Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Monday 1 October 2018**
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 6 July 2018 and of the special meeting held on 7 September 2018 (Pages 3 - 28)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. Adults Wellbeing and Health OSC Review of Suicide Rates and Mental Health and Wellbeing in County Durham - Report of the Director of Transformation and Partnerships and presentation by the Principal Overview and Scrutiny Officer (Pages 29 - 82)
8. Annual Reports 2017/18 - Health and Wellbeing Board and Local Safeguarding Adults Board - Joint Report of the Corporate Director of Adult and Health Services, Corporate Director of Children and Young People's Services, Director of Transformation and Partnerships and Director of Public Health County Durham (Pages 83 - 150)
9. Quarter 1 2018/19 Performance Management - Report of the Director of Transformation and Partnerships (Pages 151 - 166)

10. Budget Revenue and Capital Outturn 2017/18 - Report of the Corporate Director of Resources (Pages 167 - 172)
11. Budget Revenue and Capital Forecast Q1 2018/19 - Report of the Corporate Director of Resources (Pages 173 - 178)
12. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
21 September 2018

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

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

Councillors R Bell, P Crathorne, R Crute, G Darkes, J Grant, T Henderson, A Hopgood, E Huntington, C Kay, K Liddell, A Patterson, S Quinn, A Reed, A Savory, M Simmons, H Smith, L Taylor, O Temple and C Wilson

Co-opted Members: Mrs R Hassoon and Mr D J Taylor Gooby

Contact: Jackie Graham **Email: 03000 269704**

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2 - County Hall, Durham on **Friday 6 July 2018 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, R Bell, R Crute, J Grant, T Henderson, A Patterson, S Quinn, M Simmons, H Smith, O Temple and M Wilkes

Co-opted Members:
Mrs R Hassoon and Mr D J Taylor Gooby

Also Present:
Councillor L Hovvels

To mark the 70th birthday celebrations for the NHS, the Chairman presented a birthday card on behalf of the Committee to the Director of Commissioning, DDES CCG.

1 Apologies

Apologies for absence were received from Councillors Crathorne, Darkes, Hopgood, Huntington, Kay, Liddell, Reed, Savory, Taylor and Wilson

2 Substitute Members

Councillor Wilkes was a substitute for Councillor Hopgood.

3 Minutes

The minutes of the meeting held on 3 April 2018 and of the special meetings held on 2 May 2018, 9 May 2018 and 1 June 2018 were agreed and signed by the Chairman as a correct record.

The Principal Overview and Scrutiny Officer advised that in relation to the minutes of the special meeting held on 1 June 2018 regarding the NHS England Review of Specialised Vascular Services a recommendation had been raised with the North East Regional Joint Health Scrutiny Committee meeting on 22 July 2018. The joint committee could not commit to a joint response and therefore each local authority would need to respond to the proposed changes on an individual basis.
A special meeting of the Committee would take place on 7 September 2018 where representatives of NHS England would come back and report back on the information requested, after which the Committee could take a view on how they wanted to proceed.

4 Declarations of Interest

There were no declarations of interest.

5 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;

- 'Best possible care' promised to North-East patients from vascular changes – Northern Echo 6 June 2018

HEALTH chiefs say a shake-up of hospital services affecting patients requiring vascular surgery will provide the best possible care.
A strategic review has advised that services in the North-East should be reconfigured to a maximum of three hubs. The clinical review also advised that there is a strong case to remodel vascular services in the North East and that there is only sufficient specialised vascular activity and vascular clinicians to support three centres. It recommends that full vascular services should be delivered from Sunderland, Middlesbrough and Newcastle.
The recommendation means that around 12 patients a week, who live in County Durham, would have their vascular surgery done at the Royal instead of University Hospital of North Durham. University Hospital of North Durham should continue to see around 3,600 patients a year for vascular outpatient appointments. Treatment of varicose veins would also remain in Durham.

- The 35 medicines no longer available on NHS prescription from this month – Sunderland Echo 18 June 2018

The NHS has banned free prescriptions for some 'over the counter' medicines such as treatments for constipation and athletes foot, starting from this month. NHS England is hoping to free up almost £100 million for frontline care each year by bringing in the changes. The NHS will no longer be funding treatments such as paracetamol, probiotics, cough mixture, eye drops and laxatives. However, the rule changes will not affect the prescribing of over the counter items for 'longer term or more complex conditions', officials have confirmed.
NHS England has said that curbing these routine prescriptions for minor conditions, many of which will cure themselves, will free up vital funds. The NHS announced the move at the end of the March and the new guidance to GPs across the country started from May 31.

Councillor Temple was concerned that the real issue with these changes were for the people on free prescriptions and therefore could affect children, the poor and elderly. Children would be reliant on their parents to medicate them and if it was a choice between feeding their family or medicating them it was concerning. He believed that as some conditions could be symptoms of a more serious condition such as diarrhoea, this was taking risks with people's lives.

Councillor Quinn also expressed concerns about home carers not being able to give non prescription drugs and as such people could be left in pain.

The Principal Overview and Scrutiny Officer said that there were concerns raised about the equality impact assessment at a national level but queried what was happening at a local level. He asked what the CCGs had shared with GP practices and had patients been advised in writing of the new rules. The Committee were concerned about the potential adverse impact on vulnerable groups.

The Director of Commissioning, DDES CCG advised that there were two levels to these changes. NHS England had introduced the changes at a North East level where CCGs would be working together on medications for hayfever, paracetamol and travel medicines and that it was now up to them to make these changes locally. The Deputy Director of Public Health had been tasked with looking at the implications for Durham. GPs may use their judgements until guidance was published. She confirmed that children would be exempt from this.

The Medicines Optimisation Lead, North Durham CCG was introduced to the Committee. She advised that regionally across the North East and Cumbria the general public would be expected to self medicate for minor illnesses for example hay fever and aches and pains. Questions had also been asked about funding vaccines for holiday medication by the NHS when people chose to go abroad should they not pay themselves. She highlighted that the changes focussed on acute and not chronic conditions. She assured the Committee that at no point had GPs said that they would not prescribe and that the CCG did not want to disadvantage anyone. With regards to paracetamol, she advised that £1.78m was spent across the DDES and North Durham areas. People could buy up to 96 paracetamol from a pharmacy provided that a pharmacist was present.

She went on to explain that there would be a definite list of people excluded from these changes including young people and women who were pregnant however this was still being finalised. The guidance was expected to focus on conditions as opposed to individual medication, with the vast majority of those conditions being suitable for self care.

The Chairman referred to the travel medication and the fact that GPs can often interpret it differently. For example some GPs provide vaccines free of charge, some charge and some refuse to administer it. He suggested that this needs to be addressed and be fair across the board.

Councillor Bell was concerned about what was driving this change and whether this was associated with cost or a procurement issue. He also expressed concern about people self medicating as this could lead to further complications.

Councillor Temple stated that letters had been sent to patients for three of the thirty five conditions affected and he was concerned that no advice had been given that generic medicine would be available from a pharmacist. He believed that some pharmacists had also not been advised if they would still be providing these drugs. He said that the Committee should have been appraised of these changes and on what advice the CCG had been giving.

The Director of Commissioning advised that a huge amount of work had been undertaken on this including discussions with GPs, patient reference groups and regional groups and all information had been considered carefully. She confirmed that there would be

exemptions from this and they would be clearly defined. The CCG had already been looking at the three conditions and this was the reason why letters had been sent out about those. With regards to the remaining 32 conditions these would be looked at following further guidance and through impact assessments. The guidance would be used for implementation locally.

Members were informed that the Regional group were interested in appointing a lay member and that they were welcome to join.

The Director of Commissioning explained that these changes were about using the NHS funding as wisely as possible and that by allowing people to self care this could save money.

The Chairman said that it would have been preferential to have been consulted and that the Committee were concerned about the affect this would have on those people could not afford to pay. The Medicines Optimisation Lead confirmed that the only medications affected at present were for hay fever, paracetamol and travel. She advised that there was a minor ailments scheme whereby people exempt from paying could ask for a small range of medication at a pharmacy without needing a GP appointment.

The Principal Overview and Scrutiny Officer said that feedback from the CCG would be welcomed on the work to be undertaken so that the committee were aware of the changes from a local perspective.

- Council creates £130,000 role to lead health and social care integration – Northern Echo 21 June 2018

A NORTH-East authority has agreed to create a new position to lead a programme aimed at integrating social care and health services.
The new director of integrated community services at Durham County Council will help develop the Health and Social Care Plan for County Durham. Referenced in the Adult and Health Services update report.

6 Any Items from Co-opted Members or Interested Parties

There were no items from co-opted members or interested parties.

7 Review of Stroke Rehabilitation Services in County Durham

The Committee received a presentation by representatives of County Durham Clinical Commissioning Groups and County Durham and Darlington NHS Foundation Trust regarding the Review of Stroke Services in County Durham (for copy see of Minutes).

The Senior Service Manager, CDDFT gave a detailed presentation highlighting the following-

- Scope of improvement – how services would be delivered in future
- Context and best practice
- Current state for stroke rehabilitation
- SSNAP performance – August to November 2017
- Reporting periods

- Summary of key issues identified
- Engagement activity
- Proposal on best way forward – review best practice, engage and feedback responses

The Senior Service Manager added that there was a supported discharge team located in the Easington area. She would report back to the Committee in September 2018 with the feedback received on the changes.

Mrs Hassoon asked if the under performance in occupational therapy was due to staff shortages and was informed that there were some gaps in speech and language and that it was difficult to service multiple sites. The service also had difficulty recruiting staff. There was a national shortage of therapy staff across the County.

Councillor Bell was concerned that if someone was discharged from Bishop Auckland Hospital and the care was not available for them out in the community. He said that the care available in that patch was uneven and asked what outcomes the CCG were looking for with these changes.

Councillor Smith understood that staying too long in hospital was not best practice but she too was concerned about community services not being available, making recovery difficult for some patients. She asked if there would be a more systematic approach that focused on the patient group.

In response, Dr Pai, Consultant Stroke Physician and Clinical Lead, CDDFT, that better outcomes were seen at three months from a patient having a stroke and this was used as an evidence base. This would depend on the category of the stroke as sever strokes can see a patient in hospital for six weeks plus rehabilitation treatment. Minor strokes tend to see improvements after two to three weeks. He said that there was a concern about the lack of community services available from GPs and consultants. He added that most patients did recover better in their own home with familiar surroundings with much better outcomes.

Councillor Smith commented that the bottom line was that there were not enough robust community services in place to give patients the best outcome.

The Director of Commissioning advised that the therapies were diluted with acute rehab being carried out in Durham and longer intensities at Bishop Auckland. With the proposed changes, staff at Bishop Auckland would be freed up to be available in the community. She added that it was important to talk to patients about their stroke recovery and that this would help to improve communication.

Councillor Smith believed that this was a hidden agenda to remove stroke services from Bishop Auckland and move them to Durham.

With regards to shorter stays from Bishop Auckland for patients choosing to go home, Councillor Quinn asked for a breakdown of those numbers.

The Stroke Manager for CDDFT assured the Committee that anyone who opted to go to Bishop Auckland Hospital would be able to go there. Early supported discharge was available in Easington however there were different levels of rehab available in other parts of the County which could be delivered through the Teams around Patients and Community Hubs.

Councillor Wilkes said that so many other services had been drawn into the University Hospital North Durham, he believed at the expense of the rest of the County. This had an impact on staff and he was horrified to see even more services being pushed into this hospital as the capacity was already difficult with a lack of parking.

With regards to accessibility and parking, Councillor Bell agreed that this was a huge problem in Durham. He said that it was difficult for people to get from the Dales into Durham and felt that there had been a contradiction in the information given as on one hand officers had said that there was not enough of a specialist resource to provide care in hospital but that there was also not enough resource out in the community.

Mr Taylor-Gooby was advised that North Durham CCG had led on the engagement. He was assured that the AAPs had been involved in the process and went on to say that engagement should be a continuous effort with peoples concerns being fed in to the process. The Senior Service Manager responded that this was a priority for the CCG and so it would be resourced. She added that they used all of the networks and processes that they already had available to help with the engagement, including the AAPs.

The Director of Commissioning explained that they had the same number of patients from Bishop Auckland attending UHND as patients from the Durham area attending Bishop Auckland Hospital. She added that best practice would be for people to be out of hospital and in their own homes which would help aid their recovery. Therefore the best services for people would be in the community with rehab available to offer support required.

Referring to the Easington Discharge team, the Chairman said that this was a wonderful service and that we should not lose it. The Director of Commissioning said that they wanted to replicate this good practice across the whole County.

The Chairman asked if the stroke rehab unit at Bishop Auckland Hospital was being removed. The Senior Service Manager confirmed that they were trying to understand the indicators and at the moment it was not fantastic in terms of outcomes for patients. They wanted to share good practice and therefore needed to carry out further detailed work around this. They needed to work out what was the best they could offer with the resources available. Following the period of engagement they would come back to Committee with their findings.

Resolved:
That the engagement process be noted and the Committee to receive feedback to a future meeting at the conclusion of the stakeholder engagement activity.

8 Review of Urgent Care Hubs across Durham Dales, Easington and Sedgefield CCG

The Committee considered a joint report of the Joint Report of the Director of Transformation and Partnerships, Durham County Council and the Director of Commissioning, DDES CCG that provided details to review the provision of Urgent Care Hubs as part of the extended and enhanced primary care service by Durham Dales, Easington and Sedgefield CCG that had commenced on 1 April 2017 (for copy see file of minutes).

The Senior Service Office, CDDFT advised of the current state of services provided within Bishop Auckland Hospital including the number of appointments and scans made (for copy of slide see file of Minutes).

The Director of Commissioning gave a detailed presentation including:-

- Service change recap
- Summary of findings
- Primary care services patient engagement
- Engagement on our current model
- Other key issues for Dales
- Locality specific issues – Durham Dales
    - Durham Dales preferred model
- Outcomes locality specific – Sedgefield
    - Locality specific issues – Sedgefield
    - Sedgefield recommendation
- Outcomes locality specific – Easington
    - Locality specific issues – Easington
    - Easington recommendations
- Key Principles

The Director of Commissioning informed the Committee of the next steps which were to:-

- Develop a communication and engagement strategy
- Agree consultation messages and work with Healthwatch as independent support and gain support from PRG members
- Focus on what else would be needed to support the recommendations – more services, better access
- Present the findings and the consultation plans to Committee in September
- Undertake a 6-8 week consultation focusing on the areas where the most change was proposed

The Chairman welcomed Councillor Sutherland, Barnard Castle Town Council to the meeting.

Councillor Sutherland expressed concerns about proposals for the Richardson Hospital. These concerns had been discussed reference group meetings, led by Lesley Jeavons, Director of Integration. One in two patients had been informed that the hospital was closing due to there being no demand for urgent care. One in two patient wards had

closed and the hospital provided thirty outpatient services however most people in Barnard Castle were not aware of what services were available. She stated that Barnard Castle was 15 miles from Bishop Auckland and if there was no urgent care available in Barnard Castle people would have a lot of travelling to contend with. Some areas had no or very little in terms of bus services. She believed that the under use of services at the Richardson Hospital was due to the lack of publicity around it. There was a lack of information in GP surgeries and pharmacies and the CDDFT website did not have the correct address for the hospital. Only 4 of the 39 outpatient services were listed on the website and the NHS choice website had not been updated about the Richardson Hospital since 2013. Councillor Sutherland was therefore not surprised that it was under used as no one knew about it. She also stated that the 111 service direct callers to Bishop Auckland rather than the Richardson Hospital.

Councillor Sutherland concluded that she believed that the NHS and CDDFT were deliberately running the service down. She urged the Committee not to accept the recommendations and to give time for people to start using the services available.

Councillor Bell concurred with Councillor Sutherland's points and added that he had knowledge of people being directed to Bishop Auckland when in need of urgent care. He also confirmed that he could not find any reference to the Richardson Hospital providing this facility on the NHS choice website or by using Google. He asked that the decision for Durham Dales was deferred for a period of nine months and for the CCG to take immediate action on the points raised by Councillor Sutherland regarding publicity.

With regards to the sample size of people engaged in the process, Councillor Crute asked for clarity on how many people were affected and if this was adequate.

Similar reports for people in Easington or Peterlee being directed to Sedgefield was referred to by Councillor Grant.

The Chairman reported that there was no information in his surgery about where people should go to seek urgent care. He also referred to Councillor Crute's point, as he was aware that there was only a 6% return in Sedgefield, 8 people in a population of 25,000. He referred to the potential cost savings and asked what this money would be spent on.

Referring to travel, Councillor Henderson expressed his concerns about how far people would need to go from Barnard Castle to Bishop Auckland if the hub at the Richardson Hospital was removed. He also agreed that there should be more publicity around the facility so that people were made aware.

Councillor Patterson had been positive about the proposed changes but did not feel that concerns had been addressed and said that a wider group of people should be consulted with due to the low number of returns. She asked how many appointments made in a hub were a direct result of not being able to get an appointment with their own GP surgery. She was also aware of people being directed further away when using the 111 service.

The Chairman summarised the concerns raised as the 111 service referrals, travelling, the accuracy of the survey and public awareness of the services available and the cost savings.

The Director of Commissioning explained that the publicity campaign had been the same across the whole of DDES and was about people knowing that services were available and rather than people turning up they would be expected to ring the NHS 111 service. They would be booked into a hub with an appointment. Where a patient was booked in would also depend on the condition as not all hubs dealt with minor injuries. It was a direct service based on need. She added that staff were not available for all 9 hubs but that the changes would ensure that GPs and staff nurse practitioners would be available in each area. If the service was to remain the same further staff would be required in the Bishop Auckland, Easington and Sedgefield areas. She advised that talks had taken place with councillors in the Dales area very early on in the process and this formed part of the engagement plan. The hubs had seen more people being able to access urgent same day appointments with a GP that could access medical records. With regards to the survey sample size, the Director of Commissioning confirmed that questionnaires had been sent out and discussions had taken place with people who used the services. Surveys were carried out in every hub and people were encouraged to complete them. She concluded that the CCG had to look at the budget and how to make best use of the funding available. The service was not quite right and did require a variation in each area.

The Chairman asked that GPs and the role they played was considered. Following on from Councillors Bell's earlier point, he reiterated that the changes should not go out to consultation at this time as the figures and survey numbers were flawed.

Councillor Patterson pointed out that it had only been 18 months since the urgent care review had been set up and she felt that the CCG should undertake an investigation as to why the hubs had failed and the reasons behind that. She said that the small numbers involved in the survey responses did not justify the recommendations for change.

Referring to the fall in numbers at the urgent care centres, Councillor Temple was not convinced that removing centralised services would be the best option especially since it had only been a short period since this preferred system was introduced.

The Director of Commissioning confirmed that there had been the same level of publicity carried out in every area. The analysis of the data results varied across the geography and she could not see that changing. The public had been informed of talk before you walk, which was a clear and key message delivered as part of the process. A lot of hard work had been put in to try to get people to complete the surveys however as low numbers are often seen across the County they did expect the low return. She did understand the concerns expressed about the website.

