population of about 253,086 spread across a large and diverse geographical area. Clinical commissioning means that local GPs are using their knowledge about healthcare to develop services that meet the needs of our patients. We commission services from one main acute provider and one mental health trust as well as commissioning additional primary care services from member general practices by way of a core contract and enhanced services.

The NHS Five Year Forward View (5YFV) was published in 2014 and sets out a new shared vision for the future of the NHS based around new models of care. North Durham CCG is working towards implementation of the 5YFV through the refresh of this strategy and to move as much care as possible out of hospital into the community. Consequently, general practice will grow and change as will other services such as community hospitals as we implement multi-speciality community provision.

Since April 2015 the CCG has new responsibilities for commissioning primary care which was previously commissioned by NHS England. Commissioning secondary, primary and community care allows North Durham CCG to develop services around the patient.

Due to rising demand on the NHS, rising expectations regarding greater accessibility over seven days and the NHS financial challenge NDCCG has to explore new ways of delivering primary care in the future. The General Practice Forward View which was published April 2016 sets out over the next 5 years the responsibilities and investment to undertake this transformation.

Our current model of general practice is the envy of the world. However, due to rising demand on the NHS, rising expectations regarding greater accessibility over seven days and the NHS financial challenge we have to explore new ways of delivering primary care in future. The General Practice Forward View was published in April 2016 and sets out the responsibilities and investment to undertake this transformation (over the next 5 years) https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Primary care is the healthcare provided by general practitioners (GPs), nurses and other health care providers in general practice teams, as well as by opticians, dentists and pharmacists. It is typically the first, and most generalised, point of access to health care and can also have a coordinating role in a patient's care.

We strive for excellence in primary care in order to deliver the highest possible standards of healthcare for North Durham residents. This primary care strategy aims to drive forward health improvements for the entire population of North Durham CCG.

To deliver on the objectives within this primary care strategy, we believe that a stronger GP sector must have the following **key features**:

- maintains the strength of general practice in terms of personalised, continuity of care to a registered population, when necessary,
- builds organisational capacity within general practice at locality level and an infrastructure to enable cross practice working,
- is bigger, wider and integrated seamlessly with social and community services,
- is aligned and working in partnership with public health,
- enables patients to feel engaged and empowered in their care,
- provides a rewarding and enjoyable place to work, enabling adequate recruitment and retention for sustainable services.

Through North Durham CCG's vision of what primary care could look like five years in the future (2019/2020), a number of key characteristics have been emerged, which have guided the direction of this strategy:

- improved capability to respond to and manage demand,
- high standards of personal care,
- sustainability in working practices for primary care professionals,
- seven day and extended hours availability of primary care, with seamless transition between in-hours and out-of-hours care,
- federated, collaborative working that enables increased efficiency in primary care,
- movement of secondary care services into the primary care domain,
- wrapping of social care and community services around primary care,
- 'generalist-specialist' primary care clinicians,
- information sharing systems and a culture that promote patient-focused case management and timely access to information, reducing barriers to inter-agency working,
- access to effective and fast diagnostics, increasingly based in primary care investigation centres,
- pathways or protocols for specific disease/diagnosis, to guide consistently high quality care,
- speciality 'one stop' clinics, when appropriate with mobile equipment and teams,
- GPs as coordinators of care, with support from primary care teams
- specialist care teams (including Admiral Nurses)
- reduction of unnecessary admissions to Accident and Emergency.

Dr Neil O'Brien
Chief Clinical Officer

Executive Summary

What is the CCG Vision?

Better health for the people of North Durham

The Primary Care Strategy aligns with the four overarching priorities of the CCG:

- improving the health status of the population,
- addressing the needs of the changing age profile of the population,
- commissioning clinically effective, better quality services closer to home,
- making best use of public funds to ensure healthcare meets the needs of the patients and is safe and effective.

What is the CCG's Vision for Primary Care?

General Practice as partners leading healthcare for the people of North Durham

How will this strategy achieve this? – Our three objectives:

- to develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home,
- to support general practice and federations to work together to deliver high quality cost effective primary care services for the population of North Durham CCG,
- to commission clinically effective planned and unplanned out of hospital care.

Our programmes of work to deliver these objectives (appendix 1) will form part of our Operating Model and Implementation Plan:

1. Develop a fit for purpose workforce and primary care infrastructure

North Durham CCG will:

- invest the Personal Medical Services premium over the next five years into the workforce within general practice,
- actively plan our workforce to look at future demand including population growth and other factors,
- work with GP and nurse tutors to develop a rolling programme to ensure that staff training needs are met,

- develop and support our existing primary care teams,
- address the need to use a multi-disciplinary model to support and develop the use of non-medical prescribers as part of the primary care team (nurses and pharmacists),
- develop a primary care estates plan and an investment plan which takes into account changes in population and changes in ways of working to ensure need is met,
- identify practice premises that are in greatest need and prioritise support to those,
- develop functionality to deliver mobile working and support the delivery of interoperability between systems across health and social care,
- work in partnership with health and social care across the County Durham and Darlington Footprint to achieve the ambition of paper-free at the point of care. It aims to identify how local health and care systems will work together to deploy and optimise digitally-enhanced capabilities to improve and transform practice, workflows and pathways.

2. Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care

North Durham CCG will:

- encourage all practices to be part of three GP federations which we will support them to develop into successful primary care providers,
- facilitate and commission from trusts, other partners and primary care a Multi-Specialty Community Provider Model (MSCP) of care,
- effectively engage and consult with general practice and with our local community via a number of communication systems,
- continue to support general practice in terms of the implementation of the Friends and Family Test and ensure that quality is monitored and actively managed within primary care using national tools and supporting practices to develop.

3. Commission clinically effective planned and unplanned out of hospital care

North Durham CCG will:

- commission seven day primary care services tailored to those with the greatest health need,
- review and recommission out of hours services and extended primary care services,
- wrap community, social care and mental health services around primary care services to deliver an integrated service for patients,
- as a key partner and contributor to the health and wellbeing joint strategic needs assessment, ensure that public health priorities integrate through delivery of the three key objectives of the primary care strategy.

This plan sets out steps to future primary care delivery aligned to our priority health outcomes within NHS North Durham CCG.

'Delivering the Forward View' (published by NHS England) sets out steps to help local organisations to develop plans which will enable them to deliver a sustainable, transformed health service and to improve quality of care and wellbeing. This includes a new, dedicated Sustainability and Transformation Fund (STP) worth £2.1 billion in 2016/17 and rising to £3.4 billion in 2020/21. Within the STP there are nine 'must do' targets for 2016/17. These are:-

1. develop a high quality and agreed Sustainability and Transformation plans,
2. return the system to aggregate financial balance,
3. develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues,
4. get back on track with access standards for Accident and Emergency and ambulance waits,
5. improvement against, and maintenance of, the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice,
6. deliver the NHS Constitution 62-day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two-week and 31-day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission,

7. achieve and maintain two new mental health access standards [and] continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia,

8. deliver actions set out in local plans to transform care for people with learning disabilities,

9. develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures.

Where the 'must do' targets impact on primary care we will strive to ensure that this strategy encompasses the CCG's ability to achieve these targets and to also answer the questions posed in the NHS Forward View Guidance 2016/17.

(hyperlink - https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf)

Joseph Chandy

Director of Primary Care (Non-Clinical)

Patrick Ojechi

Director of Primary Care (Clinical)

How does this fit with CCG and Health and Well Being Priorities?

The Health and Wellbeing Board (HWBB) vision is to:

Improve the health and wellbeing of the people of County Durham and reduce health inequalities

The key aims/programmes of work for North Durham CCG are aligned to the Health and Well Being Board priorities/strategic objectives which are:-

1. children and young people make healthy choices and have the best start in life,
2. reduce health inequalities and early deaths,
3. improve the quality of life, independence and care and support for people with long term conditions,
4. improve the mental and physical wellbeing of the population,
5. protect vulnerable people from harm,
6. support people to die in the place of their choice with the care and support that they need.

North Durham CCG's overall vision and vision for primary care aligns with the Joint Health and Well Being Strategy (JHWBS) and the CCG will continue to work closely with the HWBB to ensure all objectives are met.

Joint Strategic Needs Assessment (JSNA)

The Joint Strategic Needs Assessment (JSNA) provides a detailed overview of the current and future health and wellbeing needs of the people of County Durham. The data and key messages from this document provide the evidence base for the development of the Joint Health and Wellbeing Strategy 2016/19, the Children, Young People and Families Plan 2016/19 and Clinical Commissioning Group Commissioning Intentions.

The key messages are focussed around the demographics of the population of County Durham alongside their health and social care. For more detail on the JSNA's key messages please visit (hyperlink)
http://www.durham.gov.uk/media/9140/JSNA-2015-key-messages/pdf/CountyDurhamJSNAKeyMessages2015.pdf)

The CCG will work collaboratively with key stakeholders to ensure the key messages are disseminated and implemented within general practice.

Engagement and feedback on the Strategy Refresh

The North Durham primary care strategy was developed with input from and consultation with:-

- member practices,
- Council of Members,
- Patient Reference Groups,
- The CCG's Management Executive.

This primary care strategy underwent a programme of engagement which was aligned to the CCG's formal engagement process which included an interactive Patient Reference Group session and Patient Public and Carer Engagement (PPCE) Committee where memberships includes stakeholders representing carers, patients, voluntary sector and health watch.
In general the feedback was positive with key stakeholders endorsing the philosophy of transforming and strengthening primary care. In particular people were keen to ensure that access to primary care was enhanced and extended to ensure members of the public are seen within a timely manner and to avoid putting pressure on other key services.

The primary care strategy does not stand alone and links into key programmes of work for the CCG for example, diabetes, out of hours and frail elderly.

As part of the refresh of the strategy further consultation will take place with:-

- Patient Participation Groups,
- Healthwatch,
- the Overview and Scrutiny Committee,

- North Durham CCG's Governing Body,
- Area Action Partnerships
- County Durham and Darlington Local Medical Council
- Tees, Esk and Wear Valley Mental Health NHS Foundation Trust,
- County Durham and Darlington NHS Foundation Trust
- GP Federations,
- Health and Well-being Board,
- Durham County Council Public Health.

The primary care strategy is aligned to the 'Not in Hospital' workstream which forms part of the Better Health Programme (BHP) (5 year forward view). It mirrors the key principles and standards outlined as part of this clinically led transformation programme.

Context

There are many factors affecting the direction of travel for primary care services over the next five years, not least the growing financial pressure being placed on the NHS. There is a greater demand on services due to an ageing population with more complex health needs as well as increasing patient expectation and fewer resources available to deliver services. Indeed within the North Durham area there has been an increase in population size of 7.2% between 2001 and 2013.

It is estimated that general practice delivers around 90 per cent of NHS contacts meaning even a slight patient shift from primary to secondary care would put unmanageable pressure on the system *(NHS Employers, 2014).* Nationally there is a drive to move services into the community and closer to home where appropriate. *The Five Year Forward View* outlines new models of care which are centred on the ability of primary care to have the capacity and capability to deliver services at scale.

North Durham CCG has always had a role to play in driving up quality within primary care and now the CCG has responsibility for commissioning primary care medical services from general practice. This strategy will begin to identify the challenges now and in the future and outline the vision for ensuring successful and sustainable primary care is commissioned and delivered within North Durham. The primary care strategy will also need to be viewed in the context of other work programmes i.e. urgent care and frail elderly.

Case for Change

Workforce

The Health Education North East (HENE) *General Practice Workforce Report* December 2015 reported that there are 155 (head count) GPs within North Durham. Evidence is also emerging from the NHS Information Centre that the GP workforce is now shrinking rather than growing. Whilst the number of GPs per 100,000 head of population across England increased from 54 in 1995 to 62 in 2009, it remained relatively stable in North Durham with 61.8.

It is most concerning to note that nationally 54% of GPs over the age of 50 are intending to quit direct patient care within five years. A recent study within North Durham (2013) found that 40% of the primary care nursing workforce is due to retire in the next ten years, (NHS England Survey).

Quality

There are a variety of methods used to measure quality within primary care including; the Quality Outcomes Framework (QoF), Valued Based Commissioning Policy (VBCP), patient surveys, practice profiles, and the Friends and Family Test.

We can also measure the quality within general practice across North Durham by looking at the primary care outcomes tool. As an overview of the overall picture in terms of quality it outlines 18 achieving and 9 higher achieving practices. As a CCG we can identify (using this tool) areas which require further quality improvement. Some examples include the need to further increase the levels of identification for conditions such as Atrial Fibrillation (AF), Chronic Obstructive Pulmonary Disorder (COPD) and Coronary Heart Disease (CHD). Also the rate of emergency admissions for those with a long term condition is slightly above the NHS England average (57.39% and 58.88% respectively).

In the 2014/15 financial year North Durham practices achieved 98.0% attainment of the Quality Outcomes Framework (QoF) compared to the Durham, Darlington and Tees sub-region of 96.1%, Durham Dales Easington and Sedgefield CCG 96.8% and Darlington CCG got 98.3%.

The Friends and Family Test was introduced into general practice in 2014 and as at June 2016 76% of respondents were likely to recommend their GP practice to a friend or family member.

Our People and Place

Within North Durham there are 31 practices and the total registered list size for North Durham is 253,086 (Health and Social Care Information Centre (HSCIC), 2015/16). By using national figures, we can estimate that approximately 2400 people are seen every day in general practice within North Durham. The average payment made to general practice per patient across North Durham is £137.12 compared to a national average of £136.

Derwentside comprises a mixture of urban, semi-urban and rural areas with the population concentrated in Stanley and Consett. Durham and Chester-le-Street cover a mixture of rural and urban areas with two main population centres, Durham City and Chester-le-Street. The University in Durham is home to a large and internationally diverse student population. There are significant variations in health across these three areas.

People who live in the North Durham area have significant health challenges and problems. They are also more likely to die sooner than those living in other parts of the country. The main causes of early death include high levels of cancer, cardiovascular and cerebrovascular diseases.

With an ageing population, we will also experience greater demand for hospital services and an increase in illnesses related to older people such as stroke, long-term conditions and dementia. The large student population in Durham City results in a demand for sexual health, alcohol and harm reduction services.

Other key challenges facing North Durham include:

- reducing lifestyle risk factors such as smoking, alcohol, obesity,
- economic inequality related to unemployment and low incomes,
- people with disabilities have worse health than those without,
- children's health and lifestyles are poorer than elsewhere in the country.

The health of the population is not something that general practice can address alone. GPs have a unique and essential contribution to make in collaboration with public health, clinical commissioners and the community.

Population

Overall, the population of North Durham CCG (6.8%) has grown at a much quicker rate than County Durham (4.0%) or North East region (3.2%) over the last ten years. Specifically this can be seen in Durham (7.6%) and Derwentside (7.8%).

Life Expectancy

The healthy life expectancy for County Durham is significantly worse for both males (58.7) and females (59.4) than for England (63.4 and 64.1 respectively).

Health Inequalities

Health inequalities exist between County Durham and England. For example:
life expectancy for men living in County Durham is 1.3 years less than the England average. For women it is 1.5 years less than the England average (at birth 2010-12).

Premature Mortality

Premature mortality rates from all cardiovascular diseases (2010-12) in County Durham (92.4 per 100,000) are significantly higher than England (81.1 per 100,000).

Disease Prevalence

- CHD prevalence in County Durham (4.9%) is higher than England (3.3%)
- Diabetes prevalence in County Durham (6.8%) is higher than England (6%)
- COPD prevalence in County Durham (2.7%) is higher than England (1.7%)

Strategic Objectives

Our overall vision within the CCG is for better health for the people of North Durham. To ***'Improve the health of the population of North Durham'*** we need to understand how general practice contributes to this vision.

North Durham CCG has four strategic objectives; our primary care strategy is aligned to these in terms of how primary care will contribute to the delivery of the CCG's vision.

1. improving the health status of the population,
2. addressing the needs of the changing age profile of the population,
3. commissioning clinically effective, better quality services closer to home,
4. making best use of public funds to ensure healthcare meets the needs of patients and is safe and effective.

Aligned to these are North Durham CCG's primary care objectives which will be used to develop primary care to ensure its fit for purpose now and in the future:

- to develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home,
- to support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care,
- to commission clinically effective planned and unplanned out of hospital care.

1. To develop a fit for purpose workforce and primary care infrastructure to deliver care close to home

1.1 Creating opportunities for the Primary Care Workforce

The CCG's Primary Care Steering Group will oversee initiatives.

Work with Health Education North East and the GP Federations to develop workforce plans for Practice Nurses and GPs in each locality, including a survey to understand the current situation and the position five years from now to identify risks and potential gaps.

Work is in progress for a CCG funded 'GP Career Start' scheme in conjunction with DDES CCG. Both CCGs aim to recruit up to 20 new GPs to the area to work in designated practices with GP mentor support. This is in addition to the continuing Career Start scheme for Practice Nurses which is an ongoing success at attracting more Practice Nurses onto a training and recruitment programme across Co. Durham.

Explore other potential initiatives with HENE and other CCGs for recruitment, retention and use of other primary care professionals for alternative access to care, e.g. Community Matrons and clinical pharmacists.

A Protected Learning Time (PLT) Steering Group with an approved budget has been set up, bringing together GP tutors, Practice Nurse tutors and locality representatives to develop a menu of education and training events that supports primary care professionals and their teams. This will include mandatory training such as safeguarding adults and children training events, and GP and Practice Nurse 'update' courses

Continuing Protected Learning Times (PLTs) for practices, but aligning them to the same 3rd Thursday afternoon each month across all localities. This provides protected time for practices and individuals to focus on key areas of education. The CCG will facilitate four PLTs a year as a whole North Durham event to engage with practices to take forward the primary care strategy.

2. Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care

2.1 Building organisational capacity through GP Federations

In North Durham we have three GP Federations based around three distinct geographical localities; Chester-le-Street, Durham and Derwentside. Each of these areas are historically used to working well with each other.

They are currently supported and resourced by the CCG through contracts to:

- develop an organisational development plan to set up themselves as legal entities, establish governance arrangements, capacity and a business plan,
- set up a weekend on call service for the frail elderly,
- identify other 'examples' of cross practice working,
- deliver an example of multi-speciality care provision.

Progress update.

- all three organisations are now set up as legal entities,
- each has completed an organisational development plan to show progress after six months in existence, and beyond,
- the weekend service for vulnerable people has been up and running since October 2015.