Councillor Grant reiterated the point that the 111 service were not highlighting some of the hubs as having urgent care available.

The Director of Commissioning responded that publicity had not been carried out in the way in which the committee were now asking for but in a way that was previously agreed. The message was to talk before you walk and this had been circulated to every household in DDES and the surrounding areas. This had been in line with the regional and national approach taken to talk before you walk. She advised that there had been leaflet drops and a radio campaign and that they would carry out far reaching engagement on the proposed changes. She added that she could not see how the result would be different.

Councillor Bell asked that the proposals be put on hold until the publicity of these services was addressed and that a greater emphasis be put on collecting data.

With reference to the website, the Acting Associate Director of Marketing and Communications, CDDFT responded that there was a reference group at the Richardson Hospital and they looked at all of the information available. A separate Task & Finish Group was also set up to look at the recommendations. She confirmed that the website had been updated, that there had been pro-active communication for the Richardson Hospital and that any concerns were being addressed by the Task & Finish Group.

The Chairman confirmed that the Committee were asking for the changes to be put on hold until all of the issues raised had been addressed, and for a report to come back to Committee.

Resolved:
That the report and presentation be noted and that the Committee recommend to DDES CCG that the proposed review of Primary Care Support Services and the associated communications and engagement activity be paused for a period of 9 months to allow for more robust patient/stakeholder engagement activity to be undertaken along with a review of the referral practices being adopted by NHS 111 service to ensure that local residents are able to access urgent appointments in primary care services within their locality and that these services are being actively promoted by the CCG.

9 Adult and Health Services Update

The Committee considered a report of the Corporate Director of Adult and Health Services that provided an update on developments across Adult and Health Services (for copy see file of minutes).

The Interim Head of Adult Care highlighted the seven key principles outlining the Social Care green paper that would help to build on integration of health and social care. A new post of Director of Integrated Community Services had been advertised to help develop a joint strategic commissioning function and integrated governance arrangements for the County. Members were advised of the seven key areas for better care fund money, and of the short term improved better care fund that would be pooled into a one off grant. This money was ring fenced over a three year period and would help to support and enhance services. With reference to delayed transfers of care it was reported that Durham had the 4th lowest rate in England. Further areas of the report were highlighted including prevention, mental health, local safeguarding peer review, learning disability transformation programme for the north east, 14+year transitions review, fee rates for residential and nursing care provision and supported living.

The Interim Head of Adult Care advised of an event held to mark World Social Work Day to reflect on the work carried out and to celebrate the contribution they make to people's lives.

In response to a question from Councillor Bell about where to find people to recruit to the roles of rural care workers in County Durham, the Interim Head of Adult Care responded that a number of areas had been looked at including developing the roles of personal care

assistants. Those people who already supported a neighbour or relative could be remunerated and could assist in less travelling times.

Councillor Quinn supported this idea but suggested that the post should be ring fenced for those staff potentially affected. The Interim Head of Adult Care explained that they held a register of personal assistants who could take on this extra work.

Resolved:

(i) That the report be noted.

(ii) That to receive further updates in relation to Adult and Health Service developments be agreed on a six monthly basis.

10 Public Health Update

The Chairman advised that this item had been withdrawn from the agenda and would come back to a future meeting.

11 Quarter 4 2017/18 Performance Management

The Committee considered a report of the Director of Transformation and Partnerships that 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 fourth quarter of 2017/18 financial year, covering the period January to March 2018 (for copy see file of minutes).

The Strategy Team Leader advised that smoking cessation had exceeded the target and breastfeeding prevalence was up from last year however still remained low. Some active promotion was taking place around this area. Under 18 conceptions were reducing and Public Health would be undertaking some intelligence work to analyse data in hotspot areas in the County.

The Principal Overview and Scrutiny Officer asked if there had been any specific studies on e-cigarettes and usage by school children. In response, the Strategy Team Leader advised that there had been lots of studies carried out and she would send a briefing note to circulate to the Committee. Councillor Crute suggested that this also be shared with Children and Young People's Overview and Scrutiny Committee.

Resolved:

That the report be received and an item be included in the Committee's work programme in respect to hospital discharge planning and co-ordination with rehabilitation and reablement services.

12 NHS Foundation Trust 2017/18 Quality Accounts

The Committee considered a report of the Director of Transformation and partnerships that informed of the responses made in respect of NHS Foundation Trust Draft Quality Accounts 2017/18 (for copy see file of Minutes).

Resolved:

(i) That the report be noted.

(ii) That the responses to NHS Organisations' draft Quality Accounts be endorsed.

13 Council Plan 2016-19: Refresh of the Adults Wellbeing and Health Overview and Scrutiny Work Programme

The Committee considered a report of the Director of Transformation and Partnerships which invited Members to consider and agree an updated Work Programme for the Adults Wellbeing and Health Overview and Scrutiny Committee for 2018-19 (for copy see file of minutes).

Members were advised that the initial review of the work programme had identified the level of activity required with the NHS Commissioning bodies and provider bodies. It had been suggested by members to look closely at the work and activity of the health provider and the promotion of activity such as through the Wellbeing for Life Service. Members were advised that the work programme would be flexible and therefore subject to change going forward.

Resolved:

That the proposed work programme for 2018-19 for the Adults Wellbeing and Health OSC be agreed subject to the inclusion of the Wellbeing for Life service as a future item for consideration.

DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Special Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in **Committee Room 2 - County Hall, Durham** on **Friday 7 September 2018** at **9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, R Bell, P Crathorne, R Crute, J Grant, T Henderson, A Hopgood, K Liddell, A Patterson, S Quinn, A Reed, A Savory, H Smith, L Taylor, O Temple and C Wilson

Co-opted Members:
Mrs R Hassoon and Mr D J Taylor Gooby

Also Present:
Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors G Darkes, E Huntington, C Kay and M Simmons.

2 Substitute Members

There were no substitute Members.

3 Declarations of Interest

Councillor A Savory declared an interest in respect of the item in relation to Community Hospitals Update as Chairman of Friends of Weardale Community Hospital.

4 Any Items from Co-opted Members or Interested Parties

The Principal Overview and Scrutiny Officer, Stephen Gwillym noted that Mr David Taylor-Gooby, Co-opted Member of the Committee, had submitted the following:

"As you are aware the community services in Durham are being reorganised following the new contract. I have been informed that this results in some services being relocated as Durham is reorganising the contract. I would like the Overview and Scrutiny Committee to look at this if possible to ascertain the effects on patients".

However, due to the number of important items on the agenda, it was noted that D Taylor-Gooby would wish for the issue to be discussed at a future meeting of the Committee as part of the work programme.

5 Community Hospitals Update

The Chairman introduced the Director of Integrated Community Services, Lesley Jeavons and asked her to present an update report on Community Hospitals (for copy see file of minutes).

The Director of Integrated Community Services reminded Members that she had attended Committee in May this year with a report on Community Hospitals and now had a further update in that respect. She reminded Members that back in April 2017 that Senior Officers from the County Durham and Darlington Foundation Trust (CDDFT) and North Durham and Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Groups (CCGs) had met and requested that consideration be given to the role and function of part of the Community Hospitals offer across County Durham, with a view to recommending options for service delivery over a medium to long term.

Members were referred to a table at Paragraph 3 within the report, setting out the complex tenure and mix within the Community Hospital estate in the County. The Committee noted previous reviews and the funding arrangements in terms of those via block contract and those via a payment by admission.

The Director of Integrated Community Services referred Members to Appendix 2 to the report which set out the current position in terms of bed use at the Community Hospitals. It was added that work undertaken had shown that some patients had experienced two discharges prior to returning home, with patients coming from acute sites to intermediate care where it may have been possible for them to return home in the first instance. Members noted that the ethos in Durham was "home first" and that this would be possible more as community services developed.

Members were referred to the types of staffing and medical cover provided at the Community Hospitals across the County and of important service development opportunities as the emphasis shifted away from acute hospital environments and to a service closer to a patient's home.

The Committee learned as regards issues in relation to therapy, day hospital functions, delayed transfers of care and other services delivered from Community Hospitals. Members were reminded of the Teams Around Patients (TAPs) initiative and how this was linked to more services being provided in local communities.

The Director of Integrated Community Services noted that since reducing the bed base in September 2017 across three of the hospitals, the remaining beds were operating at an effective level and there was a flexibility to be able to open additional beds in times of surge and increased activity.

She added there was the link to TAPs and that the recommendation from the previous Director of Integration had been for no change, noting the ongoing work in terms of Shotley Bridge Hospital, which was subject to a separate report for consideration by Members at today's meeting. It was noted that there would be additional work undertaken in terms of looking at internal efficiencies and that there would be continued monitoring in terms of the bed use within Community Hospitals to inform whether the bed base was being utilised effectively.

The Chairman thanked the Director of Integrated Community Services and asked Members for their questions and comments on the report.

Councillor R Bell asked as regards those elements of the estate that were subject to Private Finance Initiatives (PFI) and whether once the period of payments had completed was the building owned by the Foundation Trust. Councillor R Bell noted that the strategic direction seemed to be to look to discharge straight from acute care to the home wherever possible and asked how local communities would "know" as regards those patients and how local people would know that the relevant community services were in place, what safeguards were in place.

Councillor R Crute noted that the table at Paragraph 3 referred to bed compliment, however, the report in the agenda pack in connection to Shotley Bridge Hospital stated that less than 24 beds was "not effective" and asked as regards the differing statements.

The Chief Executive Officer, CDDFT, Sue Jacques noted that in respect of PFI, once the payments had been made the property would transfer to the NHS, with significant savings from that point.

The Director of Integrated Community Services noted in terms of local communities knowing about the role of Community Inpatient Beds and the new "Teams around Patients" model, there was a job to be done in terms of the publicity of services as part of the mobilisation and transformation process, and this had been identified. She added that this was an area the Committee may wish to monitor and noted she would be happy to come back to update Members in relation to progress, uptake and outcomes. She noted that from surveys and interviews it would be possible to add information in terms of peoples' actual experiences of community services. The Chief Clinical Officer, DDES CCG, Dr S Findlay noted that access to the TAPs was not direct, rather there would be referral via GPs and District Nurses and therefore there would be a coordinated flow overseen by the relevant professionals.

The Director of Integrated Community Services noted that in terms of bed compliment that how beds were used in the future would be reviewed at that time. Councillor R Crute noted that Members needed some definitive advice in terms of numbers that were cost effective and that there were concerns that the inpatient beds numbers within Community Hospitals could be linked to their long term sustainability.

Councillor R Bell supported Councillor R Crute in terms of being able to understand what "critical mass" was required and that this was an issue to be watched very carefully. Mr D Taylor-Gooby noted all involved "wanted it to work", however, there was a need for information on how it would work, as there had been an aspiration in terms of this for a long time and there was a need to have the public's confidence.

Resolved:

(i) That the update report be received for information.
(ii) That the work underway to utilise space across the estate be noted.
(iii) That a further report be brought back to the Committee which sets out the performance management framework which was to be established around the Teams around Patients model and how this was delivering improved healthcare outcomes for patients.

The Chairman noted that Item 7 on the agenda, in relation to the Review of Specialised Vascular Services, would be taken as the next item, Item 6, with the Shotley Bridge report to be taken after as Item 7.

6 NHS England Review of Specialised Vascular Services

The Chairman introduced those in attendance for this item and asked Mr Phil Davey, Clinical Lead and Vascular Consultant, CDDFT to give an update presentation in relation to the NHS England Review of Specialised Vascular Services (for copy see file of minutes).

Mr P Davey noted the background in terms of the NHS England Review and previous attendance at the Committee. He reminded Members of similar reviews in Manchester and Yorkshire and that the aim was for good staff and facilities to deliver good outcomes, while still helping locally in terms of repatriation after surgery. Members noted the proposed hub and spoke model as described at a meeting of the Committee on 6 July 2018 with the reduction from 4 to 3 specialised vascular services centres in the North East, those being Middlesbrough, Newcastle and one other. It was reiterated that the review had not been critical of services, however, the case for Sunderland had been made in terms of capacity and infrastructure, including theatres, imaging and its Integrated Critical Care Unit (ICCU). Mr P Davey added that in terms of geography and population travel times from secondary care were shown to be less than one hour, and also it had been noted the networks in place at Sunderland were felt to be superior to those at Durham. He added that the co-location of services at Sunderland, renal and interventional cardiology, also counted in Sunderland's favour.

Members noted: the data in terms of vascular in-patient activity had been refreshed for 2017/18; the outcomes of the work carried out by NHS England regarding travel times; the outcome of the travel impact assessment and modelling carried out by the North East Ambulance Service (NEAS); and the outcome of the rapid self-assessment undertaken by CDDFT and City Hospitals Sunderland (CHS) on how they would be the third arterial centre. Mr P Davey referred Members to slides showing the relevant postcodes within the County, travel times and in-patient activity for 2017/18, including heat maps for elective and non-elective admissions.

Members noted the national standards and service specification “emergency access to vascular interventional radiology must be within 1 hour from initial consultation to intervention”, not 1 hour from a patient’s postcode to a centre. Members were given further information in terms of Abdominal Aortic Aneurysm (AAA) for 2018 by postcode, in-patient length of stay for 2016/17, and travel time differences between the University Hospital of North Durham (UHND) and Sunderland Royal Hospital (SRH) for key postcodes.

Mr P Davey referred Members to modelling carried out by NEAS in terms of impact from the proposed reconfiguring of vascular services, noting that there was effectively no impact in terms of category C1 or C2 patients, those most seriously ill.

The Committee were reminded of the rationale in terms of the interdependencies with renal and interventional cardiology, and their existing co-location at Sunderland. Members were referred to information in terms of the self-assessment and the differences in terms of costs, including capital, with the total for Sunderland being around £4million, and for Durham being around £35 million.

Members noted in summary: infrastructure was already in place at Sunderland to provide key interdependencies; current networking arrangements in place at Sunderland; the majority of care would continue to be delivered in Durham, out-patient, diagnostics and day cases; the service in Sunderland would be fully compliant including travel times for emergencies; work by NEAS showed minimal impact on emergency travel times; and self-assessments had shown a significant impact on moving services to Durham in terms of finance and impact, for example renal services.

Mr P Davey noted that following the additional analysis since the July meeting of the Committee, the view had been confirmed that: clinical consensus had been reached in terms of a 3 centre model to provide the best possible care/outcomes for patients; the only viable clinical option was for the third centre to be located at Sunderland for the reasons stated, this being supported by commissioners, both Trusts and the Vascular Network; the proposals fit with NHS England’s national service specification; and that travel impact assessment demonstrated some additional travel time for patients and carers, but this was mitigated as lengths of stay were relatively short and patients would be repatriated where clinically appropriate to do so.

The Chairman asked the Medical Director, NHS England, Mr Chris Gray to speak in relation to the report and presentation. Mr C Gray noted NHS England were reassured in terms of the service change, with the solution proposed meeting the outcomes now and for the future. He added it was shown that Sunderland had the capacity and services needed and added that importantly there was commitment from both Durham and Sunderland to make the proposals work.

The Chairman thanked the speakers, and also all those involved in the additional work in bringing further information to the Committee. The Chairman noted that it was the role of Overview and Scrutiny and Elected Members to represent the people of County Durham and to ensure the viability of UHND for the future. He asked Members of the Committee for their questions and comments on the presentation.

Councillor R Bell noted the strong clinical case for Sunderland to be the third specialist vascular services centre, and noted the small proportion of emergency cases from those key postcodes as set out. He added that he disputed that the difference between UHND and CHS from those postcodes as being an additional 10 minutes and noted that this was proposed to be mitigated by NEAS by "an adjustment in resources levels". He asked what this adjustment would be, for example faster response time from NEAS. The Director of Commissioning and Development, North Durham CCG, Michael Houghton noted this did not mean an additional resource, rather NEAS would look at how resources were utilised operationally and adjust accordingly.
Councillor R Bell added that he felt that the Committee should formally ask for follow up information from NEAS, with a mind to a formal agreement in terms of this.

Councillor A Patterson noted she felt the proposals represented a significant change with significant impacts. She added she would also challenge the accuracy of some of the travel times quoted, feeling it had been a desktop exercise, not taking into account the actual geography, traffic levels or road infrastructure. She referred to the heat maps relating to elective patients, as set out in the presentation, and noted that many from the west of the County could be considered to be closer in travel time to Newcastle or Middlesbrough and they may elect to go to those hospitals rather than Sunderland or indeed Durham. Mr P Davey highlighted that the heat maps referred to in-patient activity and added that for around every 4,000 patients only one-sixth required to be in-patient. He noted that for the 60 patients that had attended Bishop Auckland for example that this would equate to in terms of the proposed model that only 10 patients would need to be admitted to Sunderland, with the remaining 50 patients being treated in the same way they would be now, via services at Bishop Auckland or UHND. The Regional Director of Specialised Commissioning North, NHS England, Robert Cornall added that the pathway for those needing surgery was proposed to be via Sunderland, and if not requiring surgery they would remain to be treated locally at Durham.

R Hassoon noted concerns, from experience, in terms of proposed repatriation after surgery and asked as regards assessments carried out before this process. Mr P Davey noted that such repatriation would only be once a vascular care episode had been completed, patients would not be moved if further care was required.

Councillor H Smith noted the additional information had been useful and agreed that the clinical case for Sunderland had been made overwhelmingly, as had the financial case. She noted however that from the perspective of the DL12 and DL13 postcodes that the travel times stated were hopelessly optimistic, especially when factoring in car parking issues and the public transport provision in those areas.

Councillor A Hopgood agreed as regards the clinical case, and added that indeed Members had understood this at the July meeting. She noted that she was not convinced in terms of the travel time issues, with an apparent change in definition of where the emergency was considered from. Councillor A Hopgood noted recent closures of the A19 over the summer period, at least one time every week, and asked if these incidents had been taken into account.

Councillor S Quinn noted issues previously discussed in terms of ambulance waiting times when dropping off at Accident and Emergency and whether this would also impact.

The Chairman noted this was an issue being looked at by Chief Executive Officer, CDDFT.

Councillor R Crute asked whether there was a particular reason for the recommendation in terms of endorsement from the Committee prior to engagement. The Chairman noted that the issue was regional and the Regional Director of Specialised Commissioning North added that the programme of engagement would inform on the process to help ameliorate impact. Councillor A Hopgood noted that informing was not the same as engagement. The Regional Director of Specialised Commissioning North noted that through the engagement process if points were raised then where possible some changes could be made.

The Principal Overview and Scrutiny Officer noted that the review was region-wide and that the North East Joint Health Scrutiny Committee had asked that information be provided to Durham County Council's Adults, Wellbeing and Health Overview and Scrutiny Committee. He noted the information in terms of the clinical case, the costs, the impact assessment from NEAS and the options in terms of the Committee. Councillor R Crute noted he felt there was no requirement for Members to endorse the proposals as set out, with the recommendation within the report asking for the Committee to receive the report and note and comment upon the presentation in terms of the proposals and associated communication and engagement plans. He added that he felt the comments from Members had been made clearly and could be added and taken forward. Councillor A Hopgood agreed that there was no recommendation to endorse the proposals, noting she accepted the clinical case, accepted the financial case, however did not accept the case in terms of travel times.

Resolved:

(i) That the Committee receive the report.
(ii) That the comments made on the report are communicated to NHS England's North Region Specialised Commissioning Team in respect of the proposals to reconfigure specialised and some non-specialised vascular services in the North East and the associated communications and engagement plans.

Councillor J Robinson left the meeting at 11.00am

Councillor J Chaplow Vice-Chair in the Chair

7 Shotley Bridge Hospital Update

The Vice-Chair introduced those in attendance for this item and asked the Director of Corporate Programmes, Delivery and Operations, North Durham CCG, Mike Brierley to give an update report in relation to Shotley Bridge Hospital (for copy see file of minutes).

The Director of Corporate Programmes, Delivery and Operations reminded Members of the background of the North Durham CCG working with NHS Property Services to look at what future service delivery options may look like, the right services in the right places.

It was highlighted that the driver for change was the current state of the building and there was an opportunity to align strategy to provide more care closer to home, through review of the actual health needs and future needs in the area.

Members were given information in relation to the economic and financial case for change, together with a clinical case for change, the latter including the changes in GP services, and the relationships between health and social care services, working closer together in delivering care, for example TAPs.
The Director of Corporate Programmes, Delivery and Operations noted a stakeholder event in October 2017 and Reference Group Meetings, with the group including local Members and MPs, with the Portfolio Holder, Councillor L Hovvels chairing the group. It was added that the Healthcare Planner had set out the requirements for a new build based upon current activity with a 10% allowance for population growth. Members noted the options as set out within the report and were informed of the issues in relation to beds, theatre, chemotherapy, urgent care and out-patients.

Councillor J Robinson entered the meeting at 11.10am

Councillor J Robinson in the Chair

The Director of Corporate Programmes, Delivery and Operations referred Members to the next steps as set out in the report, which included: an outline business case to NHS England by the end of 2018; public consultation in early 2019; a full business case Spring/Summer 2019; with construction later in 2019.

The Chairman thanked the Director of Corporate Programmes, Delivery and Operations and asked Members for their questions and comments.

Councillor O Temple noted he had not slept well since reading the report and noted two truths. Firstly that a six-storey high building was not right for modern healthcare, with local Members understanding this, however, there was an expectation that something comparable in terms of services would replace this. He noted secondly that all the statistics that had been fed into the Healthcare Planner had been from current activity at Shotley Bridge Hospital, which he felt had been run-down deliberately over a period of time. Councillor O Temple explained he felt that it should be need that was tested, not the number of people that passed through the door. He added that while paragraph 71 of the report stated “It is important to clarify that no decisions have been made about the future delivery of services within Shotley Bridge…”, paragraph 38 referred to a 24 bed ward, paragraph 41 referred to CDDFT and UHND stating they did not supportive of delivering surgical services at locations other than their main sites. Councillor O Temple added that paragraph 45 noted plans to refurbish and increase capacity at the Durham chemotherapy unit and in relation to urgent care, the report stated that urgent care was only recommended during the hours 8.00 am to 12.00 midnight. He noted that these all seemed to be decisions that have been made. Councillor O Temple asked that the Committee not accept the report, rather note the report and request that a postcode analysis based on need be undertaken and this fed into the Healthcare Planner.

The Director of Corporate Programmes, Delivery and Operations noted that in terms of any run-down of services, this was not the case and patients were not referred away from Shotley Bridge. He added that where an appointment may become available sooner at another location, this would be offered to a patient for them to make a choice. He continued by reiterating that there had not been any decisions made, and that in terms of bed provision there would be a need to provide cost-effective solution, with the recommendation being for 24 beds. The Director of Corporate Programmes, Delivery and Operations noted the refurbishment in terms of the UHND Chemotherapy Unit, however, decisions had not yet been made and work would be undertaken to understand this issue. In relation to urgent care, he added that there were many other strategies and that the options were for discussion, with the recommendation being based upon activity. The Director of Corporate Programmes, Delivery and Operations noted the first draft postcode analysis and added that further analysis work, utilising Public Health systems, may be undertaken, with some work having been done provisionally.

The Chairman asked as regards what would be in the business case. The Director of Corporate Programmes, Delivery and Operations noted it would include: the strategic case; the financial case; options; the consultation process; and engagement prior to moving to a preferred options stage.

Councillor R Crute asked what information had been presented via the Reference Group and what had been presented to Committee. Councillor R Bell noted he seconded the request by Councillor O Temple in relation to analysis by postcode of demand not simply activity. He added that by activity would be acceptable if there was not a sense that some were steered towards other services.

Councillor L Hovvels noted she chaired the Reference Group and noted that the model being developed was good. She added that Members' voices were being heard and that meaningful information was being provided to keep up-to-date on progress and affording an opportunity to shape that progress. Councillor O Temple noted he was grateful for the Reference Group.

Councillor J Chaplow noted the report referred to potential in relation to hospice provision. The Director of Corporate Programmes, Delivery and Operations noted this was one option and discussions were taking place.

Councillor A Hopgood noted paragraph 23 noted sharing of resources and facilities and added that if there was potential impact on UHND then local Members for the Durham area should also be engaged with, for example impacts in terms of infrastructure, car parking and so on.

Councillor A Patterson noted the report recommendation asked to accept the report for information, however, to have a report in terms of the next steps and options back at Committee prior to consultation, inviting the Reference Group Members to attend. Councillor O Temple agreed, with the inclusion of a report by demand and locality. The Director of Corporate Programmes, Delivery and Operations noted that this type of information was being worked on and could be reported back.

Resolved:

(i) That the report for information be noted.
(ii) That a further report be presented to a future meeting of the Adults, Wellbeing and Health Overview and Scrutiny Committee, including analysis of need by locality/postcode, with members of the Reference Group being invited to attend that meeting.

8 Review of Urgent Care Hubs across Durham Dales, Easington and Sedgefield CCG

The Chairman introduced those in attendance for this item and asked the Director of Commissioning, DDES CCG Sarah Burns to give a presentation in relation to the review of Urgent Care Hubs across DDES CCG (for copy see file of minutes).

The Director of Commissioning began by explaining the difference of Extended and Enhanced Primary Care Access (EPCA) and Urgent Care, with changes that had been made in April 2017 in terms of retaining minor injuries units at Bishop Auckland and Peterlee, expanded same day appointments during the day across DDES for illness, and evening and weekend hubs in 9 areas across the geography. It was noted this was to get the right care for individuals, with "right care, right place, right person, right time", and to "talk before you walk", access services via the NHS 111 telephone number.

Members were referred to a comparison in relation to services in DDES with those in North Durham, in terms of minor injuries units, GP out-of-hours services, and extended access hubs. It was explained that there were other services in place, including: additional same day appointments in General Practices; day time "overflow services"; out-of-hours service; Vulnerable Adults Wrap Around Services (VAWAS) extension 8am-8pm weekdays and weekends, with proactive visiting if GP has concerns; day-time visiting services, from October 2018; and seven day palliative care services, from October 2018.

In relation to how the NHS 111 service directs patients, it was noted that a Directory of Service (DoS) sets out the conditions seen by a particular service, and that they did not differ between each EPCA hub. It was added that patients presenting injury would go to a minor injuries unit, either Peterlee or Bishop Auckland, or an out of area service if that was closer. Figures from an audit in the Durham Dales for the period 1 April – 18 August were given, noting one instance where there had been a missed opportunity.

The Director of Commissioning introduced Dr David Robertson, a GP from Barnard Castle to speak in relation to how a General Practice worked.

Dr D Robertson thanked Members for the opportunity to speak and noted one of the main points to note was the burgeoning quantity of patients seen at General Practices, and there was an ageing population combined with a greater complexity with some patients having 3, 4 or 5 issues. He added that in these cases managing multiple medicines and dealing with longer term conditions were becoming more commonplace.

Dr D Robertson noted that it was important to understand that General Practices worked as a team, with a significant percentage of care being given by Nurses, Healthcare Assistants and Receptionists where appropriate, as well as outside of the practice for example via VAWAS or District Nurses. Members noted that while EPCA focused on same day appointments it was noted some chronic and day-to-day issues were being managed via EPCA. Dr D Robertson noted that there was a particular geography and cohort of people in the Dales area, and there was need to ensure that the needs of patients in this area was met.

Members were introduced to Craig Hay, Emergency Care Practitioner (ECP) who was in attendance to speak as regards the role of an ECP or Advanced Nurse Practitioner (ANP) in comparison to a GP. C Hay explained how ECPs and ANPs usually came from another discipline, for example from an A&E background, from the ambulance service or Practice Nurse and this gave them a broad range of experience in many types of patient from acute cases through to issues associated with elderly. Members noted that ECPs and ANPs worked with autonomy and had the ability to spot serious illness, with many also being able to proscribe. It was added that their decision making ability was an excellent asset to the GP provision and out in communities too. It was explained that not all issues could be addressed via ECPs or ANPs for example pregnancy issues or mental health issues, though there were other clinicians within the practice team that could assist with those areas. C Hay explained that NHS 111 were the gatekeepers in terms of service adding that they were very accurate and safe with the appropriate patients being directed to the ECPs and ANPs. He noted that while ECPAs were not A&Es and sometime patients felt they were at the wrong site, they were seeing the correct clinician.

The Director of Commissioning noted the work since attending Committee including: a consultation, communication and engagement strategy having been developed; meeting with the Chair and Vice-Chair of the Committee in terms of an evidence log; Healthwatch having agreed to provide independent advice; a “myth-buster” having been developed with information supporting the review; there has been substantial support from Patient Reference Groups (PRGs); and there had been meetings with key Councillors across DDES; work with NHS England on the “5 tests” and NHS England Assurance have support for our approach; there was further patient engagement undertaken.

The Director of Commissioning asked Angela Seward, Chair of the Durham Dales Patient Reference Group (DDPRG) and Chair of Barnard Castle GP Surgery Group to speak in relation to her experience. A Seward noted that it had been clear that the DDPRG had consulted at every turn and there had been a lot of data presented, including that during the April to July period the Stanhope/Barnard Castle hub saw no patients. She added that there had been some misunderstanding in terms of the Richardson Hospital, noting it was not a “walk-in”, rather appointments were made via NHS 111. A Seward noted that there had been consultation and the information that had been provided was clear, and the DDPRG supported the CCG in the proposed changes to help our rural population. The Director of Commissioning noted there had been similar PRGs within the Peterlee, Easington and Sedgefield areas.

Members were referred to slides highlighting the engagement and publicity undertaken, including on social media, regional publicity and via DDES Health Federations and displays within surgeries and via websites such as NHS Choices.

The Director of Commissioning noted in summary of the review: services are valued, but utilisation is very low in some areas; 111 received very positive feedback; current capacity was double the national recommended requirement; there were concerns as regards retaining staff in hubs where usage was low; value for money of current services was an issue given the health needs of the DDES population; and Practices are supportive of the proposed changes and think we could meet patients' needs in a different way. Members noted how the proposed services could look and were asked as regards what would enhance the proposals, and also noted how consultation would take place and what questions that would be put to patients.

The Chairman thanked the Director of Commissioning and the other speakers and asked Members for their questions and comments.

Councillor J Grant thanked the speakers for the clarity of their presentation and noted she felt there needed to be more publicity of the 111 and the hubs as another option other than a GP appointment, she noted that she had been asked to ring back to the GP surgery rather than the option of 111. Councillor S Quinn noted the opposite experience, with her GP surgery advising of the option to call 111.

Councillor R Bell noted promotion of the Richardson Community Hospital and felt it could be clearer as regards appointment only via 111 and that it did not treat injury, even via 111. The Director of Commissioning noted each hub had received the same publicity, with the regional message, and added that depending upon the clinical issue then each type of service would be appropriate, for example chest pains would perhaps warrant a 999 response. The Chief Clinical Officer, DDES CCG added that the entire region worked similarly, to go to the nearest service, with the DoS setting out where.

The Chairman noted that consultation, communication and engagement plan was set out from page 45 of the report and the Director of Commissioning noted the timescales in terms of consultation. Councillor R Bell noted that where 111 did not direct to a local centre, then the public should be made aware of what was available, to allow the public to challenge. The Chief Clinical Officer, DDES CCG noted that the DoS would set out suitable centres and Dr D Robertson noted his staff would look to see where a patient is directed to Bishop Auckland, whether it would be possible to direct to Barnard Castle.

The Principal Overview and Scrutiny Officer noted that given the concerns in terms of the missed opportunity and the proposed 6-8 week consultation, the Committee could take assurance and have further information over that period to monitor the situation.

R Hassoon asked as regards mental health provision at GP surgeries and noted she believed NHS Choices had been disbanded. Dr D Robertson noted that typically, though not always, ECPs and ANPs did not have mental health training and patients would be directed to a GP, for example if in the Dales area to Bishop Auckland. The Director of Commissioning noted that she would check as regards NHS Choices.

A Seward added that the Barnard Castle GP Surgery Group cared very much as regards the Richardson Community Hospital and wanted to understand the difference in services between EPCA and the Richardson.

Resolved:

(i) That the Committee receive the report and comment of the presentation and information contained therein.
(ii) That during the 6-8 consultation, information in terms of missed opportunities be recorded and monitored, and reported back to Committee at a future meeting.

9 HealthWatch County Durham Annual Report

The Chairman thanked the Project Lead, Healthwatch County Durham, Marianne Patterson and Mr Christopher Cunnington-Shore, Board Member of Healthwatch County Durham to present their annual report (for copy see file of minutes).

The Project Lead referred Members to the annual report as appended to the agenda papers and noted the background as regards the creation of Healthwatch as a consequence of the Health and Social Care Act 2012, to be an independent consumer champion and to push for change and improvements in health and social care. She added that all Local Authority areas had a "Healthwatch", with County Durham having a relatively small complement of 4½ FTE staff, albeit with a huge number of very active volunteers, including the Chairman and Board Members, including Mr C Cunnington-Shore.

Members noted an engagement statement was being worked upon and it was noted that over the first year it was clear the tone was for collaboration, and for Healthwatch to help gather meaningful feedback from service users, whilst still retaining independence, wanting outcomes for patients. Councillors noted work that had been undertaken including in terms of pharmacy services, powers to "enter and view", looking at high performing wards and UHND and seeing what lessons could be learned. It was added that Healthwatch had also provided information and signposting and had been asked by the Council to user-test in respect of data accessibility, with 6 recommendations having been taken on board. The Project Lead noted that Healthwatch County Durham was shortlisted for a Healthwatch England Award and learned as regards work in terms of barriers to Cancer Screening and Stroke Services.

Mr C Cunnington-Shore noted he felt it was important to understand what was meant by the phrases Healthwatch being "on board" and "engaged with". He felt it would be important for Healthwatch to let Overview and Scrutiny know as regards the level that Healthwatch had been involved in any issue and what support was given, and allow Overview and Scrutiny to challenge any assertions as regards engagement, consultation with Healthwatch.

Councillor R Bell asked if it was possible for Overview and Scrutiny to ask Healthwatch in terms of consultations. The Project Lead noted it was possible depending upon the issue and capacity.

The Principal Overview and Scrutiny Officer noted the requirements in terms of the 2012 Act and with the Committee inviting Healthwatch to the meetings in order to have a conduit for the exchange of information, with several examples and regular meetings of the Chair and Vice-Chair with Healthwatch representatives.

He added that it would be useful when the Committee was presented with cases for change that Healthwatch had been involved in the process, and not simply asked for a retrospective opinion.

Resolved:

That the Committee receive and note the presentation by Healthwatch County Durham in respect of their Annual Report 2017-18.

Adults Wellbeing and Health Overview and Scrutiny Committee

1 October 2018

Adults Wellbeing and Health OSC – Review of Suicide Rates and Mental Health and Wellbeing in County Durham

Report of Lorraine O'Donnell, Director of Transformation and Partnerships

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with supporting information to accompany a presentation on the findings, draft report and recommendations from the Committee's working group review into Suicide Rates and Mental Health and Wellbeing in County Durham.

Background

2 The review was undertaken between October 2016 and March 2017 following concerns identified by the Adults Wellbeing and Health OSC during consideration of Quarterly Performance Management reports which highlighted that suicide rates for County Durham were above the National and North East average figures.

3 Members examined statistics around suicides and suicide rates during a three year period 2012-14 in more detail rather than wider mental health illness or public mental health statistics. They also assessed 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.

4 Members considered evidence based on 4 key themes of service strategies, policies and plans of Durham County Council; NHS partners and Safe Durham Partnership together with how the community and voluntary sector is involved in supporting suicide prevention and the promotion of mental health and wellbeing.

5 Key findings and recommendations have been identified by the working group and are detailed within the attached draft report and will be highlighted within a presentation to members. Following consideration by the Committee, the report is scheduled to be presented to Cabinet and the Health and Wellbeing Board thereafter.

Recommendation

6 The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:-

1. receive this report;

2. note and comment on this report and the presentation including the key findings and draft recommendations;

3. Agree to submit the report to Cabinet and the Health and Wellbeing Board for consideration.

Background papers

None

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer
E-Mail: stephen.gwillym@durham.gov.uk 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 - None

Procurement - None

Disability Issues - None

Legal Implications – None

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Adults Wellbeing and Health Overview and Scrutiny Committee

Suicide Rates and Mental Health and Wellbeing in County Durham Review Report

September 2018

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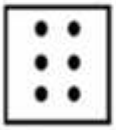
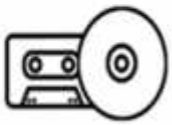
Scrutiny@Durham.gov.uk
03000 268145

 Braille  Audio  Large Print

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Foreword

We have known for some time that the North East of England and specifically areas within County Durham suffer from some of the poorest health and wellbeing measures within the country and that there is a significant gap between the life expectancy of men and women in County Durham and the England average. The rate of suicides within County Durham is higher when compared with the North East region and the England average which has prompted this review.

The Review was undertaken between October 2016 and March 2017 and the Review group examined key national strategies aimed at improving mental health and wellbeing and suicide prevention as well as those local strategies and services provided jointly by the County Council and its key partners across the NHS, the criminal justice system and the Community and Voluntary sector.

The Review Group identified key findings and recommendations which include; the importance of developing an early suicide alert system which is able to flag up those individuals at risk of suicide and which could be used to target preventative mental health services to such individuals in a proactive manner; the importance of a co-ordinated partnership approach to ensure access to preventative mental health services and mental health crisis services is timely and responsive. The need for partners to be able to share information and learning across organisational boundaries has also been highlighted as this is crucial to a co-ordinated approach to the delivery of successful mental health and wellbeing interventions and support services.