Comments

- GP Federation development is still in its infancy although each shows potential,
- whilst gaining the support and credibility of their member practices it is also important for the CCG that the GP Federation become engaged with the objectives of the primary care strategy and that we have an early success in what they can deliver.

2.2 Driving up quality of primary care services and reducing variation

North Durham CCG is committed to supporting primary care professionals through the anticipated changes in the years ahead. The CCG also encourages local approaches and innovations to addressing challenges and improving outcomes. Over the past year, North Durham CCG has supported a number of schemes and projects, aimed at achieving the CCG's objectives, for example, the *Quality Improvement Scheme* and *Improving Outcomes in Primary Care*. Furthermore, the CCG provides on-going and informal support to primary care, such as through GP variation visits, engagement work in constituencies, and direct feedback mechanisms through constituency leads and deputies

Working with NHS England Cumbria and the North East to:

1. report primary quality using the primary care web tool,
2. improve reporting of serious incidents in primary care,
3. reduce variation of quality across primary care,
4. ensure dissemination and uptake of NICE guidelines,
5. implement a programme of audit work for quality improvement in specific areas,
6. review processes for improving quality in referral pathways,
7. improve use of GP Teamnet across North Durham as an information management tool to enable dissemination of :
    a. updates, information and diary events,
    b. NICE guidelines,
    c. clinical support information (CSI) guidelines,
    d. medicines optimisation guidelines and newsletters,
    e. GP appraisal documentation.

8. Improve quality of prescribing through the prescribing incentive scheme and the medicines optimisation programme.

9. Explore potential for re-instigating the Quality Improvement Scheme at practice level to re-engage Practices in areas of Quality Improvement.

(See quality improvement strategy update)

2.3 Introducing a systematic approach to health improvement

1. To work with Public Health and GP Federations to explore how primary care can work to contribute to the health improvement programme to provide solutions to reduce social isolation.

2. Work on lifestyle schemes to reduce:
    a. smoking,
    b. obesity,
    c. cardiovascular risk through patient health checks,
    d. low exercise rates,
    e. mental illness.

3. Improve self-management schemes for people with long term conditions.

4. Increasing screening and vaccination rates.

5. Reducing health inequalities and causes of ill health.

2.4 How will we know we have made a difference?

- There will be an increase in the primary care workforce and there will be fewer under-doctored areas within North Durham.
- There will be an increased proportion of commissioned services within the community compared to secondary care.

- Patient satisfaction (measured as part of the Friends and Family Test) has improved within primary care for North Durham.
- Tailored seven day services are in place.

3. Commission clinically effective planned and unplanned out of hospital care

3.1 Service Developments:

3.1.1 Moving towards 7 day working and extended access to Primary Care

Update

A review of urgent care services and out of hours services is underway with notice given to the existing provider (County Durham and Darlington Foundation Trust (CDDFT) of the CCG's plan to re-procure the out of hours element with an updated service specification. This will require a disaggregation of the contract between North and South Durham to identify the financial envelope to re-invest in a model going forward.

In line with Government policy, there is a drive to move towards 7 day working and extended weekday working as part of the core GP contract. The Prime Minister has recently announced a new 'voluntary' GP contract that will be in place by April 2017 that requires GP opening from 8am to 8pm during both weekdays and weekends. The detail of this is not yet available but it will be delivered and contracted for through GP Federations enabling new models of working across practices in geographical localities.

The timescale to define a new model of working and contract for its implementation is by April 2017 when the first examples of new models will go live.

In addition to this the North East Urgent Care Network has been successful in its bid to be a Vanguard site in the development of a model of care across the North East to address system pressures and improve quality of care and patient safety. Urgent care will be delivered, not just in hospitals, but also by GPs, pharmacists, community teams, ambulance services, NHS 111, social care and others, and through patients being given support and

education to manage their own conditions. Another aim is to break down boundaries between physical and mental health to improve the quality of care and experience for all.

The Urgent Care Strategy puts GP practices at the heart of the Urgent Care System, recognising their role in providing access to responsive primary and community care services 7 days a week.

For example:

- central data collection and monitoring of demand,
- better self care and education of use of services,
- future use of '111' as a point of access for urgent care or advice, including availability of GP appointments,
- integration with ambulance and paramedic services,
- fewer, but more specialised centres of Accident and Emergency care through new payment models,
- more accessible integrated care 'out of hospital service' at a locality level.

Next steps

1. There is a CCG working group set up to take forward the urgent care strategy which will co-ordinate its implementation going forward, anticipating the key role 'urgent care' will play in a wider 'not in hospital' strategy in each locality.

2. The CCG will work with each GP Federation (as part of their organisational development plan) to define a model of 7 day working for general practice in each locality which will describe aspects of how that service may be provided.

   Where, when, how, who

3. Consult with patients and the public about emerging models of access to 7 day services at locality level.

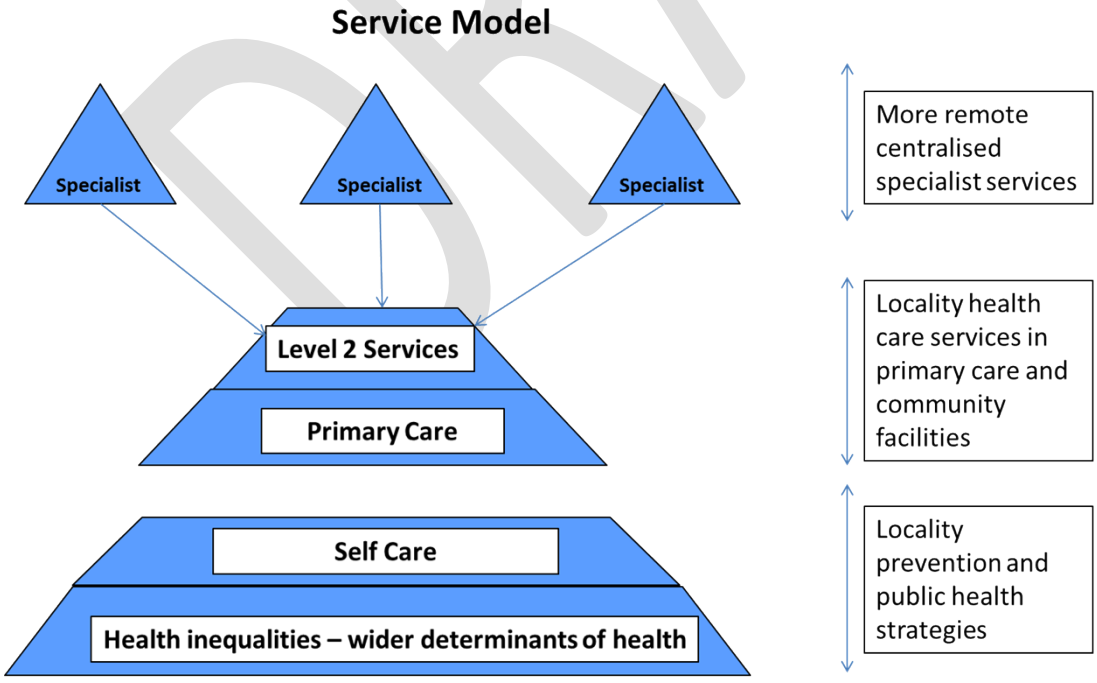
4. Work with other providers as to how this integrates with other 7 day working strategies eg Community Matrons, IC+ services, diagnostics, new consultant contracts, A&E services.

5. Understand the financial framework (from disaggregation of the out of hours contract) and new commissioning routes (new GP contract model, or Vanguard sites) that we can use to drive and implement new models of 7 day working.

6. Work with the local A&E Delivery Board previously known as System Resilience Group to understand the implications of the North East and Yorkshire Regional Vanguard initiatives.

7. Engagement with practices, GP Federations and the constituency leads is now paramount in how general practice will work within this model to find an effective solution.

3.1.2 Key features of a new operating model for 'Not in Hospital Care'



'Not in hospital care' will be delivered and co-ordinated at locality level.

Local practice teams will provide continuity to their registered population supported by aligned community services consisting of designated District Nurses and Community Matrons to each locality.

Hubs will be developed within each locality to provide supporting services across practices in each area.

This may consist of specialist clinical, specialist nursing, diagnostic, outreach, rehabilitation, out of hours services or even shared 'core' GP services.

Key elements at this level are:

- cross practice working e.g. out of hours services, weekend services,
- integration between social and community services, e.g. intermediate care plus (IC+) services,
- vertical integration between acute, community and general practice services e.g. diabetic clinics.

These hubs may be based at specified practices or community locations depending on the Primary Care and community estate or historical agreements at locality level, hence the importance of an estates strategy to follow the service strategy.

Continuity of information through effective IT solutions is imperative to enable access to a single patient record where possible and effective working across practices and community services.

A co-ordinated approach to improving health and wellbeing can be planned, contracted and integrated at practice or community level wherever is best accessible for patients.

GP Federations (or other models of scaled up General Practice at locality level) will be perfectly placed to take the lead for some, or all, of these services either providing them as a provider organisation themselves, or working with other organisations within a multi-speciality care provider model.

3.1.3 Implementing a new model of Care for Diabetes

Update

North Durham Clinical Commissioning Group wants to improve the quality of care for people living with diabetes, and to support them to manage their condition so they can stay healthy. Specialist clinicians are having to focus on managing the complications from diabetes, instead of preventing complications occurring. Historically there is not enough joined up working between primary care and acute care. Both patients and clinicians have fed back that they want a more joined up approach. 10% of the NHS budget is spent on diabetes, 1% of the whole NHS budget is spent on drugs to control blood sugar. Spend on diabetes drugs per patient is higher in County Durham and Darlington than the North East and is rising faster. Costs will continue to rise, becoming unaffordable if we do not change how we support people both at risk of diabetes and those who already have the condition.

A new model of care has been developed with input from patients, primary and secondary care clinicians and this will see:

- GPs and local hospitals working more closely together to give patients care closer to home,
- a shift from acute to primary and community services to support people with Type 2 Diabetes,
- a patient centred, integrated service for patients between primary and secondary care which ensures that future diabetes services are financially sustainable.

The new model promotes a keen focus on:

- diabetes prevention,
- individualised care planning and patient self-management,
- named specialist resources,
- consultants and Diabetes Specialist Nurses collaborating with groups of GP practices (based on local GP Federations) in newly formed ‘diabetes groups’ to upskill primary care and improve the level of care provided in practices,

- pursuing savings for reinvestment in diabetes care to ensure a financially sustainable service whilst also delivering quality care to our patients.

We have developed a training curriculum for primary care clinicians to ensure GPs and Practice Nurses are suitably qualified in diabetes care. In addition, County Durham is a demonstrator site for the new National Diabetes Programme. This will be rolled out across the County during summer 2016, initially focusing on areas where need is greatest (maybe due to deprivation or higher numbers of patients identified as being at high risk of diabetes), and we expect the first localised programme to start in early August 2016. Those referred will get tailored, personalised support to reduce their risk of Type 2 diabetes, including education on healthy eating and lifestyle, help to lose weight and bespoke exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

3.1.4 Implementing integrated services for the Frail Elderly

Update

The model for the frail elderly has been developed at four different levels of care that together form an integrated pathway for the frail elderly patient. Its implantation is already well under way the elements of which will all be in place by early 2016.

Four levels of Care

1. Prevention and wellbeing

Public health and the Health and Wellbeing Board working on a strategy to reduce social isolation.

2. Practice level

Primary care identifying a register of people with frailty in each practice using agreed search criteria as a case finding tool. Each practice are contracted to assess all patients on this register in terms of frailty, risk of falls, cognitive assessment and medication review.

According to need, to provide targeted proactive and reactive care using a case management approach on a multidisciplinary team basis where required.

3. Locality based services

- at GP Federation level, working across practices to provide a weekend GP service to support those on the frailty register, and those in care homes, providing reactive and proactive care alongside Community Matrons, to keep this vulnerable cohort of patients out of hospital or facilitate discharge where necessary,
- by summer 2016 the team of community matrons will be fully integrated into primary care multi-disciplinary teams working with GPs and practice staff to care for their frail population,

- Community services and care home provision
    - District Nurses are now aligned to specific practices and specific care homes,
    - re-align named practices to specific care homes to complete a clinical support team of GP, District Nurse and Community Matron to each care home in a locality,
    - all care homes to have completed Emergency Health Care Plans for each resident (March 2016).

- After April 2016 onwards
  Full alignment of District Nurses to practices and care homes, providing a range of proactive and reactive care on a case management basis, with integration of Community Matrons working at practice level to a register of frail elderly patients both in care homes and at their own homes.

- Locality based Multidisciplinary Intermediate Care Services
  The IC+ 'Intermediate Care Plus'
    - integrated support from specialist nurses, rehab teams and access to carer support, provided from a Single Point of Access (SPA),

- this is now in place, allowing urgent intervention in a co-ordinated approach. This can arise from either a step up referral including crisis response from the community, or a step down referral from hospital to support discharge,
- the service provides rapid access to an appropriate level of support to keep people out of hospital or facilitate discharge,
- it is available 7 days a week, 24 hours per day.

4. Linking with specialised elderly care services

- Rapid assessment clinics
  - daily clinics Monday to Friday to provide same day / next day appointments for urgent medical assessments,
  - access via Single Point of Access service,
  - locations at Shotley Bridge and Chester-le-Street Community Hospitals,
  - providing full elderly assessment, access to diagnostics, therapy, medical opinion and onward referral if necessary.

- Consultant advice lines – Daily 12.00 – 2.00 pm

- Proposed front of house service – working alongside Accident and Emergency at University Hospital North Durham (UHND) to provide a consultant led service, providing urgent assessment to the frail elderly attending A&E, including diagnostics, access to therapy and IC+ services.
  This will be integrated with other community support services described above through shared access to community service and Social Service IT systems.

Appendix 1

Operational Plan

Objective 1 **To develop a fit for purpose workforce and primary care infrastructure to deliver care closer to home**
Workforce and Training
Invest the Personal Medical Services premium over the next five years into workforce within general practice such as GP posts e.g. joint posts within urgent care and diabetes, primary care nursing, career start for GPs as well as nursing, extending the role of nurses and training.
Actively plan our workforce to look at future demand including population growth and other factor such as working patterns and retirement and plan for this demand.
Promote North Durham CCG practices as a great place to work and we will link into universities to attract the newly qualified workforce.
Work with GP and nurse tutors to develop a rolling programme to ensure that staff training needs are met and to enhance workforce skills particularly in relation to long term conditions. We will align this programme to CCG commissioning priorities.
Develop primary care teams as CCG leaders
Work with Health Education North East to maximise the impact of any workforce related programmes.
Develop and support our existing primary care teams, e.g. via Protected Learning Time
Address the need to use a multidisciplinary model to support and develop the use of non-medical prescribers as part of the primary care team (nurses and pharmacists). In particular we will identify the associated challenges such as training and work with HENE to mitigate against these.
Premises
Develop a primary care estates plan which takes into account changes in population and changes in ways of working
Develop an investment plan in line with the national capital programme for primary care premises to ensure need is met.
Identify practice premises that are in greatest need and prioritise support to those.
Informatics
Develop functionality to deliver mobile working.
Support the delivery of interoperability between systems across health and social care.
Further develop the utilisation and effectiveness of a central communication system.

Objective 2 **Support general practice to work with each other and with local people and partners to deliver high quality, cost effective primary care**
Federated working
By the end of 2015-16 all practices within North Durham will be working as part of a federated model
The CCG will support federations to set up and develop into successful primary care provider organisations.
The CCG will work with federations on an ongoing basis to share ideas and ensure two way communication is in place
In line with the Five Year Forward View, the preferred model for primary care to be part of is Multi-Speciality Community Providers (MCP). North Durham CCG will facilitate and commission from trusts, other partners and primary care organisations that develop these new models of care by the end of 2016-17.
Engagement
Effectively engage and consult with general practice via a variety of means including the constituency lead model, the Director of Primary Care role and through the central communication system as well as formal Council of Members meetings.
Play an active role in supporting the Protected Learning Time (PLT) work programme which will include time dedicated to them as commissioners.
Ensure that our member practices are involved in the priority setting process.
Strive to ensure that member practices think of the commissioning organisation as “our CCG”.
Engage with our local community about primary care services through our engagement model including Patient Reference Groups and the Patient, Public and Carer Engagement Committee.
Patient safety, experience and quality
Continue to support general practice in terms of the implementation of the Friends and Family Test, and specifically in relation to the patient experience kiosks.
Ensure that quality is monitored and actively managed within primary care using national tools and supporting practices to develop. The aim is to reduce variation, NICE guidance implementation and to ensure patient safety, experience and effectiveness of care is delivered. We will support GP practices through the CQC process.

Objective 3 Commission clinically effective planned and unplanned out of hospital care
Review the out of hours specification and recommission a service to meet the demand and needs of unplanned care provision. The service will also support patients to be cared for in their own home.
Commission seven day primary care services tailored to those with the greatest health need
Support primary care services to manage long term conditions such as diabetes, mental health, palliative care and cancer, with the aim of moving more care closer to home.
Engage with public health to support the delivery of the prevention agenda through primary care.
Evaluate the primary care outcomes scheme and commission those schemes as part of the mainstream commissioning agenda which have made an impact. Such services will be commissioned across the CCG area.
Wrap community, social care and mental services around primary care services to deliver an integrated service for patients.

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Adult Wellbeing and Health Overview and Scrutiny Committee

3 October 2016

Draft Oral Health Strategy For County Durham

Report of Gill O'Neill, Interim Director of Public Health, County Durham

Purpose of the Report

1 The purpose of this report is to present the Adult Wellbeing and Health Overview and Scrutiny Committee with the draft Oral Health Strategy for County Durham for consultation. The draft strategy is attached as Appendix 2.

Background

2 The National Institute for Health and Care Excellence (NICE) Public Health 55 Guidance makes 21 recommendations to improve the oral health of our communities. The first recommendation is the development of a stakeholder group that in turn will assist in the development of a strategy to deliver the majority of the other recommendations. The oral health strategy group has been established and has developed an oral health strategy.

Oral health strategy development

3 There are 21 recommendations within the NICE guidance. These recommendations have been mapped at a high level by the oral health strategy group to consider whether they are being met across County Durham.

4 The development of this strategy has been led by a multi-disciplinary steering group consisting of members of the local dental network, paediatrician, dental anaesthetist, Durham County Council children's services, health visiting services, Durham County Council commissioning for adult services, public health and Public Health England.

5 It is essential at a time of austerity that a new strategy and action plan is designed which is deliverable within existing resources and includes thinking differently and working more smartly by pooling resources.

6 The 21 recommendations can be applied to a 'settings based' approach. The strategy sets out the intentions for how the oral health strategy and action plan will be pragmatically applied by working with existing partners and stakeholders to embed oral health over the next three years.

7 Whilst the oral health strategy is developed and implemented, work is ongoing in partnership with Public Health England (PHE) to explore the possibility of

water fluoridation. At this point in time PHE is awaiting feedback from Northumbrian Water around the water quality zones (the geographic measure used by the water industry) and the potential locations for water fluoridation plants.

Consultation

8 The consultation process will seek the views of the public and key stakeholders across County Durham.

Next steps

9 The strategy will seek the views of key partnership groups and Overview and Scrutiny Committees. A consultation timeline is included as Appendix 3.

Recommendations

10 The Adult Wellbeing and Health Overview and Scrutiny Committee are requested to provide comment on the Draft Oral Health Strategy attached at appendix 2.

Contact: Chris Woodcock, Public Health Portfolio Lead
Tel: 03000 267682

Appendix 1: Implications

Finance: Identified from Public Health reserves. Fluoridation study may also include contributions from NHS England.

Staffing: None

Risk: Timeline for fluoridation and stakeholder opinion surrounding the activity.

Equality and Diversity / Public Sector Equality Duty: None

Accommodation: N/A

Crime and Disorder: N/A

Human Rights : N/A

Consultation: Oral Health Strategy will be consulted upon. Consultation not required for feasibility study.

Procurement: DCC to commission targeted interventions.

Disability Issues: None

Legal Implications: Linked to procurement. Linked to the legislative process surrounding fluoridation.

Oral Health Strategy

County Durham

2016-2019

DRAFT

Aim of Oral Health Strategy

1. To reduce the population prevalence of dental disease – and specifically levels of dental decay in young children and vulnerable groups.
2. To reduce the inequalities in dental disease.
3. To ensure that oral health promotion programmes are evidence informed and delivered according to identified need.

Background

Oral health is important for general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example due to pain or social embarrassment[1]. Oral health problems include gum (periodontal) disease, tooth decay, tooth loss and oral cancers. Many risk factors – diet, oral hygiene, smoking, alcohol, stress and trauma are the same as for many chronic conditions, such as cancer, diabetes and heart disease.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. While children's oral health has improved over the last twenty years, almost a third (27.9%) of five year olds still had tooth decay in 2012[2]. Children who have toothache or who need treatment may have to be absent from school. Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012 – 13. Dental treatment under general anaesthesia presents a small but real risk of life threatening complications for children[3].

People living in deprived communities consistently have poorer oral health. However, it is noted that deprived areas with fluoridated water have better oral health than comparator communities without fluoridated water.

Vulnerable groups in society are also more likely to suffer from poor oral health. NICE guidance[4] identifies a list of vulnerable groups who require specific support to improve their oral health. These include those who are:

- Socially isolated
- Older and frail
- Physical or mental disabilities
- From lower socio economic groups
- Live in disadvantaged areas

[1] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE
[2] PHE 2014 commissioning better oral health for children
[3] PHE 2014 commissioning better oral health for children
[4] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE

- Smoke or misuse substances (including alcohol)
- Have a poor diet
- Some Black, Asian and minority ethnic groups
- Who are, or who have been in care

Diseases affecting the oral cavity

The mouth is affected by diseases such as dental caries and periodontal disease and other conditions, such as trauma, mouth cancer and developmental abnormalities, all of which can have an adverse effect on an individual's wellbeing.

Dental caries (tooth decay)

Dental caries is the most common disease of the dental tissues and affects the majority of the population. It is caused by bacteria in the mouth utilising sugars in the diet as a source of food and producing acids as a by-product. The acids dissolve away the tooth substance leading to dental decay, abscess formation and eventually tooth loss.

There is substantial evidence to show that people from socially deprived backgrounds experience considerably more dental disease than other members of the population due to lack of opportunities that would enable them to improve their oral health. The main issues are poor diet and limited access to fluorides and dental care.

Periodontal disease

Periodontal disease affects the structures which support the teeth; these are the tissues and ligaments which secure the teeth to the jaw bones. This disease is caused by a build-up of plaque around the teeth leading to the development of inflammation. The gums become swollen and bleed spontaneously. In susceptible individuals the disease progresses by destroying the supporting structures of the teeth, the teeth become loose and if unchecked the disease results in tooth loss.

Trauma

Teeth may be traumatised as a result of accidents and participation in contact sports. The upper incisor teeth are at greatest risk and experience most damage.
The most recent data for England was published in March 2015[5] using a survey of 15 year olds which found the proportion of 15 year olds affected is very similar across the three countries (England, Wales, Northern Ireland), at around 4% of the

[5] Children's dental health survey 2013, Health and social care information centre, March 2015

population and there are no significant differences related to sex, free school meals, brushing or school attendance.

Mouth cancer

Mouth cancer is the major fatal condition which affects the oral tissues. There is a high risk of developing mouth cancer in people who smoke and those who consume excessive amounts of alcohol.

Developmental abnormalities of the oro-facial tissues

Although not the result of disease processes, defects in the development of oral tissues and facial skeleton may result in teeth being displaced sufficiently that the malocclusion produced impacts on oral health. Significantly adverse alignment of children's teeth makes them more susceptible to physical disease, trauma and also impacts on personal appearance, leading to potentially low self-esteem. There are a large number of rare genetic conditions which affect the teeth and facial skeleton. The most common are clefts of the lip and/or palate.

Roles and responsibilities for oral health

With the fragmentation of the NHS in April 2013 the responsibility for dental services and oral health dispersed across various organisations. The table below briefly highlights which local organisations have responsibility for which parts of the system.

Table 1: Local organisations roles and responsibilities

Organisation	Key responsibility
NHS England (Area Teams)	Commissioning all NHS dental services – both primary and secondary care Direct and specialised commissioning
Public Health England (centres)	Provide dental public health support to NHS England and Local authorities Contribute to JSNAs, strategy development, oral health needs assessment Supporting local authorities to understand their role in water fluoridation
Local authorities (Public Health)	Jointly statutorily responsible for JSNA Conducting and/or commissioning oral health surveys to monitor oral health needs to an extent that they consider appropriate in their areas Planning, commissioning and evaluating oral health improvement programmes Leading scrutiny of delivery of NHS dental services

Local dental networks	Providing local professional leadership and clinical engagement
Provider services	County Durham and Darlington Foundation Trust hold a block contract for dental services which includes the oral health promotion team

National recommendations

Within the latest public health NICE guidance 'Oral health: approaches for local authorities and their partners to improve the oral health of their communities', there are 21 recommendations for health and wellbeing boards to consider. Table 2 below provides a list of the recommendations

Table 2: NICE recommendations

Recommendations
1. Ensure oral health is a key health and wellbeing priority 2. Carry out an oral health needs assessment 3. Use a range of data sources to inform the oral health needs assessment 4. Develop an oral health strategy 5. Ensure public service environments promote oral health (e.g. plain drinking water available, healthy vending options, promoting breastfeeding etc.) 6. Include information and advice on oral health in all local health and wellbeing policies 7. Ensure front line health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 10. Promote oral health in the workplace 11. Commission tailored oral health promotion services for adults at high risk of poor oral health 12. Include oral health promotion in specifications in all early years services 13. Ensure all early years services provide oral health information and advice 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health 16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health 17. Raise awareness of the importance of oral health as part of 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary

schools in areas where children are at high risk of poor oral health

19. Consider supervised tooth brushing schemes in primary schools in areas where children are at high risk of poor oral health
20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
21. Promote a whole school approach to oral health in all secondary schools

Fluoridation

Fluoride has made an enormous contribution to the decline in dental caries over the past 60 years since research in the United States discovered that people living in an area of naturally fluoridated water had much better dental health than those who did not and, furthermore, water fluoridated at a concentration of 1 part per million did not cause significant mottling of the teeth (dental fluorosis) nor any other health related adverse effects. Fluoride produces an effect on the teeth in a number of ways that combine to slow and help prevent the decay process.

There is compelling evidence that fluoride is effective in reducing decay and that water fluoridation is the most effective way of using fluoride to reduce decay. Other fluoride interventions, such as fluoride toothpaste and fluoride varnish, are also important, effective ways of reducing tooth decay and there is an even greater reduction in decay levels when, for example, fluoride toothpaste is used together with water fluoridation. Consequently this oral health strategy for County Durham includes due consideration of water fluoridation as part of a series of oral health promotion initiatives – including other fluoride based interventions and initiatives aimed at improving diet and nutrition.

Fluoride tooth brushing schemes

The use of fluoride toothpaste has been shown to reduce levels of dental decay by 37% and the increased use of fluoride toothpaste has been largely responsible for the reductions in dental decay that have been observed over the last 20-30 years.

Published research has indicated that supervised tooth brushing schemes are effective in reducing levels of dental decay and that there remains a significant reduction in decay levels between children in test and control groups at 30 months after the programme ended.

Evidence also shows that the introduction and uptake of a tooth brushing program contributed positively to the dental health of children and reduced dental health inequalities.

Tooth brushing schemes are to be established in targeted early year's day care facilities in County Durham whilst promoting dental registration with families through universal health visitor services.

Fluoride varnish

Fluoride varnish is one of the best options for increasing the availability of topical fluoride, regardless of the levels of fluoride in the water supply. High quality evidence of the caries-preventive effectiveness of fluoride varnish in both permanent and primary dentitions is available and has been updated recently. A number of systematic reviews conclude that applications two or more times a year produce a mean reduction in caries increment of 37% in the primary dentition and 43% in the permanent. Schemes will be explored during the implementation of this strategy.

County Durham: oral health current picture

Access to dental services

A study on access to dental services carried out in 2010/11 (most recent data available) showed significant variations across the wards in the county with populations living in the poorest wards having the lowest uptake.

Perceptions surveys have been undertaken to understand why adults do not register with dentists. Two of the most significant barriers include complexity of the forms to fill in and dentist phobias.

NHS England are leading a review of the national general dental contract. Part of the consultation is regarding how primary dental health services can deliver more on oral health promotion activities and reduce oral health inequalities. The outcomes of the consultation are awaited.

Oral health status

Children: Data from the last large scale dental survey (2012) of five year old children's oral health in County Durham shows wide variations in dental disease experience between different wards, from 61% of children having had decay experience in Woodhouse Close (Bishop Auckland) to just 6% in Chester-Le-Street South. This highlights a need to narrow the gap in oral health inequalities. Oral health of five year olds is part of the children's public health outcomes framework.

Adults: There are no regular local surveys undertaken of adult dental health at a local authority level. The best data available is from the last national adult health survey which took place in 2009. The smallest geography available is at a North East level. The survey showed that 92% of the North East population had some teeth. 82% had 21 or more teeth which is the limit allowed by dentists to

demonstrate functionality. 65% of North East residents participating in the survey reported regular dental attendance above the England average of 61%.

Elderly population: With an aging population, the increase in dementia and older people retaining their teeth, there is a need to consider how the oral health of this growing vulnerable population will be managed. The challenge this group presents is the support required to maintain their oral health and how health and social care provide supportive environments to maximise their oral health and avoid unnecessary and expensive dental treatment. A recent local evaluation completed within County Durham care homes[6] has identified the complex oral health care needs of those living in residential care. The system must come together to support this vulnerable group and reduce escalating costs which are preventable.

Partnerships and governance

The development of this strategy has been led by a multi-disciplinary steering group consisting of members of the local dental network, paediatrician, dental anaesthetist, Durham County Council children's services, health visiting services, Durham County Council commissioning for adult services, public health and Public Health England.

There has also been a consultation process to ensure the views of stakeholders have been taken into consideration.

The Oral Health Steering Group is accountable to the Children and Families Partnership and the Health and Wellbeing Board.

Outcome measures for strategy

Percentage improvement: child population averages for decayed, missing and filled teeth, proportion of children with no decay experience.

Challenges going forward

The gap in oral health inequalities between children living in deprived communities and those in less deprived communities needs to reduce. Targeted work must also continue with vulnerable groups such as those with poor physical and mental health and the frail elderly population.

Due to the overlap with other health promotion messages for many other preventable conditions, such as diabetes, there is benefit in combining approaches and making sure oral health is embedded into other health promotion work rather than a stand-alone topic.

[6] Ahmad, B., 2015 oral health care provision for the elderly in residential care homes in County Durham: An evaluation of need and strategy document

The strong and newly emerging evidence[7] regarding the impact on sugar on the obesity epidemic is an opportune time to combine efforts on tackling obesity and oral health inequalities.

The 21 NICE recommendations can be applied to a 'settings based' approach. The remainder of this strategy sets out the intentions for how the oral health strategy will be delivered practically by working with existing partners and stakeholders to embed oral health over the next three years while we remain committed to progress the feasibility of fluoridation.

The first four NICE recommendations refer actions already underway such as the development of a strategy and reviewing the available epidemiological data.

Action Plan

Early years settings ACTION	**Lead**	**Timeline**	**NICE Recommendations**
1. Increase breast feeding initiation by 5% 2. Increase breastfeeding at 6 – 8 weeks by 5% 3. Breastfeeding friendly venues – UNICEF accreditation maintain status 4. Increase dental registration in families in 30% most deprived MSOAs 5. Plain drinking water in public sector venues is main drink available 6. Provide a choice of sugar free foods – including vending machines 7. Oral health part of early years strategy			5. Ensure all public service environments promote oral health 6. Include information on oral health in local health and wellbeing policies 7. Ensure frontline health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 12. Include oral health promotion in specifications for all early years services 13. Ensure all early years

[7] Public Health England, 2015. Sugar Reduction 'The evidence for action'

8. Training on oral health promotion given to front line practitioners 9. Targeted oral health promotion work for vulnerable groups: SEND and vulnerable parent pathway 10. Align dental practices to children centre cluster areas 11. Deliver and evaluate a three year tooth brushing scheme in targeted nurseries, working with local dental network			services provide oral health information and advice 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health

Primary school setting (age 5 – 11 years) ACTIONS	**Lead**	**Timeline**	**NICE Recommendation**
1. Increase number of schools following national school food plan: ensure plain drinking water available and sugar free snacks 2. Encourage schools to include oral health as part of the curriculum – PSHE resources easily available 3. School Nurses to promote dental registration at parent sessions 4. Local dental network (LDN) to establish 'pop up' dental clinics' within schools			17. Raise awareness of the importance of oral health, as part of a 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at risk of poor oral health 19. Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health

to increase dental check-ups and dental registrations 5. Oral health promotion team to work with special schools through the academic year 6. Training sessions delivered to special school support staff on oral hygiene and health promotion 7. Deliver and evaluate a three year targeted tooth brushing scheme working with the local dental network to deliver intervention			20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health

Workplace and community setting ACTIONS	**Lead**	**Timeline**	**NICE Recommendations**
1. Make plain drinking water available in community venues 2. Provide a choice of sugar free food, drinks and snacks, including from vending machines 3. Encourage and support breastfeeding 4. Healthy living pharmacy – SMILE campaign delivered annually 5. Oral health in Health at Work campaigns			5. Ensure public services promote oral health 6. Ensure front line health and social care staff can give advice on the importance of oral health 10. Promote oral health in the workplace

Vulnerable group (children and adults at high risk of poor oral health) ACTIONS	Lead	Timeline	NICE Recommendations
1. Oral health promotion team to work specifically with special schools and those educated outside of mainstream 2. Explore feasibility of minimum set of standards for oral health within care home contracts e.g. oral health assessment on admission to care home, oral health care plan established and regularly reviewed – quality metrics 3. Include training and support in residential care homes on importance of oral hygiene and dual training on dementia care as part of contract 4. Label dentures to reduce loss and cost of replacement 5. Align dental practices to each residential care home to ensure a general dentist is available for advice/guidance			7 Ensure front line health and social care staff can give advice on importance of oral health 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 12. Commission tailored oral health promotion services for adults at high risk of poor oral health

Appendix 3: Draft Consultation Timeline For Oral Health Strategy

Meeting	Date	Purpose
Health and Wellbeing Board	26th July 2016	Agree draft for wider consultation
Six week public consultation: • Including targeted consultation with Foundation Trusts	1st August – 12th September 2016	Consultation
Children and Families Partnership	13th September 2016	Consultation
CYP Overview and Scrutiny committee	29th September 2016	Consultation
AWH Overview and Scrutiny committee	4th October 2016	Consultation
Health and Wellbeing Board	17th November 2016	Agreement of strategy

Adults Wellbeing and Health Overview and Scrutiny Committee

3 October 2016

CAS –Revenue and Capital Outturn 2015/16

Report of Jeff Garfoot, Head of Finance (Financial Services)

Purpose of the Report

1. To provide the committee with details of the actual outturn budget position for the CAS service grouping, highlighting major variances in comparison with the (revised) budget for the year, based on the final position at the year end (31st March 2016) as reported to Cabinet in July 2016. The report focuses on the Adults Wellbeing and Health services included in CAS.

Background

2. County Council approved the Revenue and Capital budgets for 2015/16 at its meeting on 25 February 2015. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

- *CAS Revenue Budget - £251.770 million (original £251.450 million)*
- *CAS Capital Programme* – £40.682 million *(original £45.453 million)*

3. The original CAS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

Reason For Adjustment	£ million
Original Budget	**251.45**
Transfers to other services (Financial Services / Assessments to Resources)	(1.456)
Energy Efficiency Reduction	(0.147)
Transfer From Contingency - Soulbury Pay award	0.157
Transfer From Contingency - Cost Associated with Closed School Buildings	0.138
Transfer From Contingency - Reversal Of Car Mileage Deduction	0.076
Transfer to Capital (Aycliffe Secure Services/ DACT Estate)	(0.668)
Use of (+) / (contribution) to CAS reserves	(0.994)
Use of (+) / (contribution) to Corporate Reserves (ERVR Costs)	3.214
Revised Budget	**251.77**

4. The in-year (use of) / contribution to CAS reserves utilised in determining the year end revenue budget of £251.770 million consisted of:

Reserve	£'000
Social Care Reserve	(916)
Cash Limit	1,971
Innovations and YEI Redundancy Reserve	(1,000)
Secure Services Capital Reserve	868
Tackling Troubled Families Reserve	188
Transformation Reserve	(1,264)
Accumulated fund CPD Reserve	134
Durham Learning Resources Reserve	(8)
EBP Reserve	81
Emotional Wellbeing Reserve	(33)
Mental Health Counselling Reserve	7
Movement Difficulties Service Reserve	(13)
Re-Profiling Activity Reserve	(175)
SEND reform Grant Reserve	15
School Condition Survey Reserve	(450)
Swimming Reserve	(67)
Public Health Reserves	(330)
Total In service use by CAS	**(994)**

5. The summary financial statements contained in this report cover the financial year 2015/16 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the actual outturn;
- For the CAS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn – 2015/16

6. The CAS service outturn was a cash limit under budget of £10.690 million against a revised budget of £251.770 million, which represents a 4.2% under budget. This compares with a previously reported underspend position of £10.364 million at quarter 3.