The Community and Voluntary sector have a huge role to play in improving health and wellbeing of the population of County Durham and the review has heard evidence from a range of CVS organisations. This highlighted positive practice across the County aimed at suicide prevention and tackling some of the wider determinants of health which can adversely impact upon a person's mental health and wellbeing including relationship breakdown, loss of employment, access to housing, financial hardship and education and training. Their ability to continue to deliver projects, services and interventions during what has been a prolonged period of austerity and funding pressures is a concern.

I would like to thank all those who took part in the review for their time and support especially representatives from the Council's Public Health team, colleagues from the NHS, representatives from the prison service and Durham Constabulary and particular thanks go to the CVS organisations who have given evidence to the Review Group.

Councillor John Robinson
Chairman
Adults Wellbeing and Health Overview and Scrutiny Committee

Executive Summary

1. This review was undertaken between October 2016 and March 2017 following concerns identified by the Adults Wellbeing and Health OSC during consideration of Quarterly Performance Management reports which highlighted that suicide rates for County Durham were above the National and North East average figures. Members examined statistics around suicides and suicide rates during a three year period 2012-14 in more detail rather than wider mental health illness or public mental health statistics. They also assessed 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. Members considered evidence based on 4 key themes of policies, processes and services of Durham County Council; NHS partners and Safe Durham Partnership together with how the community and voluntary sector is involved in supporting suicide prevention and the promotion of mental health and wellbeing.

2. For the period 2012-14, County Durham had the second highest suicide rate within the North East local authorities and the highest suicide rate amongst its CIPFA nearest neighbour local authority group. The 2012-14 Suicide Audit for County Durham Suicide rates in Durham (2012-14) were 20.6 per 100k population for males and 6.1 per 100k population for females. National figures are 14.1 and 4.0 per 100k population respectively. Durham and Derwentside are the areas with the greatest numbers of suicides although not statistically significantly higher than the County Durham average. The largest number of deaths by suicide occurred in the 40-49 age group with 33% of suicide victims employed at time of death and 31% unemployed. 34% of suicides cases lived alone**.**

3. 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. It set 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. A national mental health strategy, entitled “No Health without Mental Health” and its implementation framework set 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.

4. 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 actions set out within the Strategy include a refresh of the Public Mental Health Strategy for County Durham, including the development of a Suicide Prevention Framework and an associated action plan to improve outcomes for people experiencing mental health crises in the community and in custody.

5. The County Durham Public Mental Health Strategy is delivered through a multi-agency partnership involving Durham County Council, NHS Provider and Commissioning bodies, Durham Constabulary, Durham Prisons and a range of Community and Voluntary Organisations which reports to the Health and Wellbeing Board and Children and Families Trust. The County Durham Mental Health Implementation Plan sets out delivery priorities, governance structures and reporting responsibilities.

6. Key milestones within the plan include the implementation of Public Mental Health; Children's Mental Health and Dementia strategies; the delivery of a recovery college (TEWV FT); improved accommodation offers to support inpatient discharge; an improved mental health prevention service and improved crisis response service.

7. As part of the refresh of the Public Mental Health Strategy the Council needs to develop and implement a local suicide prevention strategy which delivers against the Government's suicide prevention strategy and includes key actions aimed at reducing suicides, ensuring the mental health support services are available and accessible to those at risk of suicide and promotes effective partnership working which includes the ability to share data and learning across agencies.

8. In terms of suicide prevention, the existing suicide early alert service promotes early support and interventions for those affected by suicide but should also be able to flag up those individuals at risk of suicide and which could be used to target preventative mental health services to such individuals. This should be explored as part of the development of the suicide prevention strategy and action plan.

9. When examining NHS Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing the working group have received numerous examples of effective partnership working across NHS Organisations including liaison between mental health and acute hospital services, there are improvements that have been identified which could lead to more effective suicide prevention, more timely service provision and interventions for those in crisis and/or at risk of suicide and a clearer crisis pathway and improved accessibility to mental health services.

10. The working group have heard that often those at risk of suicide are known to one or more of the emergency services be that the police or health. Difficulties have been reported in terms of organisations ability to share information across partners in respect of those at risk of self-harm or suicide as well as learning from those incidents of suicide. The working group consider that a multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies.

11. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

12. The working group are pleased to note the success of County Durham and Darlington NHS Foundation Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. It is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

13. The mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care has been identified as a much needed improvement in current processes. Often individuals are not aware of the services available to them to support their mental health and wellbeing and avoid crisis episodes. They also need guidance to explain how to access these services and whether they can self-refer into services or whether this needs to involve health professionals.

14. The Crisis Care Concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services. Whilst this is to be welcomed, the development of a single point of access to crisis services has been identified as a key gap in current crisis service provision.

15. When examining Safe Durham Partnership policies, processes and services for suicide prevention and the promotion of mental health and wellbeing it was noted that the prison service within County Durham has an effective process known as ACCT (Assessment, Care in Custody and Teamwork) which has been assessed as fit for purpose as an effective mechanism to identify, manage and support those at risk of suicide and self-harm with the prison environment. The process has been reviewed and a series of recommendation s have been implemented which look to improvement communication and awareness amongst staff along with increased training in the process.

16. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health amongst offenders.

17. A similar process has been examined as part of Durham Constabulary's detention and custody process with risk assessments routinely undertaken across their 4 custody suites. As part of this process routine checks are made across a range of databases and records and the group heard evidence of joint working between the Police and Health services including the new street triage service which aims to ensure that Police Officers have access to mental health professionals when detentions under S136 of the Mental Health Act 1983 are being considered.

18. Notwithstanding the above, issues experienced in the past in relation to data sharing between agencies and accessing patients' records/information which may result in delays in accessing treatment need to be addressed by ensuring that a process of case conferencing is in place.

19. Community and Voluntary Sector organisations play a significant role in suicide awareness, prevention and support for mental health and wellbeing. The Rapid Response Suicide Prevention project developed by MIND, CDDFT and Durham CCGs offers a rapid response suicide prevention counselling service which significantly reduces PHQ9 depression test scores and improves mental health and wellbeing. None of the 1649 clients referred into the service between 2011 and 2016 took their own life.

20. The If U Care Share Foundation offers a support after suicide service for those who have lost someone through suicide as well as a prevention referral service. Key areas of work include awareness raising of suicide within education services; shared lived experience of suicide to support those affected by suicide; advice and guidance to mental health support and crisis services.

21. Single Homeless Action Initiative in Durham (SHAID) identifies the wider determinants of health and their impact on mental health and wellbeing. Key groups supported include the homeless, people fleeing domestic violence; ex forces personnel, prison leavers and people with mental health diagnoses.

22. Durham Samaritans deliver listening services to those at risk of suicide, those affected by suicides and also work closely with media outlets to allow for sensitive reporting of suicides. Nationally they have developed teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. Work is undertaken with young people in schools, colleges and youth settings to offer advice on looking after emotional health and a national team of specially trained volunteers work with schools and colleges affected by suicide.

23. The key issue identified across the Community and Voluntary Sector is the funding available to support projects and ensure their sustainability. It is therefore important that an assessment of the effectiveness of CVS services and projects is undertaken to enable resources to be targeted to those which demonstrate the necessary outcomes have been delivered.

Recommendations

24. The review group having considered the findings and conclusions of the review have made the following recommendations:

Recommendation one

That a suicide prevention strategy and action plan be developed and implemented as part of the refresh of the Public Mental Health Strategy for County Durham and that progress against the action plan be monitored by the AWHOSC.

Recommendation two

The existing suicide early alert system, whilst providing excellent support and interventions for those affected by suicide after the event, needs to develop appropriate systems to flag up those at risk of suicide and which could be used to target preventative mental health services and support to such individuals.

Recommendation three

A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children's social care and health services, NHS services and those within the criminal justice system.

Recommendation four

The introduction of an appropriate coding/flagging system for self-harm/attempted suicide across all A&E department attendees should be promoted which identifies those potentially at risk of suicide and allows for proactive offers of access to mental health services and support

Recommendation five

The current processes for referral into mental health services be reviewed to ensure that there is clarity available to potential service users to help them to identify the range of services available, whether the services allow for self-referral as well as referral by health professionals and the associated target timeframes for accessing services.

Recommendation six

The accessibility of the out-of-hours mental health crisis service be reviewed to ensure that individuals suffering from crisis episodes have timely access to support and interventions.

Recommendation seven

An audit of current health and wellbeing support and services within the Community and Voluntary sector be undertaken to evaluate their effectiveness and enable resources to be targeted at those interventions where demonstrable outcomes for improved mental health and wellbeing and reduced suicide risk are evident.

Recommendation eight

That a systematic review of the report and progress made against recommendations should be undertaken after consideration of this report, within six months**.**

MAIN REPORT

Suicide Rates within County Durham – Statistical Analysis

Key Findings

- **For the period 2012-14 County Durham had the 2nd highest suicide rate in the North East and the highest in our CIPFA nearest neighbour group.**
- **Suicide rates in Durham (2012-14) were 20.6 per 100k population for males and 6.1 per 100k population for females – National figures are 14.1 and 4 respectively).**
- **The largest number of deaths by suicide occurred in the 40-49 age group.**
- **33% of suicides were employed at time of death and 31% unemployed.**
- **34% of suicides cases lived alone.**

25. Public Health England in its 2014 guidance for developing a local suicide prevention action plan identified local suicide audits as being an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots.

26. An audit of suicides through the systematic collection and analysis of local data on suicides provides valuable information to learn lessons and inform suicide prevention plans. In order to draw together meaningful numbers while still preserving the anonymity of those involved, a three year pool of data is used

27. The rate of suicide per 100,000 of the population is a performance indicator in the Public Health Outcomes Framework (PHOF).

28. Between 2001-03 and 2006-08 the rate of suicide within County Durham although slightly higher, was not statistically different from the England rate. However since 2007-09 the rate for County Durham has risen significantly more than that for England. County Durham has a suicide rate of 13.3 per 100,000 population for the 2012-14 aggregated data. This remains above the suicide rate for the North East (11.0 per 100,000 population) and significantly higher than the suicide rate for England (8.9 per 100,000).

29. For the period 2012-14, County Durham had the second highest suicide rate within the North East local authorities with only Middlesbrough higher. It also had the highest suicide rate amongst its CIPFA nearest neighbour local authority group.

30. The suicide audit considered by the working group showed that in 2012-14 suicide rates for males in County Durham stood at 20.6 per 100,000 population compared with the figures for the North East (17.9 per 100,000 population) and England (14.1 per 100,000 population).

31. In 2012-14 suicide rates for females in County Durham stood at 6.1 per 100,000 population compared with the figures for the North East (4.5 per 100,000 population) and England (4.0 per 100,000 population).

32. There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and were not included in the suicide audit analysis

33. Of the 190 deaths recorded in County Durham between 2012 and 2014 75% (142) were male and 25% (48) were female.

34. The geographical breakdown of numbers of suicides reveals Durham and Derwentside areas as areas with high numbers of suicides between 2012 and 2014. Removing the cases where the death has occurred in prison identifies the former Derwentside and Durham areas as having the highest numbers and rates across the three years although not statistically significantly higher than the County Durham average.

35. Of the suicides and undetermined injuries 67% of both male and female cases were of people who were under the age of 50 at time of death. The greatest numbers of deaths were seen in those aged 40 to 49 (in part due to the age structure of the county). Whilst suicide is relatively rare in children and young people there were nine deaths recorded in those 19 and younger. At the other end of the age distribution there were eight deaths by suicide or undetermined injury in those aged 70 years or more.

36. When examining employment status amongst suicides, around 33% (63) were employed at the time of death whereas 31% (59) were unemployed, 11% were retired and 7% were long-term sick or disabled.

37. In 34% (65) of cases the person lived alone at the time of death.

Conclusions

38. The statistical analysis shows that County Durham had a relatively high suicide rates with the majority of cases relating to those under 50 and male.

National and Local Strategic Context for Suicide Rates and Mental Health and Wellbeing – Key service strategies, policies and action plans

Key Findings

- **Government policy exists to prevent suicides and includes objectives to reduce suicide rates and provide better support for those bereaved or affected by suicides.**
- **"No Health without Mental Health" national strategy requires organisations to produce a local implementation framework;**
- **House of Commons Health Select Committee into suicide prevention has identified failings in delivering the Government's suicide prevention strategy;**
- **The County Durham Joint Health and Wellbeing Strategy 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. .**
- **The County Durham Mental Health Implementation Plan sets out delivery priorities, governance structures and reporting responsibilities.**
- **Key milestones within the plan include the implementation of Public Mental Health, Children's Mental Health and Dementia strategies; the delivery of a recovery college (TEWV FT); improved accommodation offers to support inpatient discharge; an improved mental health prevention service and improved crisis response service.**
- **The County Durham Public Mental Health Strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance and set out in the Government's national suicide prevention strategy.**

National Policy Context

39. 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.

40. 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.

41. 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.

42. There is also a national mental health strategy, published in 2011, entitled “No Health without Mental Health”. The strategy 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.

43. The publication of the national mental health strategy “No Health without Mental Health” in 2011 set out at a national level the following high level objectives to improve the mental health and wellbeing of the population:

- More people will have good mental health;
- More people with mental health problems will recover;
- More people with mental health problems will have good physical health;
- More people will have a positive experience of care and support;
- Fewer people will suffer avoidable harm;
- Fewer people will experience harm and stigma.

44. The House of Commons Health Committee Inquiry into suicide prevention produced an interim report in December 2016 which set out a number of key areas that the Government needed to take account of when refreshing its suicide prevention strategy. These included:-

- the refreshed Government strategy must be accompanied by a clear implementation plan, with strong external scrutiny of local authority plans and progress and that local authority suicide prevention plans are mandatory;

- the need for services to support people who are vulnerable to suicide;

- consensus statements on sharing information with families to ensure that there are opportunities to involve families and friends in a patients recovery;

- timely and consistent data is needed to enable swift responses to suspected suicides and to identify possible clusters in order to prevent further suicides;

- greater awareness amongst the media of data breaches regarding the reporting of suicides at national and local level together with restrictions to potentially harmful internet sites and content.

45. The Health Select Committee produced its final report in March 2017 and a response to that by Government was published in July 2017 which included reference to an updated cross-Government suicide prevention strategy.

Local Policy Context

46. 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 development of a Suicide Prevention Framework and working in partnership through the Crisis Care Concordat an associated action plan to improve outcomes for people experiencing mental health crises in the community and in custody.

47. The County Durham "No Health without Mental Health" local implementation plan 2014-17 is being delivered through a multi-agency partnership and sets out how the Council and its partners will deliver against the national strategy's objectives by developing and improving mental health services covering all ages. The Plan has been developed via the local Mental Health Partnership Board, which is a sub group of the Health and Wellbeing Board and involves a wide range of agencies and stakeholders.

48. To deliver against the national priorities identified in paragraph 41, a series of local priorities has been developed and will be aligned to a specific group as part of the established governance structure. These are summarised at Appendix 1 of this report.

49. Key milestones in delivering against the County Durham Mental Health Implementation Plan have been identified and progress reported to the review group includes:-

- Public Mental Health, Children's Mental Health and Dementia Strategies being implemented;
- Recovery College (real and virtual) being delivered by Tees Esk and Wear Valleys NHS Foundation Trust;
- Detailed work on accommodation options for people with mental health needs which includes a new service in Bishop Auckland and another being built in Meadowfield;
- Increase in move-on accommodation to support hospital discharge and recovery;
- Strategic review of Mental Health Prevention services with a new operating model to be developed and implemented in 2017;
- Improving crisis responses through the Crisis Care Concordat - funding awarded for a new crisis centre;

- Local Anti-Stigma and Discrimination group in place with a bid made for national funding from ‘Time to Change’
- Multi-agency ‘Active Durham’ partnership to increase levels of physical activity.

50. In considering how to progress work against the Plan further, the local Mental Health Partnership Board has suggested that the Council and partners should:-

- Rationalise the number of strategies and consolidate joint working;
- Develop and deliver the crisis response centre in Durham;
- Improve access to ‘talking therapies’ with CCGs;
- Ensure the ‘Durham Works’ programme promotes benefits to people with mental health needs;
- Continue development of specialist accommodation;
- Consolidate the ‘Recovery College’ and extend its benefits to a wider service user group to include GPs and the ability to self-refer into the service;
- Explore and promote ongoing work with Voluntary and Community Sector
- Explore the potential of Cultural Opportunities to improve mental health and wellbeing through dance, theatre, music, etc.

Suicide Prevention

51. The National Strategy “Preventing suicide in England 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.

52. Guidance issues by Public Health England (PHE) suggests that successful implementation of the national strategy at a local level relies on:-

1. Establishing a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations;
2. Developing a suicide prevention strategy and/or action plan that is based on the national strategy and local data, and
3. Completing a suicide audit.

53. The County Durham Public Mental Health Strategy vision states that “Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing”. The strategy’s key objectives are geared towards promoting mental health and wellbeing; prevention of mental health; early identification of those at risk of mental health and recovery form mental health.

54. Specific objectives related to suicide prevention include:-

Objective 1: Improve mental health and wellbeing of individuals through engagement, information, activities, access to services and education, and

Objective 3: Reduce the suicide and self-harm rate for County Durham.

55. The strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance referenced above.

56. Governance arrangements for the delivery of the Public Mental Health Strategy exist with the performance management framework aligned to the priorities identified within the strategy. The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board. Progress on the delivery of the strategy objectives and action is reported to the Children and Families Trust and the Health and Wellbeing Board.

57. The Suicide Audit considered by the Suicide Review Working Group covered the three year period 2012-14, the key findings of which are set out at paragraphs 25 to 38 of this report. The Audit involved the collection and collation of data by the Public Health team from a variety of partners including

58. Key services, interventions and programmes have been identified and developed which are aimed at delivering against those actions detailed within the Public Mental Health Strategy specifically related to Suicide prevention. These include:-

- The development of a Suicide early alert system to inform of a death from suicide and emerging trends and which promotes early support and interventions for those affected by suicide;
- Suicide Safer Communities County Durham – a helpline and website resource detailing a range of support services which includes bereavement counselling, relationship advice, suicide bereavement support;
- If U Care Share – a post-bereavement support service for families affected by suicide;
- The County Durham Sheds Programme – a project aimed at tackling loneliness and social isolation; financial and relationship problems initially aimed at men and based on an Australian model but now widened to include women and young people;
- Wellbeing for Life service – Commissioned by Durham County Council and delivered by five partners:- County Durham and Darlington NHS Foundation Trust; County Durham Culture and Sport; the Pioneering Care Partnership; Leisureworks and Durham Community Action. The service aims to empower individuals to say what is important to them and to support them make choices that will benefit them. Specific services available on either a 1 to 1 or group activity basis includes Getting more active; healthy eating/weight loss; smoking cessation; improving one's mental wellbeing; practical cooking; cancer awareness; volunteering; access to training; alcohol and drug awareness and how to access services in the community.