7. The tables below show the revised annual budget, actual expenditure and variance to 31 March 2016. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for CAS, and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	YTD Actual £000	Variance £000	Items Outside Cash Limit £000	Contribution To From Reserves £000	Cash Limit Variance £000		*MEMO – Variance at QTR3 £000*
Employees	116,577	109,978	(6,599)	493	856	(5,250)		**(5,098)**
Premises	7,146	7,262	116	(448)	48	(284)		**(219)**
Transport	17,399	17,885	486	-	19	505		**559**
Supplies & Services	18,950	15,115	(3,835)	753	1,035	(2,047)		**(1,732)**
Third Party Payments	238,806	229,358	(9,448)	-	163	(9,285)		**(10,001)**
Transfer Payments	13,069	12,574	(495)	-	-	(495)		**158**
Central Support & Capital	63,235	88,690	25,455	(23,419)	(420)	1,616		**2,260**
Income	(223,412)	(230,412)	(7,000)	11,286	264	4,550		**3,709**
Total	251,770	250,450	(1,320)	(11,335)	1,965	(10,690)		**(10,364)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Variance £000	Items Outside Cash Limit £000	Contribution To From Reserves £000	Cash Limit Variance £000		*MEMO – Variance at QTR3 £000*
Head of Adults	124,841	118,762	(6,079)	(453)	1,483	(5,049)		**(6,024)**
Central/Other	8,935	10,327	1,392	(1,780)	203	(185)		**(258)**
Commissioning	7,858	4,641	(3,217)	-	(918)	(4,135)		**(4,004)**
Planning & Service Strategy	11,622	10,952	(670)	(14)	(375)	(1,059)		**(906)**
Central Charges (CYPS)	4,074	(2,494)	(6,568)	5,879	714	25		**-**
Childrens Services	53,767	56,758	2,991	(2,653)	(138)	200		**870**
Education	40,002	50,988	10,986	(11,991)	518	(487)		**(42)**
Public Health	671	516	(155)	(323)	478	-		**-**
Total	251,770	250,450	(1,320)	(11,335)	1,965	(10,690)		**(10,364)**

8. The table below provides a brief commentary of the cash limit variances against the revised budget, analysed by Head of Service for those areas which relate to the Adults area of the service, which is of specific interest to the Adults Wellbeing and Health Overview and Scrutiny Committee. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£199,000 under budget on employees through effective vacancy management. £237,000 under budget on transport, mainly in respect of day care. £678,000 net over budget on care provision. £24,000 over budget in respect of premises/transport/supplies and services	266
Safeguarding Adults and Pract.Dev.	£208,000 under budget on employee costs due to vacant posts. £14,000 over budget on supplies and services, mainly in respect of professional fees linked to Deprivation of Liberty cases. £4,000 net under budget on transport/other costs.	(198)
Ops Manager OP/PDSI Services	£600,000 under budget due to early achievement of employee-related MTFP savings. £2,656 million net under budget on direct care-related activity. This is after £600,000 has been allocated for future care fee pressures. £226,000 under budget in respect of premises/transport/supplies and services/other costs.	(3,482)
Ops Manager Provider Services	£1.395 million under budget on employees in respect of early achievement of future MTFP savings. £135,000 under budget on supplies and services in respect of early achievement of future MTFP savings. £105,000 net under budget on premises/transport/other costs.	(1,635)
		(5,049)

Service Area	Description	Cash limit Variance £000
Central/Other		
Central Charges/Other	£151,000 under budget on employee-related costs in respect of future MTFP savings. £46,000 over budget on premises/transport/other costs. £80,000 additional income mainly in respect of salary recharges.	(185)
		(185)

Service Area	Description	Cash limit Variance £000
Commissioning		
Commissioning Management / Other	Under budget mainly in respect of future MTFP savings, particularly agency and contracted services budgets held. A review of short term monies added to an increased under spend during the year. £1.1 million of short term funds have been carried forward to support future preventative projects.	(4,135)
		(4,135)

Service Area	Description	Cash limit Variance £000
Public Health		
Cancer Awareness/ Physical Activity /GRT	The variance relates to non- recurrent activity in relation to the Macmillan Cancer Awareness contract.	84
Capacity Building/Health Trainers	The variance relates to non -recurrent activity in relation to the patient transport schemes and health trainer for mental health services.	178
Health Checks/Smoking Cessation	Activity based smoking cessation and NRT services spent (£531K) less than the £1.08million budget available. Similarly health checks commissioned from pharmacies and GP's were under budget by (£113K). However, this was offset by the non -achievement of CCG income £158K towards Diabetes prevention, and some increased equipment costs amounting to £33K.	(453)
Oral Health and Services to Children	Expenditure on a resilience programme for children spent (£104K) less than the budget available, due to length of time taken to recruit and induct staff to the new service. (£250K) of the variance relates to the reduction in contract value of 0-5 services part year effect .	(365)
Public Health Grant and Reserves	The variance relates to the in-year reduction in Public Health grant.	3,137
Public Health Specialist Training Prog (HENE)	Income of £8K received from Health Education North East in relation to the Public Health Specialist Training Programme will be held in earmarked reserve to fund future requirements for backfill training placements.	-
Public Health Team	Following the announcement of the £3.137 million in year reduction in Public Health grant; commissioning decisions relating to the £2.45 million budget were put on hold. An underspend in employees costs due to vacancies and secondment arrangements contributed to the overall underspend.	(2,613)
Sex/Health/Alcohol/Substance Misuse/Domestic Violence/Mental Health	Commissioned services for sexual health spent £183K more than the £4.5million budget available. DACT premises expenditure was (£196K) less than the £560k budget available mainly as a result of charitable status of the provider in relation to business rates and lower than anticipated running costs. Prescription costs associated with drug and alcohol treatment spent (£56K) less than the £836K budget available. Within Domestic Violence services a non -recurrent commission contributed to the overall overspend of £115K in this service. Lower than anticipated grants to voluntary organisations in respect of the CREES scheme contributed to a small underspend in mental health.	34
		0

Service Area	Description	Cash limit Variance £000
Planning & Service Strategy		
Performance & Information Mgmt	£124,000 under budget on employees re future MTFP savings. £52,000 under budget on supplies and services budgets re future MTFP savings. £5,000 under achievement of income.	(171)
Policy Planning & Partnerships / Mgt	£118,000 under budget on employees re future MTFP savings. £89,000 under budget on transport/supplies and services/other budgets. £89,000 under achievement of income.	(118)
Service Quality & Development	Future MTFP savings linked in the main to employees (£145,000) and supplies and services (£184,000). £113,000 under budget on other areas.	(442)
Service Support	£200,000 under budget on employees re future MTFP savings. £128,000 under budget on transport/supplies and services/other budgets.	(328)
		(1,059)

9. In summary, the service maintained spending within its cash limit. The outturn position incorporates the MTFP savings built into the 2015/16 budgets, which for CAS in total amount to £8.590 million.

Capital Programme

10. The CAS capital programme was revised earlier in the year to take into account budget reprofiled from 2014/15 following the final accounts for that year. This increased the 2015/16 original budget.

11. Further reports to MOWG in May, July, October, November, December, January have detailed further revisions to the CAS capital programme, adjusting the base for grant additions/ reductions, budget transfers and budget reprofiling into later years with the revised capital budget currently totalling **£40.682 million**. Actual capital expenditure in 2015-16 totalled £34.867 million leading to an underspend of **£5.815 million**.

12. Following MOWG approval on 24th May 2016 the £5.815 million underspend has been reprofiled into future years to meet future commitments and investment leading to a revised capital Programme for the years 2016/17 to 2017-18 of **£35.051 million.**

13. Summary financial performance to 31st March 2016 is shown below together with a summary of the 2016/17 and 2017/18 budgets.

CAS	Actual Spend to 31/03/2016	Current 2015-16 Budget	2015-16 variance	Revised 2016-17 Budget	Revised 2017-18 Budget	Total Revised Capital Prog.
	£000	£000	£000	£000	£000	£000
Adult Care Provider Services	(1)	60	61	62	-	62
Support For Childs Homes	11	54	43	43	-	43
CAS AAP Scheme	2	4	2	-	-	-
PCT Co-Location	2	-	(2)	-	-	-
Increased Provision for Two Year Olds	279	408	129	129	-	129
Free School Meals Support	214	214	-	75	-	75
Secure Services	1,115	799	(316)	35	-	35
Planning & Service Strategy	74	132	58	159	315	474
Drug & Alcohol Premises Upgrade	317	200	(117)	459	-	459
Drugs Commissioning DACT	36	36	-	72	-	72
Public Health	-	-	-	284	-	284
School Devolved Capital	2,787	4,532	1,745	4,227	1,378	5,605
Childrens Access/Safeguarding	(2)	-	2	-	-	-
DFE School Capital Inc Basic Need	18,158	19,704	1,546	19,965	2,230	22,195
DSG Structural Maintenance	350	432	82	2	238	240
Prior Year Projects	(334)	-	334	-	-	-
PSBP - Additional Works Not Covered by EFA	-	200	200	200	-	200
School Modernisation	20	607	587	347	-	347
BSF	11,671	13,240	1,569	4,831	-	4,831
PFI	168	60	(108)	-	-	-
TOTAL	**34,867**	**40,682**	**5,815**	**30,890**	**4,161**	**35,051**

Recommendations:

14. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Members note the revenue and capital outturn included in the report, which are summarised in the outturn report to Cabinet in July.

Contact: Andrew Gilmore – Finance Manager **Tel: 03000 263 497**
Andrew Baldwin – Finance Manager **Tel: 03000 263 490**

Appendix 1: Implications

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital actual outturn position.

Staffing

There are no implications associated with this report. Any over or under spending against the employee budgets are disclosed within the report.

Risk

The management of risk is intrinsic to good budgetary control. This report forms an important part of the governance arrangements within CAS. Through routine / regular monitoring of budgets and continual re-forecasting to year end the service grouping can ensure that it manages its finances within the cash envelope allocated to it.

Equality and Diversity / Public Sector Equality Duty

There are no implications associated with this report.

Accommodation

There are no implications associated with this report.

Crime and Disorder

There are no implications associated with this report.

Human Rights

There are no implications associated with this report.

Consultation

There are no implications associated with this report.

Procurement

There are no implications associated with this report.

Disability Issues

There are no implications associated with this report.

Legal Implications

There are no implications associated with this report.

Adults Wellbeing and Health Overview and Scrutiny Committee

3 October 2016

CAS – Quarter 1: Forecast of Revenue and Capital Outturn 2016/17

Report of Jeff Garfoot, Head of Finance (Financial Services)

Purpose of the Report

1. To provide the committee with details of the forecast outturn budget position for the CAS service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of June 2016 as reported to Cabinet in September 2016.

Background

2. County Council approved the Revenue and Capital budgets for 2016/17 at its meeting on 24 February 2016. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

    - *CAS Revenue Budget - £251.980 m(original £247,864m)*
    - *CAS Capital Programme – £31.351m (original £31.351m)*

3. The original CAS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

Reason For Adjustment	**£'000**
Original Budget	247,864
Transfer From Contingency - Closed School Premises Cost	16
Transfer From Contingency - Pay award	771
Transfers to other services	(45)
Use of (+)/contribution to CAS reserves (-)	2,497
Use of (+)/contribution to Corporate reserves (ERVR) (-)	879
Revised Budget	**251,980**

4. The use of / contribution to CAS reserves consists of:

Reserve	£'000
AWH- Social Care Reserve	1,674
EDU-EBP Reserve	100
EDU-Re-Profiling Activity Reserve	3
CHS-Secure Services Capital Reserve	88
CHS-Tackling Troubled Families Reserve	39
PHE-Domestic Abuse-Harbour Support Reserve	(11)
PHE-W4L expansion Reserve	13
AWH-Cash Limit	1,146
PHE-Grant Reduction Support Reserve	(414)
EDU-School Condition Survey	200
PHE - CDDFT-Fresh Smoke Free NE	30
CHS-NQSW Academy Reserve - 16&17 Academic year	(371)
Total	**2,497**

5. The summary financial statements contained in the report cover the financial year 2016/17 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the forecast outturn;
- For the CAS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn

6. The CAS service is reporting a cash limit underspend of £2.146 million against a revised budget of *£251.980 million* which represents a 0.85% underspend.

7. The tables below show the revised annual budget, actual expenditure to 30 June 2016 and the updated forecast of outturn to the year end, including the variance forecast at year end. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for CAS, and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Cash Limit Variance £000
Employees	114,501	32,918	111,788	(2,713)	(2,713)
Premises	6,775	580	6,632	(143)	(143)
Transport	17,774	3,035	17,615	(159)	(159)
Supplies & Services	17,838	3,080	17,400	(438)	(438)
Third Party Payments	238,365	49,151	240,020	1,655	1,655
Transfer Payments	13,161	2,102	12,773	(388)	(388)
Central Support & Capital	73,192	2,665	74,192	1,000	1,000
Income	(229,626)	(54,872)	(230,586)	(960)	(960)
Total	251,980	38,659	249,834	(2,146)	(2,146)

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Cash Limit Variance £000
Head of Adults	126,108	25,601	123,499	(2,609)	(2,609)
Central/Other	9,598	3,913	9,538	(60)	(60)
Commissioning	5,788	(2,043)	5,050	(738)	(738)
Planning & Service Strategy	10,929	1,932	10,426	(503)	(503)
Central Charges (CYPS)	3,198	2,127	3,198	-	-
Childrens Services	50,807	13,297	53,027	2,220	2,220
Education	42,475	(1,558)	42,019	(456)	(456)
Public Health	3,077	(4,609)	3,077	-	-
Total	251,980	38,660	249,834	(2,146)	(2,146)

8. The table below provides a brief commentary of the forecast cash limit variances against the revised budget, analysed by Head of Service for those areas which relate to the Adults area of the service, which is of specific interest to the Adults Wellbeing and Health Overview and Scrutiny Committee. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£71,000 over budget on employees, offset by additional income. £31,000 under budget on transport, mainly in respect of day care. £376,000 net over budget on care provision. £46,000 over budget in respect of premises/transport/supplies and services.	462
Safeguarding Adults and Pract.Dev.	£81,000 under budget on employee costs due to vacant posts. £37,000 projected under budget on non-staff costs. £53,000 additional income, mainly to support SPA activity.	(171)
Ops Manager OP/PDSI Services	£347,000 under budget due to effective management of vacancies. £704,000 net under budget on direct care-related activity. £342,000 under budget in respect of premises/transport/supplies and services/other costs.	(1,393)
Ops Manager Provider Services	£1.437 million under budget on employees in respect of early achievement of future MTFP savings. £71,000 under budget on non-staff costs in respect of early achievement of future MTFP savings.	(1,508)
		(2,609)
Central/Other		
Central/ Other	£75,000 over budget on employee-related costs, partly offset by additional income. £32,000 under budget on premises/transport/other costs. £103,000 additional income mainly in respect of salary recharges.	(60)
		(60)
Commissioning		
Commissioning	£287,000 under budget on employees in respect of early achievement of future MTFP savings. £451,000 under budget on non-staff costs in respect of early achievement of future MTFP savings.	(738)
		(738)
Planning & Service Strategy		
Performance & Information Mgmt	£30,000 under budget on employees re effective vacancy management/early achievement of future savings.	(30)
Policy Planning & Partnerships	£47,000 under budget on employees, mainly re future MTFP savings. £2,000 under budget on transport/supplies and services/other budgets. £6,000 under achievement of income.	(43)
Service Quality & Development	Future MTFP savings linked in the main to employees.	(183)
Service Support	£79,000 under budget on employees, mainly re future MTFP savings. £168,000 under budget on transport/supplies and services/other budgets towards future MTFP savings.	(247)
		(503)

Service Area	Description	Cash limit Variance £000
Public Health		
Cancer Awareness/ Physical Activity Adults /GRT	Break even position with two continuing commissioned services- "Gypsy Romany Travellers - health trainers and evaluation", and "Pharmacy support via the Local Pharmaceutical Committee" combined value of £180,000 funded from reserves.	-
Capacity Building/Health Trainers	Break even position with contract to a value of £487,000 extended and funded from reserves. Contract extension primarily related to Adult Wellbeing, Community Health Trainers and the Patient Transport schemes. All of these services are currently under review.	-
Health Checks/Smoking Cessation	Activity in relation to Nicotine Replacement Therapy is projected to underspend by £108,000 against a budget of £574,000. Activity in relation to Health checks is also forecast to underspend slightly pending a review and possible reprocurement of the service.	(117)
Oral Health Obesity and Services to Children	Break even position with two non-recurrent commissions (£178,000) funded from reserves.	-
Public Health Team & Grant	Underspend currently forecast primarily related to vacancies in the team resulting from secondments pending potential backfill.	(103)
Public Health Specialist Training Prog (HENE)	In previous years Public Health have co-ordinated funding for the backfill of Public Health Training Placements on behalf of HENE. The funding arrangements for the scheme have now changed and this activity will no longer continue.	-
Safer Stronger Communities	The budget for £1.64 million domestic violence is on target to balance.	-
Sex Health/Alc/Subs Misuse/Domestic Vlnce/Mental Hlth	Activity in relation to drug costs and fees for contraceptive devices is forecast to overspend by £167,000 against the £703,000 budget available. Payments in relation to Supervised Methadone Consumption are forecast to be £53,000 more than the £310,000 available. The remaining variance of £126,000 relates to commissioned services on behalf of Drugs and Alcohol.	220
		-
CAS Total		**(2,146)**

9. In summary, the service is on track to maintain spending within its cash limit. The outturn position incorporates the MTFP savings built into the 2016/17 budgets, which for CAS in total amount to £17.326m.

Capital Programme

10. The CAS capital programme has been revised earlier in the year to take into account budget reprofiled from 2015/16 following the final accounts for that year. This increased the 2016/17 original budget.

11. Further reports to MOWG in May and July included revisions to the CAS capital programme. The revised capital budget currently totals £31.351m.

12. Summary financial performance to the end of June is shown below.

CAS	Actual Expenditure 30/06/2016 £000	Current 2016-17 Budget £000	Remaining 2016-17 Budget £000
Adult Care Provider Services	41	62	21
Support For Childs Homes	-	43	43
Increased Provision for Two Year Olds	22	129	107
Free School Meals Support	1	75	74
Secure Services	-	210	210
Planning & Service Strategy	-	159	159
Drug & Alcohol Premises Upgrade	152	383	231
Drugs Commissioning DACT	-	72	72
Public Health	-	360	360
School Devolved Capital	445	4,348	3,903
DFE School Capital Inc Basic Need	4,842	20,188	15,346
DSG Structural Maintenance	-	2	2
PSBP - Additional Works Not Covered by EFA	-	182	182
School Modernisation	13	107	94
BSF	375	5,031	4,656
PFI	2	-	(2)
TOTAL	**5,893**	**31,351**	**25,458**

Recommendations:

13. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Members note the financial forecasts included in the report, which are summarised in the Quarter 1 forecast of outturn report to Cabinet in September 2016.

Contact: Andrew Gilmore – Finance Manager Tel: 03000 263 497
Andrew Baldwin – Finance Manager Tel: 03000 263 490

Appendix 1: Implications

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital projected outturn position.

Staffing

There are no implications associated with this report. Any over or under spending against the employee budgets are disclosed within the report.

Risk

The management of risk is intrinsic to good budgetary control. This report forms an important part of the governance arrangements within CAS. Through routine / regular monitoring of budgets and continual re-forecasting to year end the service grouping can ensure that it manages its finances within the cash envelope allocated to it.

Equality and Diversity / Public Sector Equality Duty

There are no implications associated with this report.

Accommodation

There are no implications associated with this report.

Crime and Disorder

There are no implications associated with this report.

Human Rights

There are no implications associated with this report.

Consultation

There are no implications associated with this report.

Procurement

There are no implications associated with this report.

Disability Issues

There are no implications associated with this report.

Legal Implications

There are no implications associated with this report.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

3 October 2016

Quarter One 2016/17 Performance Management Report

Report of Corporate Management Team
Lorraine O'Donnell, Director of Transformation and Partnerships
Councillor Simon Henig, Leader

Purpose of the Report

1. To present progress against the council's corporate basket of performance indicators (PIs), Council Plan and service plan actions and report other performance issues for the first quarter of the 2016/17 financial year, covering the period April to June 2016.

Background

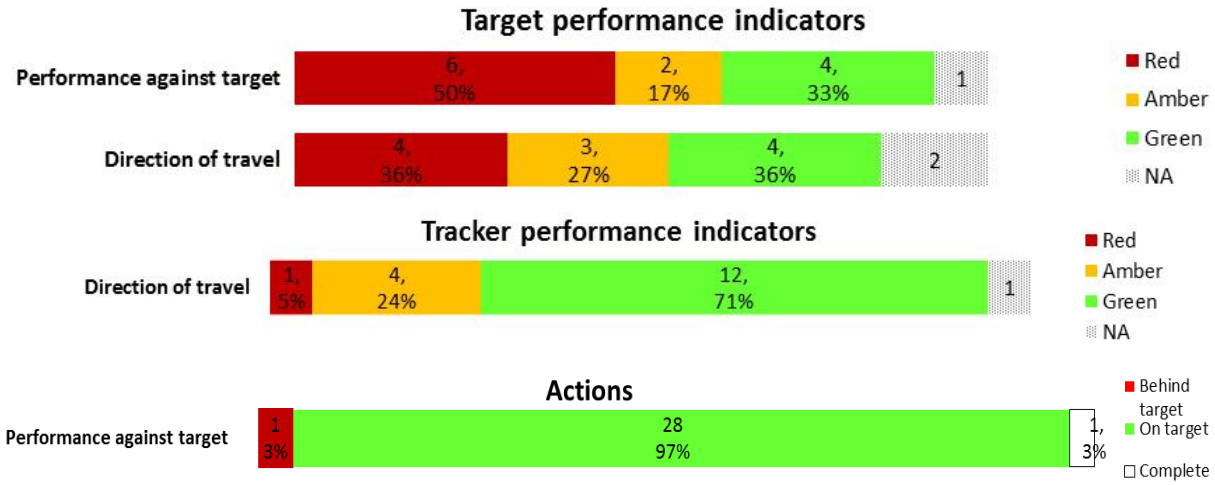
2. The report sets out an overview of performance and progress by Altogether priority theme. Key performance indicator progress is reported against two indicator types which comprise of:
   a. Key target indicators – targets are set for indicators where improvements can be measured regularly and where improvement can be actively influenced by the council and its partners (see Appendix 3, table 1); and
   b. Key tracker indicators – performance will be tracked but no targets are set for indicators which are long-term and/or which the council and its partners only partially influence (see Appendix 3, table 2).

3. Work has been undertaken by all services to develop a revised 2016/17 corporate set of indicators. This set of indicators is based around our Altogether priority themes and will be used to measure the performance of both the council and the County Durham Partnership

4. During the year a review will be undertaken to improve performance reporting, including streamlining reports and strengthening reporting of children's social care in line with OFSTED recommendations.

5. The corporate performance indicator guide has been updated to provide full details of indicator definitions and data sources for the 2016/17 corporate indicator set. This is available to view either internally from the intranet (at Councillors useful links) or can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

Altogether Healthier: Overview



Council Performance

6. Key achievements this quarter include:

   a. In 2015/16, 2,903 people quit smoking following support from stop smoking services. This equates to 3,076 per 100,000 smoking population. This achieved the target of 2,774 quitters (2,939 per 100,000).

   b. At 31 March 2016, 93.2% of adult social care users were in receipt of self-directed support (including direct payments). This has increased from last year (89.9%) and is exceeding the target of 90% and all latest benchmarking data.

   c. There were 35 delayed transfers of care on the two snapshot days in April and May 2016, which equates to a rate of 4.17 per 100,000 population. This is an improvement from a rate of 4.5 per 100,000 across the same two snapshot days in 2015/16. There were five delayed transfers of care which were fully or partly attributable to social care, which equates to a rate of 0.6 per 100,000 population. This is an improvement from a rate of 1.1 per 100,000 across the two snapshot days in 2015/16.

7. The key performance improvement issues for this theme from data released this quarter are:

   a. In 2015/16, 7% of the eligible population (11,474 of 163,780) received an NHS health check. This is below regional (7.5%) and national (9%) performance. In County Durham, a local approach was agreed to target health checks toward people with a high risk of cardiovascular disease. In 2015/16, 503 health checks were undertaken on those at high risk of CVD in GP Practices. The targeted approach is incentivised with GPs receiving £35 for a high risk CVD health check and £25 for health checks on the eligible population. In addition to the 11,474 health checks undertaken, a further 5,028 mini health MOTs were undertaken in communities in County Durham. Whilst mini health MOTs come under the banner of the Check4Life / health check programme they do not themselves constitute a full health check. As a result, activity levels of mini health MOTs are not reported to NHS England and they do not form part of the national measure.

b. Data for 2015/16 show that 18.1% of mothers (956 of 5,272) were smoking at the time of delivery (SATOD). Performance has achieved the annual target (18.2%) and is an improvement on 2014/15 figures (19%). SATOD ranges from 15.1% in North Durham Clinical Commissioning Group (CCG) to 20.7% in Durham Dales, Easington and Sedgefield (DDES) CCG. DDES CCG has the second highest SATOD rate in the North East and sixth-highest of all CCGs in England. SATOD in County Durham is significantly above the England average of 10.6% and the North East CCG average of 16.7%. Fresh, the regional tobacco control programme, commissioned the babyClear initiative to reduce exposure to smoke for unborn babies during pregnancy and to work with midwives and foundation trusts to ensure pregnant women who smoke get the best help to quit. Midwives in County Durham offer advice and support, including systematic carbon monoxide testing as part of routine tests all women receive at first booking appointment.

c. There were 177 people aged 65 and over (168.1 per 100,000) admitted to residential or nursing care on a permanent basis between 1 April and 30 June 2016. This has not achieved the Better Care Fund target of 166 admissions (163.7 per 100,000), but is an improvement on 186 admissions in the same period in 2015. Robust panels continue to operate to ensure that only those in most need and who can no longer be cared for within their own home without substantial risk or cost are admitted to permanent care. The number of bed days purchased between April and June 2016 has increased from the same period in 2015. However, this is mainly due to April and May 2015 being the two lowest months for bed days purchased in the last three years and follows a period of significant managed reduction of care placements which now against the background of ongoing demand from demographic pressures, may be plateauing. The average age of those admitted to residential care has increased from 84.36 years in 2004/5 to 86.46 years in 2015/16 and from 83.02 years to 84.34 in nursing care.

d. Latest alcohol and drug data show that successful completions have deteriorated compared to a year earlier and continue to be below target:

   i. Between July 2015 and June 2016, 27.3% of people in alcohol treatment successfully completed, below the target of 39.5% and performance last year of 32.5%

   ii. In 2015 5.2% of people in drug treatment for opiate use successfully completed, i.e. they did not re-present between January and June 2016, below the target of 8.7% and performance last year of 6.8%.

   iii. In 2015 25.4% of people in drug treatment for opiate use successfully completed, i.e. they did not re-present between January and June 2016, below the target of 42% and performance last year of 39.9%.

   Public Health have developed a performance plan for Lifeline which continues to be closely monitored on a monthly basis. Actions within the plan include:

- Identifying those clients who have been in treatment for 4-6 years and over and reviewing their needs. This include prescribing regimes and further behaviour change support

- Improving pathways to the treatment service to increase referrals, including children's services and criminal justice pathways.

- Increasing the identification of clients lost to follow-up treatment and enhancing performance management of caseloads.

- Procuring a new IT system which is due to be implemented by October 2016

8. There are no Council Plan actions which have not achieved target in this theme.

9. The key risk to successfully delivering the objectives of this theme is a service failure of adult safeguarding which leads to death or serious harm to a service user. Management consider it possible that this risk could occur which, in addition to the severe impacts on service users, will result in serious damage to the council's reputation and relationships with its safeguarding partners. As the statutory body, the multi-agency Safeguarding Adults Board has a business plan in place for taking forward actions to safeguard vulnerable adults including a comprehensive training programme for staff and regular supervision takes place. This risk is long term and procedures are reviewed regularly.

Recommendation and Reasons

10. That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising there from.

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Appendix 1: Implications
Appendix 2: Key to symbols used in the report
Appendix 3: Summary of key performance indicators

Appendix 1: Implications

Finance - Latest performance information is being used to inform corporate, service and financial planning.

Staffing - Performance against a number of relevant corporate health Performance Indicators (PIs) has been included to monitor staffing issues.

Risk - Reporting of significant risks and their interaction with performance is integrated into the quarterly monitoring report.

Equality and Diversity / Public Sector Equality Duty - Corporate health PIs are monitored as part of the performance monitoring process.

Accommodation - Not applicable

Crime and Disorder - A number of PIs and key actions relating to crime and disorder are continually monitored in partnership with Durham Constabulary.

Human Rights - Not applicable

Consultation - Not applicable

Procurement - Not applicable

Disability Issues - Employees with a disability are monitored as part of the performance monitoring process.

Legal Implications - Not applicable

Appendix 2: Key to symbols used within the report

Where icons appear in this report, they have been applied to the most recently available information.

Performance Indicators:

Direction of travel/benchmarking		Performance against target
Same or better than comparable period/comparator group	GREEN	Meeting/Exceeding target
Worse than comparable period / comparator group (within 2% tolerance)	AMBER	Getting there - performance approaching target (within 2%)
Worse than comparable period / comparator group (greater than 2%)	RED	Performance >2% behind target

National Benchmarking

We compare our performance to all English authorities. The number of authorities varies according to the performance indicator and functions of councils, for example educational attainment is compared to county and unitary councils however waste disposal is compared to district and unitary councils.

North East Benchmarking

The North East figure is the average performance from the authorities within the North East region, i.e. County Durham, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle upon Tyne, North Tyneside, Northumberland, Redcar and Cleveland, Stockton-on-Tees, South Tyneside, Sunderland, The number of authorities also varies according to the performance indicator and functions of councils.

Nearest Neighbour Benchmarking:

The nearest neighbour model was developed by the Chartered Institute of Public Finance and Accountancy (CIPFA), one of the professional accountancy bodies in the UK. CIPFA has produced a list of 15 local authorities which Durham is statistically close to when you look at a number of characteristics. The 15 authorities that are in the nearest statistical neighbours group for Durham using the CIPFA model are: Barnsley, Wakefield, Doncaster, Rotherham, Wigan, Kirklees, St Helens, Calderdale, Dudley, Northumberland, Tameside, Sheffield, Gateshead, Stockton-on-Tees and Stoke-on-Trent.

We also use other neighbour groups to compare our performance. More detail of these can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

Actions:

WHITE	Complete (action achieved by deadline/achieved ahead of deadline)
GREEN	Action on track to be achieved by the deadline
RED	Action not achieved by the deadline/unlikely to be achieved by the deadline

Appendix 3: Summary of Key Performance Indicators

Table 1: Key Target Indicators

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier											
25	CASAH2	Percentage of eligible people who receive a NHS health check	7.0	2015/16	8.0	RED	7.4	RED	9.0 RED	7.5* RED	2015/16
26	CASAH3	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period	61.2	As at Mar 2015	Not set	NA	New indicator	NA	57.1 GREEN	59.4* GREEN	As at Mar 2015
27	CASAH 10	Percentage of women eligible for breast screening who were screened adequately within a specified period	77.8	As at Mar 2015	70.0	GREEN	77.9	AMBER	75.4 GREEN	77.1* GREEN	As at Mar 2015
28	CASAH4	Percentage of women eligible for cervical screening who were screened adequately within a specified period	77.6	As at Mar 2015	80.0	RED	78.0	AMBER	75.7 GREEN	73.5* GREEN	As at Mar 2015
29	CASAS 23	Percentage of successful completions of those in alcohol treatment **(Also in Altogether Safer)**	27.3	Jul 2015 - Jun 2016	39.5	RED	32.5	RED	39.2 RED		2015/16
30	CASAS7	Percentage of successful completions of those in drug treatment - opiates **(Also in Altogether Safer)**	5.2	2015 (re-presentations to Jun 2016)	8.7	RED	6.8	RED	6.8 RED		Oct 2014 - Sep 2015 (re-presentations to Mar 2016)

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
31	CASAS8	Percentage of successful completions of those in drug treatment - non-opiates **(Also in Altogether Safer)**	25.4	2015 (re-presentations to Jun 2016)	42.0	RED	39.9	RED	37.3 RED		Oct 2014 - Sep 2015 (re-presentations to Mar 2016)
32	CASCYP 8	Percentage of mothers smoking at time of delivery **(Also in Altogether Better for Children and Young People)**	18.1	2015/16	18.2	GREEN	19.0	GREEN	10.6 RED	16.7* RED	Oct - Dec 2015
33	CASAH1	Four week smoking quitters per 100,000 smoking population	3,076	2015/16	2,939	GREEN	New definition	NA [1]			
34	CASAH 11	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	168.1	Apr - Jun 2016	163.7	RED	178.6	GREEN			
35	CASAH 12	Percentage of adult social care service users that receive self-directed support such as a direct payment or personal budget	93.2	As at Jun 2016	90.0	GREEN	89.9	GREEN	83.7 GREEN	82.9** GREEN	2014/15
36	CASAH 14	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	85.2	Apr - Jun 2016	86	AMBER	86.6	AMBER	82.1 GREEN	85.2** GREEN	2014/15
37	CASAH	Percentage of people who use services who have as	49.2	2015/16 (provision	50.0	AMBER	48.7	GREEN	44.8	47.6*	2014/15

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
		much social contact as they want with people they like		al)					GREEN	GREEN	

[1] Due to changes to the definition data are not comparable/available

Table 2: Key Tracker Indicators

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier											
133	CASCYP 18	Percentage of children aged 4 to 5 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	23.0	2014/15 ac yr	23.8	GREEN	23.8	GREEN	21.9 RED	23.7* GREEN	2014/15 ac yr
134	CASCYP 19	Percentage of children aged 10 to 11 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	36.6	2014/15 ac yr	36.1	AMBER	36.1	AMBER	33.2 RED	35.9* AMBER	2014/15 ac yr
135	CASAH 18	Male life expectancy at birth (years)	78.1	2012-14	78.0	GREEN	78.0	GREEN	79.5 AMBER	78* GREEN	2012-14
136	CASAH 19	Female life expectancy at birth (years)	81.4	2012-14	81.3	GREEN	81.3	GREEN	83.2 RED	81.7* AMBER	2012-14
137	CASAH6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population	81.7	2012-14	88.3	GREEN	88.3	GREEN	75.7 RED	85.9* GREEN	2012-14
138	CASAH7	Under 75 mortality rate from cancer per 100,000 population	168.6	2012-14	166.6	AMBER	166.6	AMBER	141.5 RED	167.9* AMBER	2012-14
139	CASAH9	Under 75 mortality rate from respiratory disease per 100,000 population	41.8	2012-14	43.4	GREEN	43.4	GREEN	32.6 RED	41.2* AMBER	2012-14

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
140	CASAH8	Under 75 mortality rate from liver disease per 100,000 population	20.1	2012-14	21.9	GREEN	21.9	GREEN	17.8 RED	23* GREEN	2012-14
141	CASAH 23	Percentage of registered GP patients aged 17 and over with a diagnosis of diabetes	7.0	2014/15	6.9	AMBER	6.9	AMBER	6.4 RED	6.7* RED	2014/15
142	CASAH 20	Excess winter deaths (%) (3 year pooled)	16.8	2011-14	19.0	GREEN	19.0	GREEN	15.6 RED	13.4* RED	2011-14
143	CASAH 22	Estimated smoking prevalence of persons aged 18 and over	20.6	2014	22.7	GREEN	22.7	GREEN	18 RED	19.9* RED	2014
144	CASAH 25	Number of residential/nursing care bed days for people aged 65 and over commissioned by Durham County Council	234,348	Apr - Jun 2016	232,638	NA	228,868	NA			
145	CASAH 13	Percentage of service users reporting that the help and support they receive has made their quality of life better	86.6	Apr - May 2016	91.6	AMBER	91.2	AMBER	91.9 AMBER	93.4* AMBER	2014/15
146	CASAH 20i	Delayed transfers of care from hospital per 100,000 population	4.17	Apr - May 2016	4.6	GREEN	4.5	GREEN	11.1 GREEN	7.4* GREEN	2014/15
147	CASAH 20ii	Delayed transfers of care from hospital, which are fully or partially attributable to adult social care, per 100,000 population	0.6	Apr - May 2016	1.1	GREEN	1.1	GREEN	3.7 GREEN	1.6* GREEN	2014/15

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
148	CASAH 21	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population **(Also in Altogether Safer)**	13.3	2012-14	13.4	GREEN	13.4	GREEN	8.9 RED	11* RED	2012-14
149	CASCYP 26	Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years) **(Also in Better for Children and Young People)**	489.4	2011/12 - 2013/14	504.8	GREEN	504.8	GREEN	367.3 RED	532.2* GREEN	England 2011/12 - 2013/14 NE 2010/11 - 2012/13
150	NS11	Percentage of the adult population (aged 16+) participating in at least 30 minutes sport and active recreation of at least moderate intensity on at least three days a week	24.0	Apr 2014 - Mar 2016	25.0	RED	24.9	RED			

Adults Wellbeing and Health Overview & Scrutiny Committee

3 October 2016

Review of Suicides and Mental Health and Wellbeing in County Durham – Scoping Report

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose

1. To provide the Adults Wellbeing and Health Overview and Scrutiny Committee with a scoping report in advance of a scrutiny review looking at suicide rates and Mental Health and Wellbeing in County Durham.