Conclusions

59. The County Durham Public Mental Health Strategy's key objectives are geared towards promoting mental health and wellbeing; prevention of mental health; early identification of those at risk of mental health and recovery from mental health. The strategy also details key objectives related to suicide prevention.

60. However, the strategy details a summarised action plan against the key objectives of the Public Mental Health Strategy rather than a specific suicide prevention action plan as recommended by the PHE guidance and set out in the Government's national suicide prevention strategy. The working group consider it important that a specific suicide prevention strategy and associated action plan be developed and implemented.

61. Whilst recognising the value of the existing suicide early alert system in terms of promoting early support and interventions for those affected by suicide, members of the working group consider that partners should work closely to develop an early alert system that would flag up those individuals at risk of suicide and which could be used to target mental health preventative services to such individuals. Such an early alert system could utilise information gathered from health services and the criminal justice system such as admissions to Accident and Emergency Departments, inpatient mental health services, mental health crisis services, drug and alcohol treatment services and those individuals within the Criminal justice system or released from prison/custodial sentences on parole. This should be explored as part of the development of the suicide prevention strategy and action plan

Recommendation one

62. That the County Council develop and implement a suicide prevention strategy and action plan as part of the refresh of the Public Mental Health Strategy for County Durham and that progress against the action plan be monitored by the AWHOSC.

Recommendation two

63. The existing suicide early alert system, whilst providing excellent support and interventions for those affected by suicide after the event, needs to develop appropriate systems to flag up those at risk of suicide and which could be used to target preventative mental health services and support to such individuals.

NHS Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing

Key Findings

- **Of the 190 suicides in County Durham (2012-14) 80 had been seen by GP services in the last three months of life; 54 had been seen by mental health services in the last three months of life and 39 had contact with A&E hospital services in the last year of life**.
- **Where individuals were seen by mental health services in the last six months of life a known diagnosis existed**.
- **TEWV NHS FT conduct an annual review of all serious incidents occurring within the Trust which when examined found no root cause with multiple factors identified including Post Traumatic Stress Disorder**; **access to mental health services; drug and alcohol abuse and chronic pre-existing health problems which impacted on mental health and wellbeing**.
- **The coding of patients presenting at A&E differs between those treat and discharged and those admitted – there is no diagnosis flag indicating intentional self-harm in the former but a sub code for this exists where patients are admitted.**
- **Coding of self-harm at A&E would potentially enable the identification of patients at risk of suicide and allow for proactive offers of access into mental health services to aid recovery and reduce the incidence of suicide.**
- **A positive element of A&E experience is the excellent relationship with rapid response access to the mental health liaison service between the hours of 08.00 a.m. and 10.00 p.m. There is an apparent gap in service provision between 10.00 p.m. and 08.00 a.m. once the mental health liaison team handover to the crisis team.**
- **A multi-agency "Crisis Care Concordat" is in place to improve the response to people in mental health crisis across services.**
- **The Concordat has introduce a number of initiatives aimed at enhancing access to mental health crisis services which include improving patient conveyance under the Mental Health Act 1983; crisis pathway mapping; the use of Section 136 "Places of Safety suites" and the implementation of a street triage model which allows for closer working between mental health professionals and the police.**

64. During the review, members have been eager to ascertain the level of engagement between health services and those individuals who had committed suicide in order to ascertain the effectiveness of diagnoses, access to preventative service and interventions and how those at risk of suicide could be identified and offered support.

65. Of the 190 suicides in County Durham between 2012 and 2014, a date of last contact with GP services was known in 125 cases. Of these cases 64% (80) were seen within three months of their death. The majority of these consultations may not have been directly related to suicidal ideation or mental health. In nine cases a suicide risk was noted in GP records, with a further 19 people having multiple risks noted. Previous attempted suicides were recorded in eight cases.

Tees, Esk and Wear Valleys NHS Foundation Trust

66. Of the 190 suicides in County Durham between 2012 and 2014, fifty percent of cases (95) had been referred to or were known to mental health services at some point in their lives. Of these individuals 63 had been seen in the 12 months prior to their death, with the majority (54 people, 57%) being seen in the three months prior to death. Of those referred to mental health services seven cases had never been seen.

67. Where cases had been seen by mental health services in the six months prior to death (57) a known diagnoses were:

Mental Health Diagnosis	Cases
Multiple diagnosis	7
Depressive illness	6
Bipolar affective disorder	Suppressed (less than or equal to 5)
Other (including personality disorder; Schizophrenia & other delusional disorders; Adjustment disorder/reaction; Anxiety/phobia/panic disorder/OCD; and drug misuse)	19

Mental Health Diagnosis 2012-14

68. Other and multiple diagnoses include:

- Depression, pathological jealousy, bi-polar and emotionally unstable personality disorder
- Alcohol and drug misuse
- Anxiety and Depression
- Bipolar Affective Disorder & Emotionally Unstable Dependant Personality Disorder
- HIV, Mental and Behavioural Disorder due to multiple drug use & use of other psychoactive substances
- Mixed anxiety, depressive disorder and schizophrenia

- Mixed anxiety and depression
- Alcohol dependence, suicidal idealisation, severe depressive disorder
- Psychotic depression, differential OCD
- Schizoaffective disorder, Personality Issues, Polydrug misuse
- Moderate depressive episode with somatic symptoms, low mood & anxiety
- Autism spectrum disorder (ASD) & Attention deficit hyperactivity disorder (ADHD)
- Mixed Anxiety and Depressive disorder
- Social anxiety & low mood

69. Tees Esk and Wear Valleys NHS FT undertake an annual review of all serious incidents which occur within the Trust to establish and identify areas of learning for the Trust and its staff. Procedures have been revised to ensure greater data reliability and the inclusion of a manual review of narrative issues in each incident. The Trust has identified that there can be flaws in the data due to delays arising from the coroner process and confirmation of verdicts into such incidents.

70. The data in respect of suicides and drug/substance related deaths requires further examination and any attempts to correlate the two should be treat with a degree of caution as it is often not known whether death was intentional.

71. The months of February, March, July and October have the highest numbers of serious incidents with the most common methods being hanging and overdose.

72. When the Trust looked for any key trends and issues arising from the investigation of serious incidents it found that:-

- No single identifiable root cause could be established;
- Improvements needed to be made in the documentation kept in respect of risk assessment and management of patients as well as the effectiveness and timeliness of record keeping;
- The involvement of family in the care of individuals could be considered;
- A number of incidents occurred when individuals were on leave from inpatient services and that the Trust were currently undertaking a thematic review of this issue;
- In a number of cases, patients have disclosed traumatic events that adversely impact upon their mental health and wellbeing and this has resulted in an identified need to reflect trauma questioning/counselling in staff training and development;
- A series of socio-economic factors including benefits, service reductions and access to social care and mental health services impacted on incidents;
- Mental health issues coupled with drug and alcohol misuse and the ineffectiveness of drug and alcohol treatment services could be linked to some incidents;

- Some individuals had pre-existing chronic physical health problems which often impacted on their mental health and wellbeing.

73. TEWV NHS Foundation Trust has reviewed these trends and embarked on a programme of actions at a Trust wide and locality level which aims to address some of the shortcomings identified during the examination of serious incidents. Actions across the Trust have been focussed on improving the existing Serious Incident review processes through enhanced governance arrangements; greater effectiveness in identifying improvement and learning from SI cases and also utilising learning from the National Confidential Enquiry into Suicide Harm and the Care Quality Commission's "Learning, candour and accountability" benchmarking.

74. Actions taken at a locality level have built on the Trust-wide learning through speciality level governance meetings within adult mental health services which includes quarterly adult mental health clinical incident reviews using "Plan, Do, Study, Apply" tools which promote change management based on learning from incidents. This process involves senior nurses, consultants and psychologists. The establishment of a Children's and Adolescent Mental Health Services (CAMHS) Crisis team has also enhanced the service provided to that age group.

75. The Working group examined the availability and accessibility of current mental health services involving TEWV. Concerns had been expressed by the working group regarding the accessibility of services, particularly whether there was open access to services or whether a referral process into the service was followed.

76. Across primary and secondary care the following services were available:-

- Community Intervention Teams – Open Access
- Crisis Teams – Open Access
- Mental Health liaison services – Accessed via Acute Trusts/A&E
- Veteran's services – Open Access
- Inpatient mental health services – Accessed through Crisis team referral
- Talking Changes (Accessing psychological therapies) – Open access

77. Members noted that these were supplemented by a range of "third sector/Community and Voluntary sector" services including links with crisis teams and MIND.

78. TEWV has identified a number of challenges facing the service, not least of which involve the current socio-economic climate and the stigma still attached to mental health conditions. The Trust is working to improve assurances that required changes identified within the Trust and its services are embedded at individual staff level. Pressures associated with capacity and demand across services must be managed alongside service user expectations as well as engaging those groups identified as hard to reach including LGBT and the Gypsy/Traveller Groups.

79. The Trust recognises the importance of continues and improved joint working across partners citing the work of the Crisis Care Concordat; the recovery college project, CVS support and ongoing work with the police which are all aimed at addressing current failings within the system including enhanced engagement across all partners; improved information sharing protocols and greater patient and family involvement in service developments.

County Durham and Darlington NHS Foundation Trust

80. Between 2012 and 2014, there were 39 cases of suicide which had contact with A&E/hospital services in the year prior to their death. While 10 were associated with overdose (of which we do not know the proportion which were intentional or indeed attempted suicide), the majority were from a range of conditions not necessarily associated with suicidal ideation or mental ill health.

81. Treatment for general medical conditions was the next most common cause of an A&E/hospital contact (six cases) followed by gastrointestinal (five cases). There were fewer than five cases per each of the remaining categories, including contact for reasons of mental illness or alcohol problems. 6 cases were known to have a psychological assessment prior to discharge.

82. The working group are aware of a range of services delivered either in partnership or directly by County Durham and Darlington NHS Foundation Trust (CDDFT) related to suicide prevention.

83. The wellbeing for life service adopts a model similar to the recovery model principles adopted by TEWV in respect of mental health and wellbeing improvement. Provided in partnership with the Pioneering Care Partnership, DCC Culture and Sport, Leisureworks and Durham Community Action, the wellbeing for life service follows the NICE stepped care model for the treatment of depression.

84. Since 1 April 2016 there have been over 2000 one-to-one contacts with the wellbeing for life service and CDDFT staff have received suicide ideation training and applied suicide intervention skills training.

85. CDDFT are also involved in the Talking Changes service commissioned by County Durham and Darlington CCGs and delivered jointly by TEWV, CDDFT and Mental Health Matters. This a self-help and talking therapies service designed to help anyone living in the County Durham and Darlington area to deal with common mental health problems such as stress, anxiety or depression, as well as panic, phobias, obsessive compulsive disorder (OCD) and post-traumatic stress disorder.

86. Offering a range of talking therapies, this free, confidential service is open to people aged 16 or over who live in County Durham or Darlington and whose mental health is causing them concern and is affecting an individual's

employment, health or home life. The service is not available if an individual is already accessing adult mental health services.

87. The service is part of the national improving access to psychological therapies (IAPT) programme and offers psychological interventions that include talking therapies and supported self-help programmes. Treatments currently include:-

- Step 2a Telephone Guided Self Help
- Step 2a Psycho-Education Groups
- Step 2b Face to Face Guided Self Help
- Step 3 Face to Face Cognitive Behavioural Therapy
- Step 3 Interpersonal Therapy
- Step 3 Eye Movement Desensitisation Therapy
- Step 2 / Step 3 Long Term Conditions Pathway
- Employment Support

88. Members were advised that around 10000 people per year access these services.

89. The Primary Care Psychology service delivered by CDDFT received 308 referrals during 2015/16 with 177 patients discharged in the first 2 quarters of 2016/17. The service treat patients including those with enduring trauma and personality disorder with the complexity and risk associated with their conditions assessed using a variety of mental health assessment tools. Patient's condition and outcomes are assessed pre and post treatment with success gauged by securing a reduction in the appropriate rating scores.

90. The working group were advised that the service was to be de-commissioned on 30 June 2017 and members were extremely concerned at the risk to patients' mental health and wellbeing and chances of securing improvements in their conditions with the cessation of this service as well as what replacement services were proposed.

91. There is a view that suicide is only associated with a person's mental health and that they relate to an associated mental health illness. The review heard evidence that within clinical (health) psychology, patients whose physical health condition deteriorates or who may have a physical disability can trigger thoughts about taking their own life. In such circumstances, the physical state of a patient is such that their quality of life may be poor and they feel unable to lead a "normal" life.

92. Several factors have been identified which may trigger such thoughts including:-

- not wanting to be a burden on their family and services as their disease/condition progresses;
- not wanting their family/spouse to witness them suffer;
- avoidance of experiencing deteriorating symptoms as their prognosis worsens;
- fear of increased pain;

- anxiety over financial implications especially if a person cannot work or has to move home due to their illness/disability;
- feeling in control about the end of their life when there has been little control or predictability in their health.

93. Many of these patients have never previously suffered with serious mental health problems and would simply view their suicidal thoughts as logical and as a way to lessen further suffering

94. CDDFT also provides a small clinical health psychology service aims to provide support to people who may experience such circumstances around a chronic physical illness.

95. Members heard evidence that with more publicity in recent years about assisted suicide, or people travelling to clinics such as Dignitas when they have a terminal condition, society in general may be more accepting of suicide when there is a physical illness perhaps because of this there is less stigma.

96. When a person has a physical condition/illness where the course is medically known to deteriorate (or an event where the person has been left with debilitating effects) these patients are perhaps more likely to have suicidal thoughts, so it is vital to ensure good support is in place. For example, in stroke, heart failure, Parkinson's disease, terminal cancer, COPD, uncontrolled diabetes, MS, HIV, motor neurone disease, and also in early stages of dementia.

97. Research suggests that patients are more likely to report suicidal thoughts soon after a diagnosis of a chronic or terminal condition. Often support is not available then, and the person's distress is not responded to appropriately. It is therefore vitally important for services like health psychology to be involved in the care of these patients, consulting with non-psychology healthcare staff to offer support and intervene in a timely manner.

98. In considering the role played by CDDFT in respect of suicide prevention and improving mental health and wellbeing, the working group have examined the procedures that exist within the Trust's Accident and Emergency Departments in Darlington Memorial Hospital and University Hospital North Durham and how these are used/able to identify suicide attempts and self-harm and highlight potential patient need for access to mental health services.

99. There is currently no relevant diagnosis flag within the A&E system that can give an indication of attempted suicide. What is coded is effectively the condition of the patient, for example overdoses would be covered by a poisoning diagnosis code but it would not be possible to tell from the data whether this was accidental or deliberate.

100. However, for inpatient clinical coding (where A&E patients are admitted) there is an intentional self-harm code that is used as a sub code alongside an eventual diagnoses.

101. Experience across the two A&E departments indicates that patients arrive via ambulance or the Police and that the department is seen as a place of safety even though this is not the best environment for a patient who is experiencing an acute crisis. With the ongoing pressures placed on the service, treatment is often seen as “patching up” rather than offering longer term mental health support that patients might need. Patients are also often keen to “just go” following their initial acute ED treatment although patients often end up staying overnight where a required mental health assessment is required.

102. The positive element of the A&E experience appears to be in respect of the excellent relationship with rapid response access to the mental health liaison service between the hours of 08.00 a.m. and 10.00 p.m. Unfortunately there is an apparent gap in service provision between 10.00 p.m. and 08.00 a.m. once the mental health liaison team handover to the crisis team.

103. CDDFT have effective liaison follow on arrangements with TEWV staff to deal with patients who need mental health support. For those patients at A&E who have experienced an identifiable self-harm event or where they feel that there is nowhere else to turn, a risk based assessment is made which can result in an offer of up to six follow up sessions as a brief intervention and solution focussed therapy.

104. For those patients who are admitted with for example delirium or dementia up to six weeks of community support post discharge can be made. There is also a potential onward referral to community psychiatric nurses/community mental health teams and mental health secondary care.

105. CDDFT acknowledges that there is an identified need to enhance the Trust’s role as an organisation in educating general medical staff in respect of mental health and wellbeing, suicide risk identification and prevention and associated mental health and wellbeing services.

106. Data collected from the Trust’s Safeguard incident management system in respect of serious untoward incidents for 2014/15; 2015/16 and 2016/17 (to December 2016) shows that there were 64 incidents over that period of which 2 were deemed to be suspected suicide. Both of these incidents were the subject of a root cause analysis and subsequent action planning.

107. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

108. The working group are pleased to note the success of the Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. The working group feel that it is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

109. The working group also acknowledged the work being done within the Trust to train employees on mental health awareness and suicide prevention and suggested that this needed to be systematic throughout the Trust.

Mental Health Crisis Care Concordat

110. The Mental Health Crisis Care Concordat is a partnership consisting of Durham Constabulary, Durham County Council, Darlington Borough Council, Tees, Esk and Wear Valleys NHS Foundation Trust, North East Ambulance Service, North Durham CCG, DDES CCG, Darlington CCG and voluntary and community sectors. The concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services.

111. The working group received information regarding three initiatives aimed at improving patient experiences during crisis episodes :-

- Patient conveyancing – the conveying of a patient who has been detained under the Mental Health Act 1983 and needs to go to hospital;

- Crisis pathway mapping – the mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care;

- Section 136 suites – usually called a place of safety, this is somewhere that a patient in crisis can be taken, usually by the police for assessment.

112. Improvements implemented for patient conveyancing involved the commissioning of a private ambulance provider to focus solely on attending mental health crisis incidents thus removing the risk which had been previously evident of NEAS ambulances being diverted to attend "blue light" calls which delays attendance at the mental health crisis incident. Whilst this has been commissioned by Durham and Darlington CCGs, it is possible that such a service could be commissioned regionally and thus benefit from economies of scale.

113. For crisis pathway mapping, work has been undertaken to map current mental health crisis services to establish what services need to be improved, what is working well and any gaps in services identified. Following this work, a

refreshed 2 year action plan for the Crisis Care Concordat has been developed focussing on prevention actions that avoid crisis episodes.

114. Nationally it has been accepted that the use of police cells as Section 136 suites (Places of Safety) is inappropriate and CCGs are required to reduce their use of police cells for this purpose and eliminate their use for those under 18 years of age.

115. The Crisis Care Concordat developed health based places of safety, one in Lanchester Road Hospital, Durham and one in West Park Hospital, Darlington which were staffed from the hospital wards. TEWV were given additional funding to enable them to staff the hospitals to a level where people could come off the wards into the s136 suite when required. The suites are used mainly by the police when they have picked someone up under s136 of the Mental Health Act and they need assessment in a place of safety.

116. Working jointly with the Police and TEWV, commissioners found that this model was ineffective in that it was not as easy as hoped to get a member of staff from a ward to the s136 suite quickly.

117. Consequently, the Concordat has developed a street triage model which involves TEWV staff (a mental health professional) working in the police force control room and out on the street in the car to provide support in cases where mental health issues may be a factor in a crisis incident.