Background

2. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee indicated their intention to carry out a focused piece of work on suicide rates and mental health and wellbeing in County Durham at its meeting held on 4 July 2016.

3. The 2015/16 Quarter 4 Performance Management report indicated that the suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population for County Durham is 13.3 which is higher than both the National figure of 8.9 and the North East figure of 11. During consideration of the Quarter 3 Performance Management report and refresh of the Adults Wellbeing and Health OSC 2016-17 Work programme, members expressed concern around the suicide rates within County Durham and suggested that a review on suicide rates in County Durham and mental health and wellbeing be undertaken.

National Policy and Research

4. In September 2012, the Government published "Preventing suicide in England: A cross-government outcomes strategy to save lives", a new strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy sets out key areas for action; states what government departments will do to contribute; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.

5. The strategy sets out overall objectives to :-

   - Achieve a reduction in the suicide rate in the general population in England; and
   - Provide better support for those bereaved or affected by suicide.

6. There are six key areas for action to support delivery of these objectives:-

   (i) Reduce the risk of suicide in key high-risk groups;
   (ii) Tailor approaches to improve mental health in specific groups;
   (iii) Reduce access to the means of suicide;
   (iv) Provide better information and support to those bereaved or affected by suicide;
   (v) Support the media in delivering sensitive approaches to suicide and suicidal behaviour, and
   (vi) Support research, data collection and monitoring.

7. There is also a national mental health strategy, published in 2011, entitled "No Health without Mental Health". The implementation framework sets out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported. This is vital, because suicide prevention starts with better mental health for all - therefore "Preventing suicide in England: A cross-government outcomes strategy to save lives" has to be read alongside that implementation framework.

Local Policy

8. The Sustainable Community Strategy (SCS) 2014-30 is an overarching plan that underpins all other strategies and policies. The SCS includes within its Altogether Healthier priority theme, the high level objective to improve the physical and mental wellbeing of the population. An important element of this objective is to reduce suicides through the implementation of the Mental Health and Suicide Prevention Strategy. This includes a local workplace health programme which will support employers to promote healthy workplaces, and tackle the causes of mental ill health at work. Access will be improved for individuals into support and recovery, through early provision of activities such as supported employment, housing support, and debt advice. The Strategy commits that the Council and partners will work to reduce stigma and discrimination towards people who experience mental health problems through awareness raising campaigns.

9. The Council Plan 2016-19 also identifies that mental health improvements and suicide prevention are key priorities for the county, particularly as suicide rates in County Durham are higher than the national average. The plan states that the Council "will work with partners to improve mental health in County Durham and address the priority areas including suicide prevention, stigma and discrimination and recovery."

10. The County Durham Joint Health and Wellbeing Strategy 2016-2019 includes a strategic objective to "Improve the mental and physical wellbeing of the population" as well as a key outcome to reduce self-harm and suicides. Key strategic actions set out within the Health and Wellbeing Strategy include a refresh of the Public Mental Health Strategy for County Durham, including the Suicide Prevention Framework and working in partnership through the Crisis

Care Concordat action plan to improve outcomes for people experiencing mental health crises in the community and in custody.

Reviews by Other Authorities

11. There are a number of local authorities that have undertaken review activity in respect of suicide prevention in recent years. Appendix 2 provides details of some of these reviews and links to the review reports and recommendations.

Terms of Reference

Rationale

12. The rationale for the Review stems from the Adults Wellbeing and Health OSC concerns during consideration of Quarterly Performance Management reports which highlighted that suicide rates for County Durham are above the National and North East average figures. Members decided to examine the performance information in more detail and also assess the measures that the Council and its partners have put in place to ensure improved mental health and wellbeing and which aim to reduce the incidence of suicides within County Durham.

Scope

13. The Review will examine the incidence of suicide within County Durham and consider the key findings and outcomes of the Director of Public Health's 2016 report "Deaths by suicide, suspected suicide and undetermined injury 1st January 2015 to 31st December 2015". The Review will examine historical data regarding suicide rates within County Durham and also seek to profile suicides within County Durham.

14. The Review will examine the policies and procedures that the Council and its partners have put in place to ensure improved mental health and wellbeing of the population of County Durham and how they aim to reduce the incidence of suicides within County Durham.

Objectives

15. The aim of the review is to examine the incidence of suicides within County Durham; to identify the Council and partners' policies and action plans which have been developed to improve the mental health and wellbeing of the population of County Durham and to investigate how intervention and support can be improved following key lines of enquiry:

- What policies and procedures does Durham County Council have in place to help, support, prevent and intervene where vulnerable adults and young people have identifiable mental health and wellbeing problems and are at risk of suicide?
- How reliable/accurate is the performance data and what does it tell us about suicides in this area compared to regional and national data?

- What services are available in the community for people with anxieties or mental health problems to talk to people and how accessible are these services?
- How can awareness of suicides and the availability of support and advice for people with have mental health and wellbeing problems be improved?
- What steps are being taken by the Council and its partners to address some of the potential root causes of suicide?
- What services are available to support families of suicide victims in coping with their loss?

Approach

16. In undertaking the proposed review, the Working Group will aim to hear from a full range of stakeholders including representatives from the NHS and criminal justice system. The group will review existing policies and plans which seek to address the increase in suicides which have been reported with on performance reports and which identifies Durham as having significantly worse statistics for the incidence of suicide than both the North East region and England.

17. The working group will review data in respect of the incidence of suicide and closely examine the key actions of the Council and its partners aimed at improving mental health and wellbeing and reducing suicides across County Durham.

18. The working group will also consider evidence and information from support groups within the community which provide an opportunity for those family and friends impacted by suicide to discuss the effectiveness of mental health and wellbeing services and also how lessons learned from suicides can be shared.

Membership

19. The Review Group will consist of members of the Adults Wellbeing and Health Overview and Scrutiny Committee and be chaired by Councillor John Robinson.

Reporting

20. The Review Group will report back to the Adults Wellbeing and Health Overview and Scrutiny Committee, Cabinet and the Health and Wellbeing Board on its findings and recommendations.

Timescale

21. The review will commence in October 2016 with the aim of a report being presented to Cabinet by April 2017.

Recommendation

22. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to:

a. Provide comment and approve the draft terms of reference for the review of suicides and mental health and wellbeing in County Durham.
b. Agree the project plan attached at appendix 3.
c. Receive periodic verbal updates on the review as it progresses.

Background Papers

- Sustainable Community Strategy (SCS) 2014-30
- Council Plan 2016-19
- County Durham Joint Health and Wellbeing Strategy 2016-2019

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Appendix 1: Implications

Finance – None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues – None

Legal Implications – None

Background Reading

Reviews into Suicide prevention by other Local Authorities

London Borough of Camden

Suicide Prevention Scrutiny Panel – July 2004

https://www.camden.gov.uk/ccm/cms-service/stream/asset/final_report.pdf?asset_id=425499

Sunderland City Council

Public Health, Wellness and Culture Scrutiny Panel – Policy Review 2014/15 – Strategies for the prevention of suicide.

http://www.sunderland.gov.uk/Committees/CMIS5/Document.ashx?czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo=gos6LyNp7GTkrvd9sp5gO8ypa%2FvodCob73MqMlggXc9YhKNTDvDBtw%3D%3D&rUzwRPf%2BZ3zd4E7Ikn8Lyw%3D%3D=pwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%2FLUQzgA2uL5jNRG4jdQ%3D%3D&mCTIbCubSFfXsDGW9IXnlg%3D%3D=hFflUdN3100%3D&kCx1AnS9%2FpWZQ40DXFvdEw%3D%3D=hFflUdN3100%3D&uJovDxwdjMPoYv%2BAJvYtyA%3D%3D=ctNJFf55vVA%3D&FgPIIEJYlotS%2BYGoBi5olA%3D%3D=NHdURQburHA%3D&d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK=ctNJFf55vVA%3D&WGewmoAfeNR9xqBux0r1Q8Za60lavYmz=ctNJFf55vVA%3D&WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO=ctNJFf55vVA%3D

Lincolnshire County Council

Health Scrutiny Committee for Lincolnshire – May 2015 – Review of Suicides and deliberate self-harm with intent to die within Lincolnshire Partnership NHS Foundation Trust

http://lincolnshire.moderngov.co.uk/documents/s10182/Review%20of%20Suicides%20and%20Deliberate%20Self-Harm%20with%20Intent%20to%20Die%20within%20Lincolnshire%20Partnership%20NHS%20F.pdf

Lancashire County Council

Health Equalities Overview and Scrutiny Committee Task Group – May 2002 – Suicide prevention in Lancashire

http://www3.lancashire.gov.uk/council/meetings/displayFile.asp?FTYPE=A&FILEID=1817

Devon County Council

Health and Adults Services Scrutiny Committee – January 2011 – Suicide Prevention

http://democracy.devon.gov.uk/documents/s1812/Suicide%20Prevention.pdf

PROJECT PLAN: Suicide Rates and Mental Health and Wellbeing in County Durham

Appendix 3

WHEN Times/Dates/ Locations	**DESIGNATED LEAD** Member/ Officer	**WHO** Key Witness	**WHAT** Evidence/Information	**HOW** Meeting/Visit/ Correspondence/ Briefing Paper/ Research	**OUTCOMES**
Session 1 Monday 17 October 2016 at 10.00 a.m. in Committee Room 1B	Cllr John Robinson and Stephen Gwillym	Stephen Gwillym, Principal Overview and Scrutiny Officer Tom Gorman, Corporate Scrutiny and Performance Manager/Peter Appleton, Head of Quality and Service Strategy Keith Allan – Specialty Registrar in Public Health	Proposed Review scope, Terms of Reference and Project Plan 2015/16 Quarter 4 Performance Management Information – Suicide Rates Deaths by suicide, suspected suicide and undetermined injury 1st January 2015 to 31st December 2015 Suicide Comparisons with Regional Neighbour LAs and also the Nearest Neighbour LA group	Working Group Meeting	Working Group agree the Review scope, terms of reference and project plan. To provide members with the latest data sets in respect of Suicide Rates/Incidence within County Durham
Session 2 Monday 21 November 2016 at 10.00 a.m. in Committee Room 1B	Cllr John Robinson and Stephen Gwillym	Keith Allan - Specialty Registrar in Public Health Gill O'Neill, Interim Director of Public Health	Service strategies and action plans which seek to address the SCS and Council Plan priority to reduce suicides and improve mental health and Wellbeing	Working group Meeting	To provide members with key service strategies, policies and action plans which aim to reduce suicides in County Durham

		David Shipman, Strategic Commissioning Manager (LD/Mental Health)			
Session 3 Wednesday 21 December 2016 at 10.00 a.m. in Committee Room 1A	Cllr John Robinson and Stephen Gwillym	Patrick Scott, Director of Operations, Tees Esk and Wear Valleys NHS FT County Durham and Darlington NHS FT Keith Allan - Specialty Registrar in Public Health Gill O'Neill, Interim Director of Public Health	To examine the number of Serious Untoward Incidents that result in suicide/death within the NHS and establish the steps that NHS are introducing to reduce the incidence of suicides and increase learning amongst staff to identify service users at risk of suicide	Working Group Meeting	To establish the links between suicide, mental health and wellbeing and whether those who commit suicide are known to mental health service providers.
Session 4 Thursday 17 January 2017 at 10.00 a.m. in Committee Room 1A	Cllr John Robinson and Stephen Gwillym	Criminal Justice System Durham Constabulary Prison Services Representatives	To examine the incidence suicides within police custody and prisons and to establish the work undertaken to prevent suicides within the criminal justice system	Working Group Meeting	To identify work being undertaken within law enforcement and prisons to address suicides within custody and the risks of suicide following release from prison
Session 5 Tuesday 14 February 2017 at 10.00 a.m. in Committee Room 1A	Cllr John Robinson and Stephen Gwillym	Community Involvement and support networks Gill O'Neill, Interim Director of Public Health	To examine the extent and effectiveness of community involvement and support networks in identifying the risks and potential root causes associated with suicides and the provision of support to those people at risk of suicide and their	Working Group Meeting	To examine how existing community involvement networks can identify potential risks which may trigger suicides including mental health and wellbeing, socio-economic risks (poverty/debt advice/welfare reform)

			families		
Session 6 Thursday 23 March 2017 at 10.00 a.m. in Committee Room 1A	Cllr John Robinson and Stephen Gwillym		To present draft report to members.	Working Group Meeting	Members will provide comment on the findings and conclusions of the report and formulate recommendations

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Adults Wellbeing and Health Overview and Scrutiny Committee

3 October 2016

Better Health Programme Joint Health Scrutiny Committee - Update

Report of Lorraine O'Donnell, Director of Transformation and Partnerships

Purpose of the Report

1 This report provides members with further information regarding the Better Health Programme which includes details of the Joint Health Scrutiny Committee's agreed terms of reference and the minutes of the Joint Committee's meetings held of 7th and 21st July 2016.

Background

2 The Adults Wellbeing and Health Overview and Scrutiny Committee have received a series of updates in respect of the Better Health Programme under its former guises of the Quality Legacy Project and Securing Quality in Health Services (SeQIHS), the last being received at the Committee's meeting held on 1 March 2016.

Better Health Programme

3 The Better Health programme is about meeting patient needs now and in the future with constantly improving health and social care delivered in the best place. Commissioners want to make sure that:

- We improve results for patients;
- Care is of the same high standard wherever, and whenever it is provided;
- Services have the resources to be sustainable for the next 10 -15 years;
- We can provide services across 7 days a week where necessary;
- We make services easier for patients to understand and use;
- We improve life expectancy and quality of life for everyone in Darlington, Durham and Tees.

4 The programme aims to continue improving the services available in Darlington, Durham and Tees but in doing so, key challenges have been identified including:

- The changing health needs of local people;
- Meeting recommended clinical standards;
- Availability of highly trained and skilled staff;

- High quality seven-day services;
- Providing care closer to home;
- Making the best use of our money.

5 Commissioners have worked with over 100 clinicians over several months, asking them to consider what the best possible care would look like for patients across Darlington, Durham and Tees. Specifically they were asked to look at the following hospital services:

- Acute Medicine
- Acute Surgery
- Accident and Emergency
- Critical Care
- Acute Paediatrics, Maternity and Neonatology (services for very small babies)
- Interventional radiology.

6 They are also looking at care outside of hospital ("not in hospital care") including services and support which will help reduce the number of people who require hospital care, and help people maintain independent lives in their homes or normal places of residence.

7 Clinicians are agreeing a set of clinical standards for these services. These include standards recommended by national experts, for example:

- London Quality Standards
- Royal College of Obstetricians and Gynaecologists
- Royal College of Physicians
- Royal College of Paediatrics and Child Health
- Royal College of Emergency Medicine
- National Confidential Enquiry into Patient Outcome and Death
- The National Institute for Health and Care Excellence (NICE).

8 Clinical standards cover issues like:

- Availability of consultant staff
- Staffing levels and availability during the day and at night or weekends
- Numbers of patients who should be seen and treated by a service to make sure skill levels are maintained
- Use of best practice and recommended treatments
- Access to diagnostic tests, where required
- Timescales for assessment by a senior clinician.

Provisions for consultation and engagement with Overview and Scrutiny Committees

9 The Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 require the formation of a joint scrutiny

arrangement, where an NHS body or relevant health service provider consults more than one local authority on proposals to make substantial variations or developments to services. They provide that all the local authorities whose residents receive such services must participate in the joint scrutiny arrangement for the purpose of responding to the consultation, using the method most appropriate to the areas and issues being considered.

10 A local authority can opt-out if, having considered the information provided by the NHS body or relevant health service provider proposing the service change, they determine that the proposal is not "substantial" for their residents. Where a local authority opts out in this way, they will relinquish the power to refer the proposed change to the Secretary of State for the purposes of that particular consultation.

11 Only the joint scrutiny committee can require the organisation proposing the change to provide information to them, or attend before them to answer questions. That organisation is under a duty to comply with these requirements. If a local authority has opted out of the joint arrangement, they may not request information or attendance from the NHS body or relevant health service provider proposing the change.

12 In scrutinising the proposals, the joint committee should aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal. Only the joint scrutiny arrangement can then make a report and recommendations back to the organisation proposing the change.

Establishment of a Joint Health Scrutiny Committee

13 The establishment of a joint Health Scrutiny Committee was agreed consisting of representatives from Darlington Borough Council, Durham County Council, Hartlepool Borough Council, Middlesbrough Borough Council, North Yorkshire County Council, Redcar and Cleveland Borough Council and Stockton-upon-Tees Borough Council.

14 In accordance with the regulations detailed above, the Joint Committee will be the vehicle through which the respective Local Authorities will respond to the consultation.

15 A protocol and terms of reference were agreed by the Joint Health Scrutiny Committee at its meeting held on 7 July 2016, setting out the role and function of the joint Committee as well as the proposed representation from each Council. A copy of these are appended to this report. (Appendix 2 and 3).

16 The Better Health Programme Joint Health OSC has met on three occasions on 7th and 21st July and 8th September 2016. The minutes of the meetings held in July are attached to this report for members' information. (Appendices 4 and 5). The minutes of the meeting held on 8th September will be brought to this Committee when approved by the Better Health Programme Joint Health OSC.

Better Health Programme Joint Health OSC – Key issues

17 During the course of the Better Health Programme Joint Health OSC meetings held to date, key issues considered and raised by the Committee members include :-

- Feedback reports from Phases 1 and 2 of the BHP Stakeholder Engagement activity undertaken earlier this year;

- The identification and examination of the specialist services being examined as part of the BHP together with the potential implications for "not in hospital" services including NHS Community based services and local authority led social care services;

- The identification of key lines of enquiry and information regarding performance at acute hospital sites across the BHP "footprint" including average waiting times at A&E; Handover times for NEAS/Yorkshire Ambulance service to acute hospital sites; elective surgery procedures across the BHP "footprint" including cancellations and reasons for cancellations;

- The need to identify and clarify the relationships between the Sustainability and Transformation Plans and the BHP programme and any potential interdependencies;

- The identifications of any BHP "givens" such as whether James Cook Hospital would remain the identified Major Trauma Centre for the Durham, Darlington and Tees BHP area?

- The potential development of a longlist of options/scenarios for service reconfiguration and the consideration of suitable options evaluation criteria to be used in developing both longlist and shortlist options;

- The membership and governance arrangements for the BHP;

- The risks associated with the potential absence of mechanisms for ensuring democratic accountability in respect of the Sustainability and Transformation Plan process;

- The emphasis stated by the BHP Joint OSC that statutory public consultation should only commence once the Committee has received the necessary assurances in respect of the process for devising the service options to be consulted upon and the proposed communication, consultation and engagement plans.

18 The Better Health Programme Joint Health OSC will next meet on 13 October 2016.

Recommendations and reasons

19 The Adults Wellbeing and Health Overview and Scrutiny Committee are recommended to receive and note the information detailed within this report in respect of the Better Health Programme Joint Health Overview and Scrutiny Committee.

Background papers

Agenda and reports to the Adults Wellbeing and Health OSC – 1 March 2016

Agenda and Reports to the Better Health Programme Joint Health OSC – 7 July 2016 and 21 July 2016

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer
Tel: 03000 268140

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – This report details the Council's statutory responsibilities in respect of any proposed consultation and engagement activity in respect of the Better Health Programme.

Procurement - None

Disability Issues - None

Legal Implications – This report has been produced in response to the Council's statutory responsibilities to engage in health scrutiny consultations as detailed in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 and associated Department of Health Guidance.

Protocol for a Joint Health Scrutiny Committee

Better Health Programme

1. This protocol provides a framework under the Local Authority (Public Health, Health and Wellbeing Boards and Public Health) Regulations 2013 for considering and providing a formal consultation response in relation to proposals for substantial development and variation to health services as contained in the 'Better Health Programme'. The proposals affect the Durham and Tees Valley region and are being proposed by the following:

   - Darlington Clinical Commissioning Group (CCG);
   - Durham Dales, Easington and Sedgefield CCG;
   - Hartlepool and Stockton-on-Tees CCG;
   - North Durham CCG;
   - South Tees CCG.

2. The terms of reference of the Joint Health Scrutiny Committee is set out at **Appendix 3**.

3. A Joint Health Scrutiny Committee ("the Joint Committee") comprising Darlington BC; Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC; and Stockton-on-Tees BC ("the constituent authorities") has been established in accordance with the Regulations for the purposes of formal consultation by the relevant NHS Bodies in relation to the matters referred to at paragraphs 1. In particular in order to be able to:-

   (a) respond to the consultation

   (b) require the relevant NHS Bodies to provide information about the proposals;

   (c) require members/employees of the relevant NHS Bodies to attend before it to answer questions in connection with the consultation.

4. The Joint Committee formed for the purpose of the consultation outlined at paragraph 1 will, following approval of this protocol and terms of reference at its first meeting, circulate copies of the same to:-

   Local Authorities

   Darlington Borough Council (BC); Durham County Council, Hartlepool BC, Middlesbrough BC, North Yorkshire County Council, Redcar and Cleveland BC and Stockton-on-Tees BC;

   Clinical Commissioning Groups
   Darlington; Durham Dales, Easington and Sedgefield; Hartlepool and Stockton-on-Tees; North Durham; South Tees.

   [This may be replaced by 'Better Health Programme Board' or similar]

NHS Foundation Trusts

County Durham and Darlington Trust
North Tees and Hartlepool Trust
South Tees Hospitals Trust

Membership

5. The Joint Committee will consist of equal representation, with three representatives to be appointed by each of the constituent authorities.

6. The term of office for representatives will be for the period from the date of their appointment by their constituent authorities until their relevant authority's next annual council meeting. If a representative ceases to be a Councillor, or wishes to resign from the Joint Committee, the relevant council shall inform the joint committee secretariat and the replacement representative shall serve for the remainder of the original representative's term of office.

7. To ensure that the operation of the Joint Committee is consistent with the Constitutions of all the constituent authorities, those authorities operating a substitution system shall be entitled to nominate substitutes.

8. The Joint Committee may ask individuals to assist it (in a non-voting capacity) and may ask independent professionals to advise it for the purposes of the consultation process.

9. The quorum for meetings of the Joint Committee shall be a minimum of one member representative from each of the constituent authorities.

Chair and Vice-Chair

10. The Chair of the Joint Committee is Councillor John Robinson, Durham County Council and the Vice-Chair is Councillor Ray Martin-Wells, Hartlepool Borough Council. The Chair will not have a second or casting vote.

11. If the agreed Chair and Vice-Chair are absent from a meeting, the Joint Committee shall appoint a member to chair that meeting from the representatives present who are members of the same constituent Council as the Chair.

Terms of Reference

12. The Joint Committee will be the formal consultee under the Regulations and the Directions for the purposes of the consultation by the relevant NHS Bodies concerning those matters outlined at paragraphs 1. Terms of reference are set out at Appendix 1.

Administration

13. Meetings shall be held at the times, dates and places determined by the Chair in consultation with each of the constituent authorities.

14. Agendas for meetings shall be determined by the secretariat in consultation with the Chair.

15. Notice of meetings of the Joint Committee will be sent to each member of the Joint Committee at least 5 clear working days before the date of the meeting and also to the Chair of the constituent authorities' relevant overview and scrutiny committees (for information). Notices of meetings will include the agenda and papers for meetings. Papers "to follow" should be avoided where possible.

16. Minutes of meetings will be supplied to each member of the Joint Committee and to the Chairs of the constituent authorities' relevant overview and scrutiny committees (for information) and shall be confirmed at the next meeting of the Joint Committee.

Final Report and Consultation Response

17. The relevant NHS body are required to notify the Joint Committee of the date by which its consultation response is required, and the date by which it intends to make a decision. The Guidance highlights that it is sensible for the Joint Committee to be able to consider the outcome of public consultation before its makes its consultation response.

17. The Joint Committee is independent of its constituent councils, executives and political groups and this independence should not be compromised by any member, officer or relevant NHS bodies. The Joint Committee will send copies of its final report and formal consultation response to the relevant NHS Bodies and the constituent authorities.

18. The primary objectives of the Joint Committee will be to reach consensus, but where there are any aspects of the consultation as regards which there is no consensus, the Joint Committee's final report and formal consultation response will include, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

Following the Consultation

19. Any next steps following the initial consultation response will be taken with due reference to the 'Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny' (Department of Health; June 2014).

Principles for joint health scrutiny

20. In scrutinising the proposals, the joint committee will aim to consider the proposal from the perspectives of all those affected or potentially affected by that proposal.

21. The constituent authorities and the relevant NHS Bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their codes of conduct. Personal and prejudicial and/or disclosable pecuniary interests will be declared in all cases in accordance with the code of conduct and Localism Act 2011.

22. The Joint Committee's procedures will be open and transparent in accordance with the Local Government Act 1972 and the Access to Information Act 1985 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be able to be considered in private. Papers of the Joint Committee may be posted on the websites of the constituent authorities as determined by them.

23. Communication with the media in connection with the Joint Committee's views will be handled in conjunction with each of the constituent local authorities' press officers.

Appendix 3

Better Health Programme Joint Health Scrutiny Committee

Terms of Reference

1. To consider proposals for substantial development and variation to health services as contained in the 'Better Health Programme' and as proposed by the following:

   a) Darlington Clinical Commissioning Group (CCG);
   b) Durham Dales, Easington and Sedgefield CCG;
   c) Hartlepool and Stockton-on-Tees CCG;
   d) North Durham CCG;
   e) South Tees CCG.

2. To consider the following in advance of the formal public consultation:

   - The aims and objectives of the Better Health Programme
   - Information on the Options Appraisal process
   - The plans and proposals for public and stakeholder consultation and engagement

3. To consider the Programme's substantive proposals during the period of formal public consultation, and produce a formal consultation response, in accordance with the protocol for the Joint Health Scrutiny Committee and the consultation timetable established by the relevant NHS Bodies.

4. In order to be able to formulate and provide views to the relevant NHS bodies on the matters outlined above, the Joint Committee may:-

   a) require the relevant NHS Bodies to provide information about the proposals the subject of the consultation with the constituent local authorities and the Joint Committee; and

   b) require an officer of the relevant NHS Bodies to attend meetings of the Joint Committee, in order to answer such questions as appear to them to be necessary for the discharge of their functions in connection with the consultation.

5. To ensure the formal consultation response of the Joint Committee includes, in full, the views of all of the constituent authorities, with the specific reasons for those views, regarding those areas where there is no consensus, as well as the constituent authorities' views in relation to those matters where there is a consensus.

6. The Joint Committee does not have the power of referral to the Secretary of State.

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Better Health Programme – Minutes
7 July 2016

1) Present

Councillors:

Darlington Borough Council – Councillors Newall, Taylor and Tostevin
Durham County Council – Councillors Robinson and Blakey
Hartlepool Borough Council – Councillors Martin-Wells, Cook and Belcher
Middlesbrough Borough Council – Councillors Dryden and Brady
North Yorkshire County Council – Councillors Clark, Blackie and Dickinson
Redcar and Cleveland Borough Council – Councillors Goddard, Ovens, Cooney and Sedgwick
Stockton Borough Council – Councillors Bailey and Hall
Officers:
Stephen Gwillym (Durham County Council), Elise Pout (Middlesbrough Borough Council), Sharon Jones (Stockton Borough Council), Joan Stevens and Laura Stones (Hartlepool Borough Council), Alyson Pearson (Redcar and Cleveland Borough Council), Peter Mennear (Stockton Borough Council)
Better Health Programme:
Amanda Hume, Dr Boleslaw Posmyk, Rebecca Hassack, Dr Neil O'Brien, Ann Farrer, Mary Bewley, Derek Cruikshanks and Andrew Robinson

2) Appointment of Chair

Councillor John Robinson (Durham County Council) was appointed as Chair of the Better Health Programme Joint Health Scrutiny Committee.

3) Appointment of Vice-Chair

Councillor Ray Martin-Wells (Hartlepool Borough Council) was appointed as Vice-Chair of the Committee.

4) Apologies for Absence

Apologies for absence were received from the following:-

Councillor Walker – Middlesbrough Council
Councillor Stelling – Durham County Council
Councillor Scott – Darlington Borough Council (Cllr Tostevin as substitute)
Councillor Akers-Belcher – Hartlepool Borough Council (Cllr Belcher as substitute)

5) To receive any Declarations of Interest by Members

No Declarations of Interest were received.

6) Better Health Programme Joint Health Scrutiny Committee – Proposed Protocol, Terms of Reference and Project Plan

The Principal Overview and Scrutiny Officer presented a report setting out the proposed Protocol, Terms of Reference and Project Plan for the establishment of a Joint Health Scrutiny Committee under the provisions of the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013. The Committee had been established to examine the Better Health Programme (BHP) and any associated service review proposals.

The membership of the Committee reflects the footprint for the Better Health Programme (BHP) and has been extended to include North Yorkshire County Council in view of the patient follows from North Yorkshire into the Better Health Programme area.

The Principal Overview and Scrutiny Officer highlighted to Members that the Committee was the formal statutory body to comment on the proposals but the Committee will not have the power to refer any decision to the Secretary of State, this power being retained by each individual Local Authority.

Future meeting dates have been set but if additional meetings are required, this would be an option.

The Principal Overview and Scrutiny Officer notified Members that representatives of the Better Health programme were in attendance at the meeting to outline the background to the BHP and the pre-engagement activity undertaken and the outcomes.

The Chair confirmed that the Local Authorities adjacent to the Better Health programme area had been informed of the meeting and received copies of the agenda papers to keep them informed.

7) Better Health Programme

A representative from the BHP thanked the Committee for the opportunity to attend the meeting and for the establishment of the Joint Committee. Members were given an outline of what was going to be covered at the meeting, which included the background to the programme, how it had developed overtime, how feedback had helped shape the programme. Members were informed that formal consultation would take place in the Autumn 2016.

The Committee was informed that the BHP had developed over time and now incorporated out of hospital care and was looking at improving standards both in and out of hospital. A BHP representative welcomed early dialogue with the Committee and feedback from the Committee.

The Committee requested details of the specialist services that are being examined as part of the Better Health Programme and also how these services are currently provided at each of the BHP Acute hospital sites i.e. Hours of

operation and how staffing levels are arranged and monitored to deliver the services.

The importance of statistical evidence was highlighted by the Committee and specific information was requested in respect of current performance at acute hospital sites regarding:-

- Current performance in respect of average waiting times in A&E.
- Current performance regarding handover times from NEAS and Yorkshire Ambulance service to Acute Hospital staff.
- Current performance in respect of Elective surgery across the BHP sites including the numbers of elective surgery cancellations and the reasons for these cancellations.
- NEAS Response times across the BHP area.
- Mortality levels across the BHP footprint and beyond.
- What benchmarking statistics are available?

The Chair was also aware that the potential Phase 4 long list of options had been shared at a stakeholder event and requested that this be shared with the Committee along with the key principles to be used during the options appraisal process to ascertain short list options.

The BHP representative confirmed that this information would be available for the next meeting on 21 July 2016.

A member questioned how this ties in with North Yorkshire CCG and it was confirmed that the BHP team were working closely with North Yorkshire CCG. The Committee identified that public engagement needed to take place in the North Yorkshire area.

A presentation was delivered to the Committee by representatives from the BHP, covering the following key points:-

- The BHP programme had evolved from the Acute Services Legacy Project and Securing Quality in Hospital Services (SEQHIS).
- The vision for the BHP is “meeting patient needs now and future proofing for the coming generation with consistently better health and social care delivered in the best place and within available resources.
- Both the Acute Legacy Project and the SEQHIS project looked at best practice and as a result 700 clinical standards were developed and it is now a commissioner led process working closely with partners.
- The project has transformed to include out of hospital care, as the vast majority of contacts people have are with GPs and community health services.
- Some of the reasons why the BHP has developed include an increasing elderly population, recognised shortage of specialist skill and specialist teams provide better outcomes.
- Care delivered through a network of hospitals and community services.

- More seamless care close to or in the patient's home where safe and effective, access to urgent and community care 24/7.
- Patients only admitted to hospital where it is no longer safe or effective for them to be cared for in the community.
- Access to specialist opinion 24/7 where this improves outcome, e.g. heart attack, stroke, trauma, or internal bleeding.
- Planned care organised so there is no unnecessary waiting, no cancellations and patients not exposed to risk of infections.
- Highly responsive, effective and personalised services outside of hospital for people with urgent but non-life threatening needs.
- People with more serious or life threatening emergency needs treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery.
- Planned care in an environment separate from emergency care which avoids unnecessary delays and cancellations.
- Quality, workforce, access, resources all need to be taken into account when making a decision.

Following the presentation, a Councillor questioned the distance that you have to travel for specialist care, as this is a major concern for patients, families and carers as not everyone drives. For example, it is not only the travelling as part of the specialist care, but the follow up appointments are often at the same hospital, requiring people to travel. For people who cannot drive, trying to get to an appointment at 8.30am is very difficult. A representative from the BHP informed the Committee that there is a whole range of issues relating to access to services and it is one of the areas that the BHP team are looking at and where the services can be delivered locally and safely then they can look at this. Specialist services will need to be balanced with Access. For example, some care that used to be provided at hospital accident and emergency units is now provided by North East Ambulance Service paramedics in ambulances to prevent hospital admissions. Members were informed that whatever can be brought local will be. It is about organisations working together and providing a network of services. A Councillor highlighted that the joining up of services was very flawed, with a lack of connection between services. A BHP representative stated that this was a common theme that had been voiced throughout the consultation events. For example, when people attend Accident and Emergency (A&E), they assume that the department has access to their GP records, and many do not.

A Councillor was of the view that there seems to be a lot of talking around the issues but not necessarily any action. A BHP representative confirmed that action had been taken on some areas, for example, the sharing of GP records. GPs are signing up to the North Care Record in order to be able to share data. It was confirmed by a BHP representative that at the next meeting a list of 'early wins' would be provided to the Committee.

A Councillor questioned whether the BHP will ever come to an end, as it seems to have been developing over many years, moving from one project to the next. In response, a BHP representative recognised that the programme had started out as hospital services and through engagement has broadened out, and

developed and improved as it has moved along. In terms of new technologies being developed, there will always be improvements and transformation of services but it will be carried out in a structured way. For example, the development of trauma centres has demonstrated a 30% reduction in mortality and there are always continual improvements with the NHS trying to keep up. It is similar with stroke, the outcome for stroke patients is improved but the technologies are expensive with specialist doctors providing the services in fewer centres. Feedback received from the public has shaped the programme and changes are a direct result of the feedback. For example, cancelled operations were introduced into the programme as a result of feedback.

A Councillor was interested to hear what penalties were in place for Trusts who cancelled planned operations/procedures.

Regarding the comments contained in the report on public feedback received to date, a member commented that it seemed as though the public comments had been scripted.

A Councillor was of the view that the BHP was another way of the NHS removing local services from local people. Everyone wants better health and the best services but people still like emergency care to be close.

A Councillor questioned what the objective of the meeting was and raised a concern that it had been said that any changes would be met from existing resources. He asked if this would this result in people being left in the community very ill? The Councillor asked whether the Committee would be inviting different people to future meetings. The Principal Overview and Scrutiny Officer informed Members that this meeting was to start the process in order for Members to be satisfied that the options/proposals developed have been done so correctly, that the public engagement is robust and wide ranging. It was confirmed that the meeting was not about endorsing any proposals but 'taking stock' and looking at what evidence the Committee may wish to see at future meetings before moving forward into the formal consultation phase.