118. The other major implication of the Policing and Crime Bill (which includes the prohibition of the use of Police Cells as Places of Safety for under 18s) is the reduction of time an individual can be held on a s.136 from 72 hours to 24 hours. This may have implications when someone under 18 has been assessed as needing admission but there is difficulty finding a bed. Also, there is a potential issue in obtaining an opinion from a second doctor should admission be required because there is a national shortage of doctors who are able to assess and admit. TEWV are working these issues through with commissioners.

119. Ongoing areas of development reported to the working group include the need to identify high intensity users of all emergency services. In mental health, these individuals invariably also use other emergency services (police, social services) frequently and the theory is that the response they are receiving is not helping them. If it were, they wouldn't ring back. People behave in this manner for a variety of reasons and the response they need will need to be individualised.

120. The Crisis Care Concordat aims to identify these individuals who are common to us all, then work out what they need to support them personally. We will then need to agree a way of identifying people who start to behave in this way and work out how we are going to support them as they become known to the services.

121. This will involve all statutory bodies working together and sharing information. This is complicated because of the laws surrounding information sharing and patient confidentiality.

122. The development of a single point of access to crisis services has been identified as a key gap in current crisis service provision. In a crisis scenario it has been suggested that currently patients are expected to work out if they are in a social crisis (and need social services support); an emotional crisis (and need support for that such as bereavement support or relationship counselling) or a clinical crisis (and are in need of support from the TEWV crisis team). This often leads to patients accessing services that are inappropriate to their crisis needs.

123. Crisis Care Concordat partners agree that one point of access is needed where patients can go and say they need help, then be given the time to talk through the help which they need so that they can be directed to the right place. This could be the patient themselves, or a third party. The service would receive self-referrals as well as referrals from other professionals (GPs could refer someone they are seeing for sleep problems but are concerned that there is a different underlying cause) as well as from the community and voluntary providers.

Conclusions

124. Whilst the working group have received numerous examples of effective partnership working across NHS Organisations including liaison between mental health and acute hospital services, there are improvements that have been identified which could lead to more effective suicide prevention, more timely service provision and interventions for those in crisis and/or at risk of suicide and a clearer crisis pathway and improved accessibility to mental health services.

125. The working group have heard that often those at risk of suicide are known to one or more of the emergency services be that the police or health. Difficulties have been reported in terms of organisations ability to share information across partners in respect of those at risk of self-harm or suicide or alternatively learning from those incidents of suicide. The working group consider that a multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies.

126. The working group are concerned that there is no diagnosis flag within the A&E system that could give an indication of attempted suicide for patients who present at A&E but who are not admitted. This presents a risk to such patients in that they may not be offered access to mental health services at an early stage which could improve their chance of recovery and prevent potential for suicide.

127. The working group are pleased to note the success of the Trust's work with TEWV NHS FT liaison team in ensuring that those patients who have been

admitted and have been identified with an intentional self-harm code are able to access mental health services. However it is noted that this appears to be more effective from 08.00 a.m. until 10.00 p.m. with a liaison gap having been identified when the team handover to the crisis team. It is essential that a consistent level of service should be provided 24/7 to mitigate against risks of potential self-harm and suicide during crisis episodes.

128. The mapping out of services to support individuals escalating towards clinical crisis and averting the crisis or ensuring the person is helped into the right clinical care has been identified as a much needed improvement in current processes. Often individuals are not aware of the services available to them to support their mental health and wellbeing and avoid crisis episodes. They also need guidance to explain how to access these services and whether they can self-refer into services or whether this needs to involve health professionals.

129. The Crisis Care Concordat is a commitment made by all partners to joint working to improve the response to people in mental health crisis across services. Whilst this is to be welcomed, the development of a single point of access to crisis services has been identified as a key gap in current crisis service provision.

Recommendation three

130. A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children's social care and health services, NHS services and those within the criminal justice system.

Recommendation four

131. The introduction of an appropriate coding/flagging system for self-harm/attempted suicide across all A&E department attendees should be promoted which identifies those potentially at risk of suicide and allows for proactive offers of access to mental health services and support.

Recommendation five

132. The current processes for referral into mental health services be reviewed to ensure that there is clarity available to potential service users to help them to identify the range of services available, whether the services allow for self-referral as well as referral by health professionals and the associated target timeframes for accessing services.

Recommendation six

133. The accessibility of the out-of-hours mental health crisis service be reviewed to ensure that individuals suffering from crisis episodes have timely access to support and interventions.

Safe Durham Partnership - Policies, processes and services for suicide prevention and the promotion of mental health and wellbeing

Key Findings

- **Of the 190 suicides in County Durham (2012-14), 9 occurred in prison with a further 5 within a year of release from prison; 27 were known to the probation service and 97 were known to police prior to death with 24 having their last contact with police in the last three months of life.**
- **The prison service has reviewed and improved its Assessment, Care in Custody and Teamwork (ACCT) process which identifies, supports and manages those at risk of suicide or self-harm.**
- **Issues of prison officer staffing, the availability of psychoactive substances and an increase in prison violence have been suggested as reasons behind an increase in self-harm in prisons nationally.**
- **Whilst nationally suicides in or following custody are higher now that before 2012, there have been no deaths in police custody during 2012-14 and 2 following police custody.**
- **Durham Constabulary have an established detention and custody process which safeguards against suicide risk.**
- **The new street triage process is welcomed by Durham Constabulary although some issues are experienced regarding data sharing protocols between partners.**

134. As part of the review, the working group examined the extent to which those individuals who had committed suicide were known to the various parts of the criminal justice system.

135. Between 2012 and 2014 there were 9 deaths from suicide in prison. A further five suicides took place within a year of release from prison.

136. Only a minority of 14% (27) of suicide cases had ever been known to the Probation Services. Eight people had their last contact with the probation service within three months prior to their death and a further four people had contact a year prior to their death.

137. A small majority of cases (51%, 97) were known to the police prior to death. A quarter (24) had their last police contact within three months of death. A

further 18% (17) had their last contact with the police within a year of their death.

Suicide and Self Harm in Prisons

138. The Safe Durham Partnership Board undertook a prison suicide audit in 2016 specifically examining deaths by suicide at Low Newton Remand Centre; HMP Frankland and HMP Durham across the period January 2009 to December 2015. During this period there were 20 deaths by suicide within County Durham prisons, the highest number occurring in HMP Durham.

139. The Audit aimed to identify key areas within prisons where pathways may be improved to reduce the suicide risk within prisons

140. By utilising four case study reviews, findings showed that in these cases suicide risk factors were noted but that the prison emergency procedure (Code Black) was not implemented immediately.

141. Across the prisons, the emergency procedure has been changed and all staff are now trained in this procedure as well as receiving suicide prevention training also. All prisoners now have a suicide assessment upon entry to prison.

142. Additional recommendations from the audit included the inclusion of probation data within future audits; a transfer from prison to community pathway to be established; consent from individuals must be requested and medical information and suicide risk shared with GPs and probation within 24 hours of discharge.

143. Members noted the many vulnerable groups in prison populations including those with drug/alcohol issues, financial crisis, mental health problems and abuse all of which contribute to the risk of suicide. The prison service's own Assessment, Care in Custody and Teamwork (ACCT) process is considered to be fit for purpose as an effective system to identify, manage and support those at risk of suicide or self-harm, when it is applied properly.

144. Members note that for the last five years 35-40% of self-inflicted deaths within prisons have been of people within the ACCT process which indicates that the quality of care and supervision that is provided for prisoners on ACCT needs to be improved. The prison service also acknowledged their need to improve the identification of prisoners at risk.

145. A review of the ACCT process resulted in several recommendations being made in areas such as communications, national policies, process improvements and increase training all of which have been referenced in the Director of Public Sector Prisons' Suicide and Self Harm project. The project's objectives are:-

- Implementation of the ACCT review recommendations;

- Delivering improvement in the prison service early weeks in custody work;
- Improving identification of individuals at risk of self-harm and / or suicide;
- Addressing repeat Prison and Probation Ombudsman recommendations;
- Enhancing staff and partner involvement in supporting those at risk, providing clear operational guidance and information and by improving training packages;
- Developing appropriate interventions for male and female offenders;
- Increasing the evidence base and understanding of what drives self-harm and self-inflicted deaths.

146. Extensive work has been done to establish whether reasons for the increase in self-inflicted deaths can be identified. The National Offender Management Service's (NOMS) continuing work with partners and academics through the National Suicide Prevention Strategy Advisory Group and the Ministerial Board on Deaths in Custody is important in ensuring that the prison service learns from experience in other sectors.

147. There are also difficulties in quantifying the effect of other changes and challenges facing prisons and prisoners. Operational experience suggests that there is less predictability and familiarity in the prisoner experience with the reductions in overall prison officer headcount combined with vacancies and the use of detached duty. Other known challenges include the increase in the use of new psychoactive substances, which may have health implications for users, and relate to problems of indebtedness and violence which may increase feelings of despair or vulnerability. Violence in prisons has increased and feeling less safe in prison could also heighten fear or despair. Extensive programmes of work are tackling both these issues.

148. Analysis suggests that the reasons for the increase in self-inflicted deaths are complex and involve an interplay between heightened levels of vulnerability amongst prisoners as a cohort, and factors which may affect the way in which NOMS is managing these risks amongst prisoners. For example, operational feedback frequently identifies the challenges of convening timely case management conferences with all relevant partners, the challenges of releasing staff for training, and the need to support prisoners through key periods of vulnerability such as the first month in custody.

149. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health.

Durham Constabulary

150. Deaths in or following police custody include deaths that happen while a person is being arrested or taken into detention. It also includes deaths of people who have been arrested or have been detained by police under the

Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

151. This also includes deaths that happen:

- during or following police custody where injuries that contributed to the death happened during the period of detention;
- in or on the way to hospital (or other medical premises) following or during transfer from scene of arrest or police custody;
- as a result of injuries or other medical problems that are identified or that develop while a person is in custody;
- while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other related legislation

152. This does not include:

- suicides that occur after a person has been released from police custody;
- deaths that happen where the police are called to help medical staff to restrain individuals who are not under arrest.

153. Apparent suicides following Police Custody include apparent suicides that happen within two days of release from police custody. This category also includes apparent suicides that occur beyond two days of release from custody where the time spent in custody may be relevant to the death.

154. In examining the national picture in respect of deaths in or following police custody and apparent suicides following police custody, members found that the number of deaths in or following police custody had decreased to 14, similar to the levels observed in the three years before 2014/15.

155. The number of recorded apparent suicides following custody has decreased to 60 compared to 70 recorded in the previous year. This is the lowest figure recorded since 2012/13 when there was a notable increase in this category. However, it remains considerably higher than the average before 2012/13.

156. Reporting of these deaths relies on police forces making the link between an apparent suicide and a recent period in custody. The overall increase in these deaths over the 11 year period may therefore be influenced by improved identification and referral of such cases.

157. Of the 60 apparent suicides following police custody, 56 were male and four were female. More than half of the individuals (33) had known mental health concerns. Twenty-eight people were reported to be intoxicated with drugs and /or alcohol at the time of the arrest, or it featured heavily in their lifestyle. Eighteen apparent suicides occurred on the day of release from police custody, 24 occurred one day after release, and 16 occurred two days after release.

158. Twenty-two of those who died had been arrested for a sexual offence. Of these, 17 were in connection with sexual offences or indecent images involving children.

159. There were no deaths in custody within Durham Constabulary and 2 apparent suicides following police custody.

160. When examining the impact of mental health upon police activity within County Durham, out of an average of 15000 calls per month to Durham Constabulary's force control over 800 (5%) have a mental health need or component identified which equates to around 27 calls per day. Whilst this may not appear high, such calls take up an estimated 15 to 20% of an officer's time on duty, each requiring the attendance of 2 police personnel.

161. The use of police to convey individuals to places of safety designated under Section 136 of the Mental Health Act 1983 has been examined as part of the work of the Crisis Care Concordat referenced at Paragraph of this report. As stated earlier, the Policing and Crime Bill includes the prohibition of the use of Police Cells as Places of Safety for under 18s. There has been no such use of a police cell for under 18s since 2014 in County Durham.

162. In examining Durham Constabulary's detention and custody processes, members were advised that all persons arrested and detained in one of Durham Constabulary's 4 Custody Suites are risk assessed on arrival or as soon as practicable after arrival depending on that person's presenting behaviour. This covers questions around the following:-

- How are you feeling in yourself now?
- Do you have any illness or injury?
- Are you experiencing any mental ill health or depression?
- Would you like to speak to the doctor/nurse/paramedic (as appropriate)?
- Have you seen a doctor or been to a hospital for this illness or injury?
- Are you taking or supposed to be taking any tablets or medication? If yes, what are they and what are they for?
- Are you in contact with any medical or support service? If yes, what is the name of your contact or support worker there?
- Do you have a card that tells you who to contact in a crisis?
- Have you ever tried to harm yourself? If yes, how often, how long ago, how did you harm yourself, have you sought help?

163. Answering "Yes" to any of the questions will result in more detailed questioning around that area.

164. As part of the process the checks are made of the PNC, previous custody records, risk assessments and other parties such as the Arresting Officers, relatives, friends, legal representatives and medical professionals including Liaison and Diversion services.

165. All these as well as the answers from the detainee and their behavior/ demeanor affect the risk assessment. Key elements are those highlighted around alcohol/drug misuse and dependency as well as mental ill health including depression, and medical conditions and ailments.

166. If necessary formal assessments by trained health care practitioner's or force medical examiners take place, available 24/7. In addition there is access to criminal justice liaison nurses from Liaison and Diversion services who work within custody suites 7 days a week. Children and Adolescent Mental Health Services are also contactable 7 days a week as are the crisis team for advice/referrals. This helps to reduce the likelihood of suicide or self-harm both while detained and in preparation for release.

167. Pre-Release of a detainee is considered at an early stage in the process so that a suitable care plan, post release, is in place prior to release of the detainee. The custody officer is required to complete a pre-release risk assessment. They do not leave this until the point of release. Instead it is an ongoing process throughout detention and concluded at the point of release. This is in line with approved professional practice for detention and custody.

168. Custody officers refer to all existing risk assessment information for the detainee. They speak to all detainees prior to release to confirm suitable processes are in place prior to release to reduce the risk of suicide or self-harm. They then need to decide what action, if any, is appropriate to support vulnerable detainees upon release. This can be anything from making sure there are suitable transport arrangements and clothing available to release the detainee to ensuring there is the required support of parents, carers, or indeed referrals to Community Mental Health Teams, Alcohol or Drug dependency support schemes, local authorities regarding homelessness, GP services or hospitals for medical issues and referrals for service veterans.

169. Custody Officers are encouraged to reduce the risk of re-offending by actively considering alternatives to charge or formal Out of Court Disposals such as a caution where appropriate. An approach such as the Checkpoint program or restorative justice approaches, can also help address the issues that might be the root cause of that offending or behaviour such as alcohol, drugs, homelessness or dealing with mental health issues such as Post Traumatic Stress Disorder.

170. All Custody Sergeants receive training prior to being in post. This training received is approved by the College of Policing and forms part of the Detention and Custody Learning Program for Custody Sergeants. Custody Sergeants continue in post to receive 2 additional Continuous Professional Development days training each year as in addition to mandatory training refreshers around PST and First Aid. Training also covers mental health issues, risk assessment and Pre-Release.

171. Reference has been made within this report to the introduction of street triage service as a partnership between Durham Constabulary and Tees, Esk and Wear Valleys NHS Foundation Trust which aims to assist police officers in

accessing mental health professionals where s.136 detentions are being considered/carried out. This is particularly welcomed by Durham Constabulary in view of the demand being placed upon their service for such instances and the importance of appropriate access to mental health/crisis services.

172. The importance of joint working between Durham Constabulary and mental health practitioners cannot be overstated as problems have been experienced in the past regarding the protocol for data sharing between agencies and accessing patients records/information which may result in delays in accessing treatment.

173. Durham Constabulary are also key partners within the suicide and attempted suicide early alert process which commissions “If you care, share” to provide support to the families of suicide victims.

Conclusions

174. The prison service within County Durham has an effective process known as ACCT (Assessment, Care in Custody and Teamwork) which has been assessed as fit for purpose as an effective mechanism to identify, manage and support those at risk of suicide and self-harm with the prison environment. The process has been reviewed and a series of recommendations have been implemented which look to improvement communication and awareness amongst staff along with increased training in the process.

175. Work is underway to ensure that there is a greater integration between the criminal justice system and health/social care services particularly around multi-agency casework and information sharing regarding mental health amongst offenders.

176. A similar process has been examined as part of Durham Constabulary’s detention and custody process with risk assessments routinely undertaken across their 4 custody suites. As part of this process routine checks are made across a range of databases and records and the group heard evidence of joint working between the Police and Health services including the new street triage service which aims to ensure that Police Officers have access to mental health professionals when detentions under S136 of the Mental Health Act 1983 are being considered.

177. Notwithstanding the above, the problems experienced in the past in relation to data sharing between agencies and accessing patients’ records/information which may result in delays in accessing treatment needs to be addressed by ensuring that a process of case conferencing is in place.

Recommendation three

178. A multi-agency approach to develop learning from suicides is needed with case conferences introduced for each incident with shared learning across partner agencies including adult and children’s social care and health services, NHS services and those within the criminal justice system.

Suicide prevention and the promotion of mental health and wellbeing – Community and voluntary sector involvement and support networks

Key Findings

- **The Community and Voluntary Sector play a significant role in suicide awareness, prevention and support for mental health and wellbeing.**
- **The Rapid Response Suicide Prevention project developed by MIND, CDDFT and Durham CCGs offers a rapid response suicide prevention counselling service which significantly reduces PHQ9 scores and improves mental health and wellbeing. None of the 1649 clients referred into the service between 2011 and 2016 took their own life.**
- **The If U Care Share Foundation offers a support after suicide service for those who have lost someone through suicide as well as a prevention referral service. Key areas of work include awareness raising of suicide within education services; shared lived experience of suicide to support those affected by suicide; advice and guidance to mental health support and crisis services.**
- **Single Homeless Action Initiative in Durham (SHAID) identifies the wider determinants of health and their impact on mental health and wellbeing. Key groups supported include the homeless, people fleeing domestic violence; ex forces personnel, prison leavers and people with mental health diagnoses.**
- **Durham Samaritans deliver listening services to those at risk of suicide, those affected by suicides and also work closely with media outlets to allow for sensitive reporting of suicides.**
- **The Samaritans have developed teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. Work is undertaken with young people in schools, colleges and youth settings to offer advice on looking after emotional health and a national team of specially trained volunteers work with schools and colleges affected by suicide.**
- **The key issue identified across the Community and Voluntary Sector is the funding available to support projects and ensure their sustainability.**

179. In examining the extent and effectiveness of community involvement and support networks in identifying the risks and potential root causes associated with suicides, the working group received evidence from:-

- Darlington MIND

- If u Care Share Foundation
- Single Homeless Action Initiative in Durham (SHAID)
- Central Durham Samaritans

Darlington MIND – Rapid Response Suicide Prevention project (RRSSP)

180. The RRSSP was developed in response to a significant increase in the number of suicides within County Durham around 2010. The partnership project involved three local MIND associations (Darlington; Derwentside and Hartlepool and East Durham) together with County Durham and Darlington NHS Foundation Trust. The project was funded initially by NHS County Durham and Darlington (PCT) and more recently North Durham CCG and Durham Dales, Easington and Sedgefield CCG.

181. The project offers a rapid response suicide prevention counselling service for residents of County Durham or those registered with a County Durham GP. Referrals are received from the TEWV NHS FT Crisis or access teams only and aim to help those identified as at risk of or have attempted suicide but who do not need inpatient care.

182. Each referral is triaged within 24 hours with each client seen by a psychotherapist or counsellor within 5 working days of receipt of the referral, although in practice this is often quicker than that.

183. Clients are seen in either local MIND counselling rooms or in GP surgeries in their locality. The MIND facilities are in Stanley, Consett, Peterlee, Darlington, Newton Aycliffe or Durham City.

184. Clients are offered an initial assessment and up to six counselling sessions which can be weekly, monthly or more frequent depending on need with BACP registered psychotherapists or counsellors. A report is submitted back to the client's GP upon completion of the sessions and aim to provide an assessment of what longer term interventions may be necessary.

185. The project has a management board and robust governance arrangements.

186. Members learned that from July 2011 to December 2016, 1649 referrals had been made into the service with 818 referrals from North Durham CCG and 831 from the DDES CCG. Of the referrals, 56% were male and 44%were female which is quite different from the incidence of suicides across the gender groups.

187. The PHQ9 depression test scores for clients are taken at the start and end of the course of counselling with dramatic and positive results. Members noted that none of the clients referred to the service took their own lives during therapy with satisfaction levels above 95%. In terms of PHQ 9 scores, the most severe is 27 and after these sessions 90% of clients have scores under 10.

188. The project has been funded on an annual basis with the current contract running until March 2019. Whilst funding has not increased over the duration of the project, the number of referrals into the service is increasing with the largest number of referrals in a single month being 44.

189. Members note the concerns around the funding of the project and the success of the rapid response suicide prevention counselling service. Key risks identified by members include the importance of rapid referral into specialised mental health services following counselling where this is identified as necessary. Members have heard anecdotal evidence from service users about the pressure that existing mental health crisis teams are facing, the ability to access crisis services and the impact that this has on the timeliness of required interventions.

190. Reference has been made to the funding crisis in mental health services and the government promise for further investment in these services. However an integrated service is needed that addresses not just mental health but also contributing factors such as debt, housing need, social care, pain management, social isolation and employment.

If u Care, Share Foundation

191. The If U Care Share Foundation was established as a campaign in 2005 after the loss of a young man to suicide aged 19. It aims to provide prevention services, intervention and support after suicide. The service is linked to Durham Constabulary who offer referral into the service to those affected by suicide with services having grown due to an increase in demand for these services.

192. As at March 2017, 658 people had been referred into the Foundation's support after suicide service within County Durham after the loss of a loved one through suicide with 443 of these being female and 215 male. A further 172 prevention referrals have also been made.

193. The Foundation works at national and international level to raise awareness of suicide and suicide prevention. The Foundation provided evidence to the Government Health Select Committee on suicide prevention and this featured within the Committee's interim report into Suicide Prevention published in December 2016.

194. Key evidence provided to the parliamentary select Committee suggested that health professionals should consider how information about those who feel suicidal can be shared with families. Whilst acknowledging the importance of patient confidentiality, it has been suggested that encouraging the option to involve a trusted family members or friend could improve support and aid recovery.

195. The Foundation are members of the:-

- National Suicide Prevention Strategy Advisory Group

- All-party Parliamentary Group on Suicide and Self-harm prevention
- Support after Suicide Partnership
- International Association for Suicide prevention
- The Alliance of Suicide prevention charities.

196. The Foundation is a small organisation of 10 staff and volunteers who have been affected by suicide and have worked with over 14000 young people in respect of suicide prevention and mental health. Key issues identified by the Foundation during their work include:-

- The importance and need for education services to highlight/promote the availability of mental health crisis and support services to children and young people;
- The value of sharing lived experience stories with young people to encourage them to seek support and to increase awareness of the support that is available;
- The need to provide mental health support and access to interventions at an early stage;
- Concerns about the availability and sustainability of suicide prevention and support services in the ongoing climate of public sector funding cuts and government austerity measures;
- The availability of IAPT (Improved Access to Psychological Therapies) services and the long waits to access these services.

Single Homeless Action Initiative in Durham (SHAID)

197. During the course of the Review, members of the working group have commented on the wider determinants of health and wellbeing, noting the importance of employment, housing accommodation and social interaction as contributing to positive mental health and wellbeing. This report has previously identified that of the 190 deaths recorded in County Durham between 2012 and 2014, around 31% (59) were unemployed and in 34% (65) of cases the person lived alone at the time of death.

198. SHAID has worked with a number of priority groups identified as at risk of suicide including homeless people of all ages; women fleeing domestic violence; ex-Armed Forces homeless of all ages; LGBT clients; prison leavers; people with diagnosed mental health issues.

199. Key support services offered by SHAID, include: pre-tenancy advice; social isolation navigation; floating support; Plan 4 Life / DurhamWorks; St Peter's Court Armed Forces; Support Groups; Police, Crime and Victims' Commissioner (PCVC) recidivism housing programme.

200. The Working Group learned that 127 people had been helped with pre-tenancy advice and other interventions such as negotiations with landlords to stop tenancies ending. Other support included: access to furniture; securing energy suppliers; help in terms of accessing Housing Benefit and; challenging decisions from statutory services.

201. Councillors were reminded of the issue of social isolation, with SHAID having set up a social isolation navigator which looked to help any people who were lonely or isolated within the Derwentside area. It was explained that 187 people were supported face-to-face, above the target of 100, and it was added that the service was not a wellbeing service rather it looked to help individuals enrich their lives. Members noted many referral routes to the navigator with good buy-in from GPs, Pharmacists and the Police and Fire Service.

202. SHAID were a partner in the DurhamWorks programme and have set up their "Plan 4 Life" programme which provides personal development training to 16-24 year olds living in County Durham. It aims to help individuals broaden their aspirations and explore career prospects.

203. SHAID have also assisted 175 ex-Armed Forces individuals to access accommodation at the St. Peter's Court apartments, Sacriston. Tenants can stay for up to 2 years during which SHAID can offer tenants support and advice on issues such as funding avenues for training and employment as well as housing support to allow a tenant to more on to their own accommodation.

204. Councillors learned of the work with LGBT clients, and how their specific group had integrated with the youth group and they have an excellent rapport, there being no stigma amongst the group.

Central Durham Samaritans

205. Members of the working group noted the vision of the Samaritans was that fewer people died by suicide and to bring about this vision they worked to make an impact through:-

- Reducing the feelings of distress and despair that can lead to suicide
- Increasing access to support for people in distress and crisis
- Reducing the risk of suicide in specific settings and vulnerable groups
- Influencing Governments and other agencies to take action to reduce suicide

206. Notwithstanding the resilience of some people affected by thoughts of suicide, the Samaritans received a call every 6 seconds, and every 30 seconds from someone with suicidal feelings. It was added that talking to someone and being listened to can help to give a sense of perspective and find solutions to problems. Two-thirds of people did not like to burden others with their problems and the Samaritans were trained listeners available 24 hours a day, every day of the year and were confidential and listen without judging.

207. Anyone could contract the Samaritans, by telephone, e-mail, text, letter or face-to-face and that encouraging people to talk about what was bothering them contributed to good mental wellbeing. People could speak to the Samaritans anonymously and even if they had given details, the Samaritans

would not pass on their information to anyone else or intervene against their wishes.

208. The Samaritans ethos was that a reduction in suicide comes from the actions of many different organisations working together and that they would provide information on other services that offered further support and help. It was noted that certain groups had a heighten vulnerability to suicide and that certain settings contributed to an increased suicide risk and therefore these situations required a tailored range of interventions. The Samaritans offered training for those working in contact with vulnerable people and also to editors and journalists from national and local newspapers in terms of how to sensitively report suicides and sensitively depict the issue within television dramas.

209. The Samaritans also work in partnership with Network Rail and the wider rail industry to help reduce suicide on the railways, post-vention advisors were also made available post-incident at stations to support passengers and staff.

210. The work of the Samaritans in prisons, supporting and providing training for the last 25 years, including for "Listeners", inmates that provided emotional support for fellow inmates was highlighted. The Samaritans had many respected teaching materials, including Developing Emotional Awareness and Listening (DEAL) which was used by professionals. The organisation also delivered talks to young people in schools, colleges and youth settings to offer advice on looking after emotional health and had a national team of specially trained volunteers that could go into schools and colleges affected by suicide.

211. Samaritans worked to support those bereaved by suicide through "Facing the Future", in partnership with Cruse Bereavement Care. The Samaritans also work with the Police in terms of a missing people partnership, to reach out to those who are missing at risk of suicide. Samaritans also work to support those from the Armed Forces with issues such as Post-Traumatic Stress Disorder (PTSD) and that the Samaritans had worked with politicians to drive policy change, including the "Five Year Forward View for Mental Health" by the Mental Health Task Force, a key report outlining recommendations for the NHS and Government to improve mental health in England.

Conclusions

212. The Community and Voluntary sector have a huge role to play in improving health and wellbeing of the population of County Durham and the review has heard evidence from a range of CVS organisations. This highlighted positive practice across the County aimed at suicide prevention and tackling some of the wider determinants of health which can adversely impact upon a person's mental health and wellbeing including relationship breakdown, loss of employment, access to housing, financial hardship and education and training.

213. Their ability to continue to deliver projects, services and interventions during what has been a prolonged period of austerity and funding pressures has been identified by the CVS organisations engaged in the review as a concern.

214. It is therefore important that an assessment of the effectiveness of CVS services and projects which addresses suicide prevention and improved mental health and wellbeing is undertaken to enable resources to be targeted to those which demonstrate that the necessary outcomes have been delivered

Recommendation seven

215. An audit of current health and wellbeing support and services within the Community and Voluntary sector be undertaken to evaluate their effectiveness and enable resources to be targeted at those interventions where demonstrable outcomes for improved mental health and wellbeing and reduced suicide risk are evident.

No Health without Mental Health Objective	**Local Priorities**	***APPENDIX 1*** **Lead Group**
1. More people will have good mental health *More people of all ages and back grounds will have better wellbeing and good mental health. Fewer people of will develop mental health problems – by starting well, developing well, working well, living well and ageing well.*	1.1 Undertake and assessment of the mental health needs of the population of County Durham	Public Mental Health Strategy Implementation Group
	1.2 Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles	Public Mental Health Strategy Implementation Group
	1.3 Develop an Integrated Primary Care Model for Access to talking therapies	Mental Health Care Delivery Working Group
	1.4 The development and implementation of the Children and Young People's Mental Health and Emotional Wellbeing Plan	Children and Young People's Mental Health and Emotional Wellbeing Group
	1.5 Implement the multi-agency Public Mental Health and Suicide Prevention Strategy for County Durham	Children and Young People's Mental Health and Emotional Wellbeing Group
2. More people with mental health problems will recover *More people who develop mental health problems will have a good quality of life – greater ability to manage*	2.1 Work together to find ways that will support the armed services community who have poor mental or physical health	Mental Health Care Delivery Group
	2.2 Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment	Mental Health Care Delivery Group

their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.	2.3 Implement the Recovery College to offer training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing opportunities to learn from others with similar experiences	New Recovery Working Group
	2.4 Ensure that all services adopt a Recovery orientated approach and use validated recovery measure to evaluate outcomes. By using relevant recovery related Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) enables service providers and service users to evaluate progress	New Recovery Working Group
	2.5 Explore opportunities to embed co-production and peer support models within contracts	All Groups to contribute
	2.6 Ongoing monitoring and awareness of the financial challenges and how the welfare reforms impact on the ability to access services	Public Mental Health Strategy Implementation Group
	2.7 Ensure service users and their carers have access to NICE recommended guidance and evidence based interventions	All Groups to contribute
3. More people with mental health	3.1 Develop a more integrated response for people with both mental and physical health conditions	Mental Health Care Delivery Group

problems will have good physical health *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health*	3.2 Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles	Public Mental Health Strategy Implementation Group
	3.3 Ensure that people with mental health conditions have their physical health needs actively addressed	Mental Health Care Delivery Group
4. More people will have a positive experience of care and support *Care and support, wherever it takes place, should offer access to timely, evidence based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.*	4.1 Continue to improve access to psychological therapies and other interventions	Mental Health Care Delivery Group
	4.2 Improve the experience of hospital discharge processes	Mental Health Care Delivery Group
	4.3 Through co-production involve individuals and carers more closely in decisions about the shape of future service provision	All Groups to update
	4.4 Work together to give people greater choice and control over the services they purchase and the care that they receive	All Groups to update
	4.5 Improve awareness of the range of service provision available to General Practices and improve the accessibility and uptake to these services	Mental Health Care Delivery Group
	4.6 Development and Implementation of the County Durham Dual Needs Strategy	Dual Needs Strategy Implementation Group

5. Fewer people will suffer avoidable harm *People receiving care and support should have the confidence that the services they use are of the highest quality and at least as safe as any other public service*	5.1 To co-ordinate a local response to the Crisis Care Concordat	Mental Health Crisis Care Concordat Task Group
	5.2 To develop a more extensive, accessible crisis team	Mental Health Care Delivery Group
	5.3 To ensure close working with all Co. Durham partnership groups that have an impact on mental health issues	Public Mental Health Strategy Implementation Group
6. Fewer people will experience stigma and discrimination *Public understanding of mental health will improve and , as a result, negative attitudes and behaviours to people with mental health problems will decrease*	6.1 Work with the voluntary and community sector to develop opportunities for early identification of those people at risk of social isolation	Public Mental Health Strategy Implementation Group
	6.2 Undertake local campaigns to raise awareness as well as taking an active part in any regional or national campaigns	Public Mental Health Strategy Implementation Group

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Adults Wellbeing and Health Overview and Scrutiny Committee

1 October 2018

Annual Reports 2017/18 - Health and Wellbeing Board and Local Safeguarding Adults Board

Report of Corporate Management Team
Jane Robinson, Corporate Director of Adult and Health Services
Margaret Whellans, Corporate Director of Children and Young People's Services
Lorraine O'Donnell, Corporate Director of Transformation and Partnerships
Amanda Healy, Director of Public Health County Durham
Councillor Lucy Hovvels, Cabinet Portfolio Holder for Adult and Health Services and Chair of the Health and Wellbeing Board
Councillor Olwyn Gunn, Cabinet Portfolio Holder for Children and Young People's Services
Councillor Joy Allen, Cabinet Portfolio Holder for Transformation

Purpose of Report

1 The purpose of this report is to present Adults Wellbeing and Health Overview and Scrutiny Committee with the following Annual Reports for information:

(a) Health and Wellbeing Board Annual Report 2017/18 (Appendix 2)

(b) Safeguarding Adults Board Annual Report (Appendix 3)

Background

2 The Health and Social Care Act 2012 required all upper tier local authorities to establish Health and Wellbeing Boards. The County Durham Health and Wellbeing Board (HWB) was formally established as a committee of Durham County Council in April 2013.

3 This is the fifth Health and Wellbeing Board Annual Report, which outlines the achievements of the Board during its fifth year of operation. It also includes details of locality health and wellbeing projects, which support the priorities of the Health and Wellbeing Board, as well as details of the future work for the Health and Wellbeing Board moving forward.

4 The Care Act 2014 placed Safeguarding Adult Boards (SABs) upon a statutory footing with a requirement to produce and publicise an annual report. The

supplementary Care & Support Statutory Guidance informs that the LSAB Annual Report should have prominence on each core member's website and be made available to other agencies.

5 This is the third LSAB Annual Report, which provides information about achievements and challenges during the year 2017-18. It also includes perspectives of the key partners, key data and analysis on safeguarding activity, details of consultation activities and future actions for the Safeguarding Adults Board for the period 2018-21.

Health and Wellbeing Board Annual Report 2017/18

Achievements

6 The HWB Annual Report outlines a number of achievements, including key performance indicators which demonstrate improvements in the health of the population; developments in key programmes of work which have progressed the health agenda in the county; and, examples of initiatives which have taken place to achieve the strategic objectives in the Joint Health and Wellbeing Strategy.

- An Integration Board has continued to lead on the plans for Health and Social Care Integration to meet the government's target of achieving full integration by 2020, including:
  - Jointly commissioned local services, for example: Carers' Services and the post diagnosis Autism Service.
  - 'Teams Around Patients' (TAPs) are operational across Durham, Dales, Easington and Sedgefield (DDES) and North Durham (ND) Clinical Commissioning Group (CCG) areas. They are working in partnership to reduce avoidable admissions, permanent admissions to Care Homes, reduce delayed transfers of care and improve the health and wellbeing of older people and those with long term conditions.

- The 'Wellbeing for Life' service has continued to deliver projects which are improving the health and wellbeing of the local population. They have adopted a multi-pronged approach to achieving their goals, focusing on one-to-one interaction, group sessions, increasing community capacity and training. For example, Health Trainers work with people one to one, over 8 sessions, to set personal goals which may include eating healthier, being more active or stopping smoking.

- The actions within the County Durham Oral Health Strategy are making good progress, with nurseries in the top 30% most deprived communities to implement tooth brushing schemes.

- The HWB received and approved the County Durham Joint Commissioning Plan 2017-2018 for Special Educational Needs and Disabilities (SEND). The plan sets out Durham's joint commissioning priorities for 2017-2018 across education, health and social care and details how each of these priorities will be taken forward. The HWB

agreed to adopt the principles set out in the SEND 'Promise', which is a charter for young people with SEND presented by the eXtreme group (Investing in Children group made up of young people with special educational needs and disabilities).

- The Healthy Weight Alliance have continued their work to halt the rise of obesity across the county by 2022. They have developed a strategic direction for this with 4 themes - leading by example, increasing play, give every child the best start in life and engaging the whole system. Linked to this is the work underway to deliver the Sugar Smart campaign across the county, which encourages local organisations to take varied actions to help their communities reduce their sugar consumption as part of their daily business.

- The Dementia Action Alliance has continued to deliver a variety of projects across the county with the aim of reducing the impact of dementia. This work, linked to the Dementia Advisor Service, the Alzheimer's Society and the Area Action Partnerships (AAPs) is being delivered under the Dementia Friendly Communities umbrella.

- The HWB received a report on the Cancer Health Equity Audit 2017 and agreed to develop a strategic action plan to address the identified inequalities in cancer incidence and mortality. Health equity audit (HEA) is an important tool when considering how to reduce health inequalities and inequities in the provision of appropriate services. It identifies how fairly services or other resources are distributed relative to the health needs of different groups and areas.