A Councillor questioned the sharing of X-Rays between hospitals and whether this happened. It was confirmed that this would be reported to a future meeting. A concern was also raised that primary care practitioners had not received training in line with specialist services.

A Councillor raised concern that the BHP was a 'done deal' and felt as though we had been here before with a reduction in access for local people at local hospitals. The Councillor was of the view that local hospitals were deliberately and carefully being run down. Distance travelled to access services remained a real concern. The Chair reiterated that the Committee will challenge all elements of the BHP process. The BHP representative confirmed that the team will listen and in particular they welcome he views of the Committee. Members were informed that the programme will be consulting on genuine options and the team will listen.

A Councillor questioned whether ambulance services had been involved in discussion as there are already ambulance delays outside hospitals. It was confirmed that the North East and Yorkshire ambulance services had been involved and will be a significant part as the programme moves forward.

A Councillor raised a concern about the workforce and that due to the cost of medical training not as many people were training. The Councillor questioned whether this would be considered? A BHP representative confirmed that workforce was the main driver and the ability to recruit and retain was essential. Centralising expertise helps to recruit and retain, and this is a significant area of the programme. In relation to recruitment a Councillor highlighted that a shortage of staff was often used to close services on the basis of clinical safety and this has resulted in the public losing confidence in consultations. A BHP representative recognised and understood where the concerns were coming from regarding lack of confidence but welcomed the support and challenge from the Committee. It was confirmed that independent views had also been used, in addition to those of the programme board. The Chair reiterated that the Committee will take evidence from elsewhere such as highways and transport and Child and Adult Services to challenge.

A concern was raised about the knock on effect of the programme on child and adult social care. It was confirmed that Local Authorities were structured into the programme and very much engaged. It was questioned whether community services costs would increase due to the programme. It was confirmed that people are discharged from hospital when medically fit and all areas would be looked at so the system was not destabilised, for example, physiotherapists may be able to treat people at home rather than in hospital.

A discussion ensued on trauma centres and a Councillor asked what would happen if James Cook hospital lost its designated status. It was confirmed by a BHP representative that the BHP is not changing its status and did not expect that its status would change. A Councillor questioned the ‘givens’ within the programme as it was suggested that James Cook as the Regions Specialist Emergency Centre was a given.

The designation of Trauma Centres was a national decision by Bruce Keogh and it was agreed that 40 to 70 centres should be designated. A Councillor commented that this was a vast difference in number and if some haven’t been allocated can the North East increase their number of centres. The Committee requested information around the Keogh review and the recommendations in respect of the number of Major Trauma Centres which should exist in England, including why there is only two designated in the North East.

A Councillor commented that this was a huge programme and how would timescales fit. A BHP representative commented that this will be an ongoing evolving process but a timescale will have to be given.

A Councillor questioned whether the BHP was part of the Sustainability and Transformation Plans (STPs). Reference was made to what the relationship is between the STP for Durham, Darlington, Tees, Hambleton, Richmondshire

and Whitby and the BHP and the Committee would like to know where the synergy exists between them. The Committee agreed to invite lead representatives including clinicians to a future meeting to discuss any links.

A representative from the BHP briefed members on the engagement timeline for the programme and how people can get involved. A Councillor suggested using a texting service, which representatives said they would implement.

Decision

(1) That the contents of the presentation and comments of Members be noted.

(2) That details of the specialist services that are being examined as part of the BHP and also how these services are currently provided at each of the BHP Acute hospital sites i.e. Hours of operation and how staffing levels are arranged and monitored to deliver the services be provided at a future meeting.

(3) That the following information, in respect of current performance at acute hospital sites be provided at a future meeting:-

- Current performance in respect of average waiting times in A&E.
- Current performance regarding handover times from NEAS and Yorkshire Ambulance service to Acute Hospital staff.
- Current performance in respect of Elective surgery across the BHP sites including the numbers of elective surgery cancellations and the reasons for these cancellations.
- NEAS Response times across the BHP area.
- Mortality levels across the BHP footprint and beyond.
- What benchmarking statistics are available?
- Patient data flows between hospitals and specialisms.

(4) That details of the potential Phase 4 long list options that have been identified alongside the key principles to be used during the options appraisal process to ascertain short list options be provided at a future meeting.

(5) That information is provided to a future meeting of the Committee detailing what input Local Authority Social Care specialists have had so far.

(6) That details of ‘quick wins’ that have been identified regarding advances and improvements in services and care be provided at a future meeting.

(7) That details of Workforce modelling, including how is this being undertaken and where is the programme in establishing an “optimum workforce level” to deliver future services under the Programme be provided at a future meeting.

(8) That information be provided to the Committee around the Keogh review in respect of the number of Major Trauma Centres which should exist in England including what are the 'givens' in the programme.

(9) That lead representatives on the STPs be invited to attend a future meeting to provide information on the relationship between the STP for Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby and the BHP.

(10) Details of performance in respect of Hospital discharges, reasons for delays and the undertaking of healthcare assessments pre/post discharge be presented to a future meeting of the Committee.

Better Health Programme Joint Health Scrutiny Committee

At a Meeting of **Better Health Programme Joint Health Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Thursday 21 July 2016 at 2.00 pm**

Present:

Councillor J Robinson in the Chair

Councillors –

Councillors W Newall, J Taylor and L Tostevan (Darlington Borough Council)
Councillor J Blakey (Durham County Council)
Councillors R Cook and R Martin-Wells (Hartlepool Borough Council)
Councillors B Brady and E Dryden (Middlesbrough Council)
Councillors J Blackie, J Clark and C Dickinson (North Yorkshire County Council)
Councillors N Cooney, R Goddard and M Ovens (Redcar & Cleveland Borough Council)
Councillors S Bailey and L Hall (Stockton-on-Tees Borough Council)

Officers –

Stephen Gwillym (Durham County Council), Joan Stevens (Hartlepool Borough Council), Bryon Hunter (North Yorkshire County Council), Alison Pearson (Redcar & Cleveland Borough Council) and Peter Mennear (Stockton-on-Tees Borough Council)

Better Health Programme –

Nicola Bailey, Derek Cruikshanks, Edmund Lovell, Dr Boleslaw Posmyk and Dr Neil O'Brien

Also in attendance –

Councillor L Hovvels – Cabinet Portfolio Holder for Adult and Health Services and Chairman of Health and Wellbeing Board (Durham County Council)
Peter Appleton – Head of Planning and Service Strategy, Children and Adult Services (Durham County Council)

Representatives from North East Empowerment and Diversity Group

1 Apologies for Absence

Apologies for absence were received from:-

Councillors –
Councillor Scott – Darlington Borough Council
Councillor Stelling – Durham County Council

Councillor S Akers-Belcher – Hartlepool Borough Council
Councillor Walker – Middlesbrough Council
Councillor Mitchell – Stockton-on-Tees Borough Council

Officers –
Elise Pout – Middlesbrough Council

2 Substitute Members

Councillor L Tostevan for Councillor H Scott (Darlington Borough Council)

3 Declarations of Interest

There were no declarations of interest declared.

4 Minutes

The minutes of the meeting held on 7 July 2016 were confirmed by the Committee as a correct record and signed by the Chairman (for copy see file of Minutes).

The Chairman advised that the ten decisions outlined in Item 7 would be re-visited following the BHP presentation.

As a matter of clarity, it was agreed that Councillors would be identified by name within the minutes.

5 Better Health Programme (BHP) - Phase 3 Engagement

The Committee considered a report and presentation of the Communications and Engagement Lead, Better Health Programme (BHP) that shared information from a stakeholder forum event held on 29 June 2016 and highlighted the long list of possible scenarios and evaluation criteria to be used for decision making (for copy see file of Minutes).

The Better Health Team gave a detailed presentation that included information on the following:-

- Better Health Programme Governance Structure
- Executive Membership
- Board Membership
- Engagement with Stakeholders
- Deciding what to consult on
- Workshop discussions – format
- Possible Solutions
- Proposed weighting criteria for engagement
- Key questions – discussion
- Key Services
- Combination of Services and Long list of Solutions
- NHS England Guidance

- Next Steps & Timeline

The Chairman referred to the focus on NHS Sustainability and Transformation Plans (STP) and the fact that nothing has been provided to the Joint OSC in this respect. Councillor Clark asked about funding through the STP and that further clarification was required. Councillor Martin-Wells asked who the STP were answerable to.

Dr O'Brien explained that the BHP was a focused piece of work and that the STP was about a combined planning approach to look at the financial gaps within the NHS over the next 5 years. He indicated that the BHP was a programme that sits under the STP and stressed that there were close links between the two projects. Dr Brien added that Mental Health and Hambleton and Richmondshire were not part of the BHP but did form part of the STP. He also pointed out that the work of the BHP commenced before the work of the STP.

Councillor Martin-Wells re-iterated his point about who the STP was responsible to and was advised that there are a number of professional people and bodies who judge the plan including representatives from NHS England, NHS Improvement, the Local Government Association and the Care Quality Commission. Dr O'Brien also advised that financial bodies and the department of health also feed into the plan. He went on explain that funding through the STP would be directed to NHS Foundation Trusts.

Moving on to the membership of the board, the Chairman was advised that there were no elected members involved. The Committee was, however, assured that there is Local Authority involvement in the Programme Board in terms of a nominated Chief Executive and Director of Social Care.

Referring to the stakeholder events, and in particular the ones held in Hartlepool, Councillor Cook asked how it had been decided who to invite, how the events were advertised and how people became involved in the process. Mr Lovell explained that the meeting in Hartlepool had been well attended and that those who had attended were from the local community including the Patient Reference Group. He informed Members that adverts had been placed in local newspapers, leaflets and been placed in GP practices and libraries and social media had been used to promote the events. He added that there had been varied attendances but that they had strengthened as the process developed. He went on to explain that there were a group of people who did come back to meetings and that were sharing the journey in terms of the development approach. Healthwatch had also been involved and had been e-mailing interested groups.

Councillor Martin-Wells said that as a cross-section of people had been attending the events there was no neutral base and therefore no consistency in terms of feedback. Mr Lovell explained that there had been similar attendances with the background being explained at each meeting. He felt that there had been a shared sense across all meetings that included concerns about travel, care outside of the hospital, community service and therefore believed the meetings to be consistent.

The Chairman had attended an event at Sedgefield racecourse and a follow up event at the Excel Centre and felt the audience to be very consistent.

Councillor Bailey had also been to a well-attended event in the Stockton area.

Councillor Tostevan asked for clarity regarding the proposed weighting criteria. Mr Lovell explained that it was about how much weight we give to one thing over another. For example, do we give 'Quality' 30% or 50%.

Councillor Martin-Wells said that option 4 was the favoured option with deliverability at 15% and pointed out that if the service could not deliver then this exercise was meaningless. He stated that surely the deliverability of any option must be a paramount consideration.

Councillor Ovens asked how Councils could become involved with regards to reducing the wait for delays and discharges. She said that unless we link closely with social services there would be a knock on effect for the level of care.

Dr O'Brien said that every local authority have officers within the Adult Social care environment that were working closely with the Better Health Programme.

Dr Posmyk explained that there was a level of importance when looking at different ways of delivery service. The feedback during the engagement process about accessibility was very important and the weighting factors were not set in stone. The Better Health Programme Executive Group preferred option 4.

In relation to the score for 'Deliverability', it was clarified that this referred to whether options would ensure that NHS Constitutional standards would be met.

The Principal Overview and Scrutiny Officer, DCC said that the comments made today would be reflected in the minutes and said that the Committee needed to have sight of information requested.

Mr Hunter referred to the existing resources and affordability and asked if there was potential to make savings working within the financial environment. Dr O'Brien said that the programme was about efficiency rather than making savings. The range of costs differ in each hospital environment and if this could be changed it would allow the money to be spent in a better way.

Moving on to the population figures, Councillor Blackie said that there were concerns with regards to the cuts and as people travel to Darlington from North Yorkshire it would have been helpful to see an estimate of figures. He went on to ask why Hambleton and Richmond were not full members of the BHP board as this could have an impact on decisions being made. Dr O'Brien informed Councillor Blackie that they had been invited on a number of occasions and had chosen to be associate members. Councillor Clark expressed concerns as they had received assurances regarding Darlington hospital in the past. He said that he would talk to Hambleton and Richmond about taking up full membership of the board.

Members requested sight of patient flows such as from Durham to Newcastle, North Yorkshire to Leeds/Bradford and for the Tees Valley area.

Councillor Cook said that the information needed to be clearer and asked which areas Bishop Auckland planned surgeries would cover. Mr Cruikshanks said that Bishop Auckland had a good reputation for outcomes for elective surgery. Councillor Cook asked what we could expect after this exercise.

Dr Posmyk said that one of the big drivers for the BHP is to ensure excellent services. He said that the board had no preconceptions but would use all of the information gathered so far to go out to consult upon. He added that a small number of patients would not be able to be seen as planned surgeries but as many patients as possible would go down this route. The BHP would concentrate on the best possible outcomes for patients.

With regards to planned surgery, Councillor Dryden was informed that some patients may need to be transferred to emergency care facilities, as happens now. It was hoped that better planning would ensure patients would be selected for surgery and would less likely need to be transferred.

Councillor Bailey asked if high risk units such as intensive care would run alongside midwifery units and if there would be guarantees that the mother could travel with the baby should the need arise. Dr Posymk informed her that the neonatal unit would run in parallel and that the mother would always be able to go with the baby, preferably being transferred to specialist care with the baby in the womb.

Councillor Clark said that as status quo was not an option he believed it to be a done deal.

The Chairman pointed out that the Committee would require evidenced based decisions.

Mr Lovell advised that there were 133 possible combination of services and that work was ongoing on prioritising possible solutions. All possible combinations would be explored together with patient flows.

Councillor Cook asked if one possible combination would be for North Tees to lose emergency care and was astounded to hear that this could be the case. He expressed concerns as Hartlepool had already closed. Dr O'Brien explained that all options would be looked at and decisions would be made using patient flows across the whole population and the services required. He stressed that no decisions had been made at this point.

The Chairman expressed similar concerns should Durham or Darlington lose out. He reminded Members that no decisions were being made today and asked again that evidence be provided for each option.

Mr Lovell said that the BHP were not looking for a recommendation from the Committee at this stage. They were analysing possible solutions and a lot of

detailed work still needs to be carried out. He added that over the next few months the board would be talking the Committee through the process.

Councillor Dryden asked if with planned care were the BHP building assumptions that private hospitals would take up capacity. Dr Posmyk gave the Committee assurances that patient flows would be taken into account and some volume of planned care would go to the private sector.

Mr Lovell explained that in order to create space in the emergency hospitals some planned care would need to move. Councillor Dryden asked if staff would also move and was advised by Mr Cruikshanks that the workforce would be networked and available to provide a service at more than one site. The benefit of a bigger workforce would enable planned care to be more effective. Mr Cruikshanks further explained that cancelled operations and delays due to beds being blocked by emergency care would be managed and would create capacity to plan more.

Councillor Newall said that Darlington residents would be equally as angry at losing emergency care. She referred to the urgent care facility at Darlington and the proposal for a £5m investment that had now been reduced to £½m. With £27m for an extension at University Hospital of North Durham (UHND) she felt that it was already a done deal.

Dr O'Brien said that it was not a done deal and no decisions had been made. Decisions for the plans to extend UHND had been made before the BHP commenced.

Councillor Taylor said that people were drawing conclusions from the information received as £5m had been promised to be spent at Darlington. Dr O'Brien said that the refurbishment for Darlington would happen but he assured the Committee that this was an open and honest engagement and consultation exercise and that no decisions had been made on where services would be delivered from.

Councillor Martin-Wells said that he hoped he would be proved wrong but that he had to listen to the people he represented and they were saying that decisions had already been made.

Mr Cruikshanks suggested that they could look at the current activity of accident and emergency and look to see what does happen at A and E, compared to what should happen. The Chairman welcomed this.

In relation to the feedback, Councillor Martin-Wells was concerned that only 5% had been received about A&E. He asked what questions had been asked of the public. Mr Lovell advised that the questions asked were 'What do the NHS do well?' and 'Where it could be improved'. An outside organisation had compiled a report and analysed the feedback. In the early stages of the BHP people started feeding back that they were more concerned about travel, having care closer to home, community social care, GP appointments, 111 service and ambulance response times. Mr Cruikshanks added that the public wanted to spend more time at home and have earlier integration back into the community.

Councillor Cook felt that the two questions asked have left the consultation wide open and felt that there should have been more specific questions asked.

Councillor Tostevan felt that the information was not clear enough about what was being consulted upon. She felt that the information needed to be more explicit so that the public could understand.

Mr Lovell reminded Members that at present this exercise was about engagement not consultation. Conversations were still taking place with people about their concerns over services and specialist care.

The Principal Scrutiny Officer reminded Members of the recommendations made at the last meeting and what further action and evidence needs to be provided to the Better Health Programme Joint Health OSC by the BHP representatives.

Referring to the previous set of minutes he said that paragraph 4 had been addressed as Members had received a presentation and had an in-depth conversation about the appraisal criteria and the weightings to be applied.

Further information was still required as outlined in recommendations 3, 5, 7, 8, 9 and 10.

In mitigating on behalf of the Programme Board, the Principal Overview and Scrutiny Officer explained that they had a very short timescale from the last meeting to collate all of the information that had been requested by members and it was not the intended for Members to receive that today. As some Councils have a recess period during August it was unlikely that a special meeting would be arranged and therefore he requested that all information be provided for the 8 September meeting.

He pointed out the importance of the Committee receiving the information requested and the requirements placed upon the NHS in respect of the provision of information and evidence requested by Health Scrutiny Committees as set out in Department of Health's Local Authority Health Scrutiny Guidance. The Committee would need all information before they could offer informed opinions leading up to the start of the consultation period in November.

He advised that all Better Health Programme Joint Health Scrutiny Committee meeting papers were available on Durham County Council's website.

The Chairman thanked everyone for attending and for their contribution.

Resolved that:-

(1) The contents of the presentation and the comments of the Committee thereon be noted;

(2) The Better Health programme Executive provide the requested information and evidence set out in the minutes of the Joint OSC meeting held on 7 July 2016 to the meeting scheduled for 8 September 2016;

(3) Data be provided in relation to current activity at each of the A&E units within the Programme footprint; and

(4) The comments made by the Joint OSC in respect of the long list options evaluation criteria weightings be noted.

6 Date and time of next meeting

The next meeting would be held on Thursday 8 September 2016 at 2.00 p.m. in the Mandela Room, Middlesbrough Town Hall.