- Durham has been chosen by the Local Government Association (LGA) as one of the prevention at scale pilot sites, looking at improving the scale and pace of mental health prevention and early intervention initiatives.

- As part of the HWB statutory duties, the Board has agreed the recommendation of the County Durham Pharmaceutical Needs Assessment 2018-21, which has looked at the current provision of pharmacy services across County Durham.

Community Based Projects

7 A number of local community based projects across County Durham support the priorities of the Health and Wellbeing Board, which aim to improve the health and wellbeing of people in their local communities. Details of the projects, including those delivered by the Area Action Partnerships, are included in the Annual Report. Examples include:

- Public Health and Durham County Council Education Service have rolled out a resilience programme for 75 schools in County Durham. Across the county we now deliver a flexible and responsive service

24/7, 365 days a year, for children and young people experiencing a mental health crisis.

- The Macmillan Joining the Dots Programme, working with Durham Community Action and the Wellbeing for Life service, has been delivering the 'Coproduction Volunteers' project for cancer sufferers and survivors. They have successfully recruited ten coproduction volunteers to the project. The volunteers have attended 'Joining the Dots' engagement events, analysed the issues and begun to develop solutions.

- Each AAP has received £25,000 to support community led initiatives which are designed to reduce social isolation. For example – Great Aycliffe and Middridge AAP have established a 'Buddies Befriending' service which helps people to become more socially active.

Challenges

8 The Health and Wellbeing Board vision is to 'improve the health and wellbeing of the people of County Durham and reduce health inequalities'. As life expectancy continues to increase in County Durham, it is important to determine whether these additional years are being spent in good health or prolonged poor health and dependency. Healthy life expectancy at birth in County Durham is lower than the England average and there is substantial variation within the county.

9 One of the greatest challenges facing the health service and providers of adult social care is how to respond to an increasingly older population and its changing needs. For example, falls in the over 65's age group has significant impact upon people's quality of life and the costs to health and social care services increases substantially following a person suffering a fall, and incidences of falls in County Durham are above the national average.

10 A high proportion of Health and Social Care budgets are spent on treating ill health, yet 80% of heart disease, stroke and type 2 diabetes incidences, and 50% of cancers could be avoided. This can be done by, for example, improving the numbers of women screened for cervical cancer to identify issues at an early stage, and provide an opportunity to improve the chances of successful treatment.

11 An integrated whole system approach will facilitate a move away from episodic ill health and care towards a greater emphasis on early intervention, prevention and promoting independence. For example, the focus on 'children having the best start in life' will ensure that when a child is born they have the greatest possible opportunity to live a healthy life. This will be done by introducing interventions which reduce the numbers of mothers smoking whilst pregnant, improving breastfeeding rates and reducing the levels of excess weight in children of all ages by encouraging a more active lifestyle.

Future work of the Health and Wellbeing Board

12 There are a number of initiatives that the Health and Wellbeing Board will continue to take forward during the coming year to support this approach, including the following:

- Produce a new Joint Health and Wellbeing Strategy from 2019. This will include a review of the priorities for the Health and Wellbeing Board, based on the evidence in the Joint Strategic Needs Assessment, to ensure a focus on improving the health and wellbeing of people in County Durham and reducing health inequalities.

- Successfully enhance the quality of health and social care services by delivering the improvements being planned by the County Durham Integrated Care Board. This will include improving care quality, addressing the changes to demographics across the county, shifting towards prevention to ensure budgets are utilised to best effect, and managing the system to ensure the needs of the population are met where the population use services across a wider footprint than County Durham.

- Continue the work to on the Oral Health Strategy to improve oral health of both children and adults across the county.

13 Further details of the Health and Wellbeing Board's future work are included in the Annual Report.

Local Safeguarding Adults Board Annual Report 2017/18

Achievements

14 The LSAB Annual Report evidences the progress of the LSAB during the financial year as outlined in the Care and Support Statutory guidance, including a number of notable key achievements.

- In October 2017, the LSAB in partnership with the Safe Durham Partnership (SDP) hosted a successful event with focus upon financial abuse and related issues. The event raised awareness across wider stakeholders, providers, as well as adults and carers in receipt of services. It has contributed to a strengthened working relationship with wider partnerships, and services.

- The LSAB raised awareness of safeguarding adults and related issues through the Local Safeguarding Children Board (LSCB) safeguarding week. Over 860 staff (including partner agencies) attended events during that week, with a clear message shared that 'Safeguarding is Everyone's Responsibility'.

- 20,359 members of the wider workforce received some form of safeguarding training supportive of the board priorities of prevention and early intervention. It demonstrates a continued commitment to update staff and volunteers' skills and knowledge across the wider workforce.

- The LSAB undertook a Training Needs Survey across all partners of the board, and wider organisations for a second year. It has helped the LSAB identify the support needed for wider agencies in the promotion of person centred safeguarding and training.

- The LSAB continues to raise the profile of safeguarding adults across the wider communities, and of how to report concerns. Durham County Council website page views for safeguarding adults reached 34,420 in 2017-18, with 22,551 unique page views of the SAB website. Visits to the LSAB website included reporting a concern.

- Effective safeguarding placing the person at centre means working towards achieving their desired outcomes. In 97 per cent of cases, the desired outcomes expressed by adults involved in safeguarding were fully or partially achieved.

- Consultation with adults and social care staff led to improvements in the ways we gather the views of adults and carers who have accessed safeguarding services. As a result, an information pack has been developed, to share information about safeguarding and other services with adults who have experienced abuse or neglect.

- The LSAB commissioned the Local Government Association (LGA) to undertake a peer review in March 2018. The peer review was a positive experience, it illustrated a number of key and varied strengths of the LSAB including positive partnership working and engagement. The peer team concluded, "from what was read, heard and seen that the LSAB is in a strong position with positive working relationships and professional and respectful challenge when needed. Since the Care Act in 2014 there have been really positive changes in the way the LSAB works and there is a clear sense that everyone is there to make a difference".

Challenges

15 Working within a climate of financial restraint will remain a continual challenge for all partners.

16 A continued challenge for the LSAB is the exploration and strengthening of performance reporting across all agency data. This year, the LSAB revisited its performance reporting, identifying a number of areas to take forward, including developing further enhanced narrative and analysis of data to inform challenge and impact.

17 The LSAB needs to continue its exploration and strengthen the evaluation and impact of training provision across all partners.

Future work of the Local Safeguarding Adults Board

18 Collectively, the LSAB will continue its journey of working innovatively and with creativity in support of its vision, and working with the wider thematic partnerships. This includes working in smarter ways across partnerships and reducing duplication of effort.

19 The LSAB agreed to revise its priorities for the period 2018 to 2021, and to adopt a streamlined approach by reducing the priorities from eight to four. This plan forms the basis of the activities of the LSAB working groups, with each group agreeing a set of objectives to take forward to meet board priorities.

LSAB Strategic priorities and planned outputs:

- Prevention and Early Intervention
  - Provide information and advice in accessible ways for communities
  - Website development
- User/Carer Voice and Awareness Raising
  - Consultation and engagement across wider and diverse communities
  - Increased involvement with Healthwatch
- Performance, Quality and Governance
  - Cycle of audits agreed
  - Performance data that fits with the priorities
- Safeguarding Adult Reviews Learning and Training
  - Learning and development events
  - Improved training evaluation

20 A key piece of work over the next year is a full review of the locally agreed policy and procedures to coincide with a relaunch of the LSAB website.

21 A range of Safeguarding Adult Review workshops will continue to be made available to LSAB members and other professionals more broadly.

Recommendations and Reasons

22 Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:

(a) Note the achievements of the Health and Wellbeing Board during 2017/18 and receive the Health and Wellbeing Annual Report 2017/18 for information.

(b) Note the progress made by the Local Safeguarding Adults Board during 2017/18 and receive the Local Safeguarding Adults Board Annual Report 2017/18 for information.

(c) Note the future work of the Health and Wellbeing Board and Safeguarding Adults Board.

Background Papers

Contact:	**Gordon Elliott**	**Tel:**	**03000 263605**

Appendix 1: Implications

Finance – Ongoing pressure on public services will challenge all agencies to consider how best to respond to the safeguarding, health, social care and wellbeing agendas.

Staffing – The sustaining of adult safeguarding activities requires continued priority to staffing to ensure adequate resource is maintained. The continued contribution to staffing from partner agencies supports the sustainability of dedicated safeguarding adults posts/ functions.

Risk – The Safeguarding Adults Board puts considerable effort into training and awareness raising to ensure that abuse and neglect is recognised and reported. Screening of all reported concerns takes place and directed appropriately to ensure the most appropriate response.

Equality and Diversity / Public Sector Equality Duty – Adult safeguarding is intrinsically linked and this is covered in the SAB policies and procedures with equalities impact assessments undertaken where appropriate.
The key equality and diversity protected characteristic groups are considered as part of the process to identify the groups/organisations to be invited to the Partnership engagement events.

Accommodation - No direct implications.

Crime and Disorder – The Integrated Needs Assessment (INA) provides information relating to crime and disorder, and this is covered in the SAB policies and procedures. There are close working relationships with the Safe Durham Partnership.

Human Rights - Human rights is fundamental to the work of the SAB and its related partners in the context of safeguarding and adult protection.

Consultation – Consultation on the priorities of the Health and Wellbeing Board is undertaken on an annual basis through the Partnership Event and other engagement activities.
LSAB consultation report is available for all partner agencies.

Procurement – The Health and Social Care Act 2012 outlines that commissioners should take regard of the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy (JHWS) when exercising their functions in relation to the commissioning of health and social care services.
The adoption of safeguarding principles in the procurement of health and social care services is essential.

Disability Issues – The needs of disabled people are reflected in the Integrated Needs Assessment and Joint Health & Wellbeing Strategy.
Safeguarding Adults procedures apply to ‘adults at risk’, who are adults with needs for care and support, whether or not the local authority is meeting those needs.

Legal Implications - The Health and Social Care Act 2012 places clear duties on local authorities and Clinical Commissioning Groups (CCGs) to prepare a JSNA and JHWS. The local authority must publish the JHWS. The Health and Wellbeing Board lead the development of the JSNA and JHWS.
Statutory requirement to publicise SAB Annual Reports and publication of an Annual Report from 1st April 2015 in line with the Care Act 2014 and any Safeguarding Adult Reviews in that period, lessons learnt and any actions incomplete.

Improving the health and wellbeing of people in County Durham and reducing health inequalities






County Durham Health and Wellbeing Board Annual Report

2017/18

Altogether healthier

County Durham Health and Wellbeing Board

www.countydurhampartnership.co.uk

Foreword from Chair and Vice Chair

The County Durham Health and Wellbeing Board Annual Report demonstrates how we have worked collectively to achieve the challenges we set ourselves each year. Our Plan describes how we have performed against what we set out to achieve in the previous year and how we plan to move forward.

Our vision is to '**improve the health and wellbeing of the people of County Durham and reduce health inequalities'** and we are on a journey to achieve this.

This plan will help the people of County Durham to understand how we have performed, where our priorities lie and the challenges we need to overcome in 2018/19.

Mental Health is a key focus for the Board and we are reviewing our strategy to make sure that we are doing all we can to promote mental wellbeing for everyone. The national agenda for Health and Social Care Integration means we are doing significant work to change the way we deliver health and care services to provide a more joined up offer to adults and children in our communities.

We take this opportunity to thank those volunteers, carers, professionals and our communities who work tirelessly to make our shared vision a reality.

Councillor Lucy Hovvels MBE

Chair of the Health & Wellbeing Board
Cabinet Portfolio Holder for Adult & Health Services

Dr Stewart Findlay

Vice Chair of the Health & Wellbeing Board
Chief Clinical Officer, Durham Dales, Easington & Sedgefield Clinical Commissioning Group (DDES CCG)

Who are the Health and Wellbeing Board?

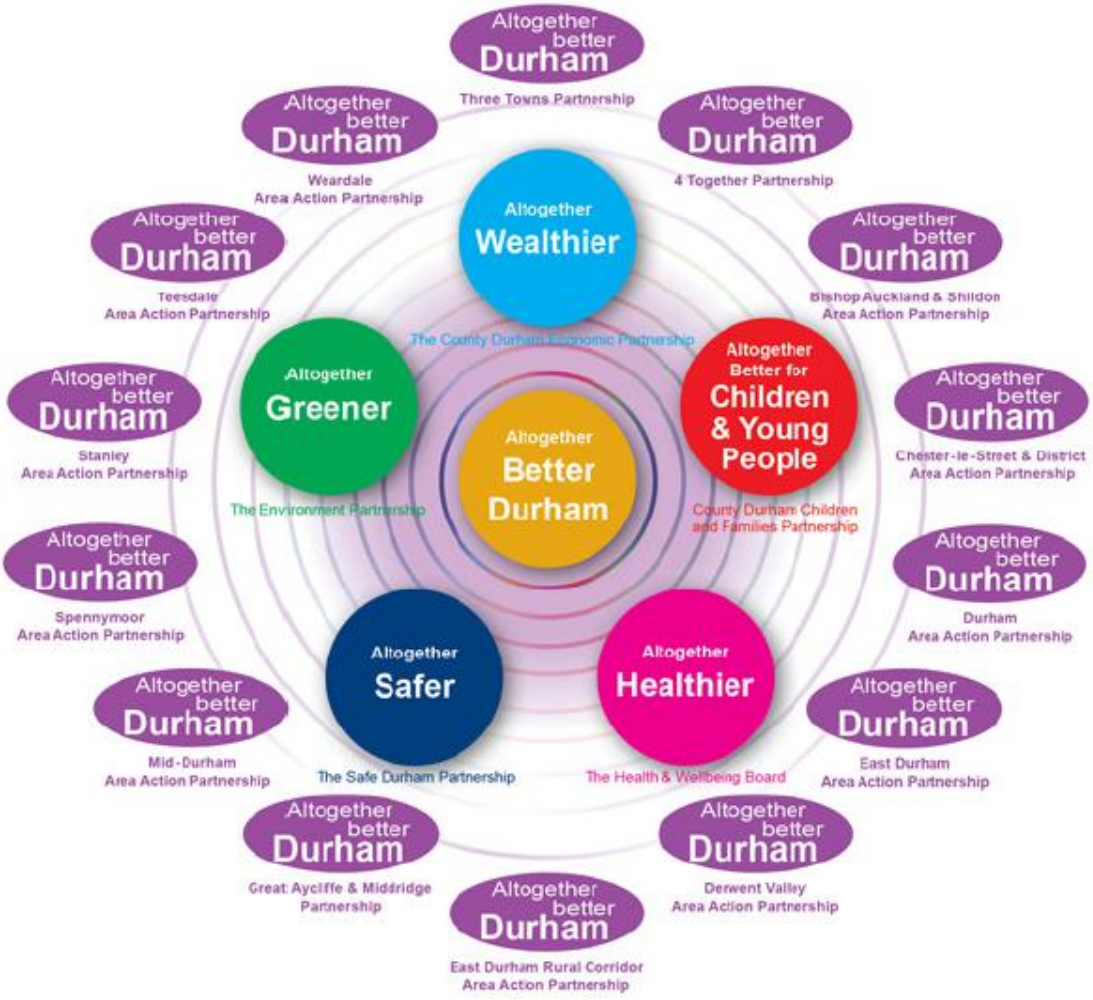
Altogether healthier

County Durham Health and Wellbeing Board

The Health and Wellbeing Board includes the following partners:

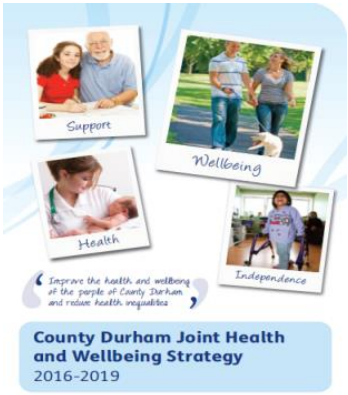
- Durham County Council
- North Durham Clinical Commissioning Group
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group
- Healthwatch County Durham
- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valley NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust
- County Durham and Darlington Fire and Rescue Service
- Office of the Durham Police, Crime and Victims' Commissioner

The Health and Wellbeing Board, under the banner of 'Altogether Healthier', is one of the 5 thematic partnerships that make up the County Durham Partnership, whose role it is to provide for an 'Altogether Better' County Durham; supported by our 14 Area Action Partnerships.



What do we do?

The Health and Wellbeing Board ensures all partner organisations are delivering on the vision to ***'Improve the health and wellbeing of the people of County Durham and reduce health inequalities'***. The formal Board meetings are open to the public.



The Health and Wellbeing Board has a legal responsibility to develop a Joint Strategic Needs Assessment (JSNA), to provide the evidence base for everything we do, and a Joint Health and Wellbeing Strategy (JHWS), that demonstrates how we fulfil our duty to encourage integrated working between commissioners of health services, public health and social services, for advancing the health and wellbeing of the people of County Durham.

The JSNA provides an overview of the current and future health and wellbeing needs of the people of County Durham. The health and social care evidence base is included in an Integrated Needs Assessment (INA) as a 'one stop shop' for all strategic assessments. The evidence in the JSNA is used to inform the Joint Health and Wellbeing Strategy.

We developed the County Durham Joint Health and Wellbeing Strategy 2016-19 to ensure health and social care agencies work together and agree the services that should be prioritised to ensure all partners are delivering against the vision.

The Health and Wellbeing Board is also responsible for the production of a Pharmaceutical Needs Assessment (PNA) every three years, with the latest iteration published in April 2018. A PNA considers whether there are sufficient pharmaceutical services (such as community pharmacies and dispensing GP practices) to support the health needs of the population. We look at where pharmacies are located, their opening hours and how easy they are for people to access.

Key performance achievements in County Durham 2017/18

Under 18 conceptions is reducing and has more than halved since 1998.

Self-harm hospital admissions for young people aged 10 - 24 has reduced, and is lower than regional and national averages.

A high percentage of young people are seen with a face to face second contact within 9 weeks of referral to CAMHS.

The proportion of young people leaving substance misuse treatment in a planned way is better than national average and exceeding target.

The proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services is average above the national.

Durham has one of the lowest rates per population of delayed transfers of care from hospital in the country.

The number of people in receipt of Telecare in Durham continues to rise.

The proportion of people using social care who receive self-directed support is above the national average.

The cancer death rate in people under 75 has been reducing over time.

The percentage of people who have been screened for breast and bowel cancer is higher than regional and national averages.

Patients receiving cancer treatment within 31 days of diagnosis is above target.

2,790 people stopped smoking with support from stop smoking services.

Achievements of the Health and Wellbeing Board

This section details key programmes of work for the Health and Wellbeing Board and developments that have taken place in 2017/18 to achieve the strategic objectives in the Joint Health and Wellbeing Strategy.

Health and Social Care Integration

County Durham has a strong track record of integrated health and social care working based on effective partnerships. For example, the development of:

- Intermediate Care Plus (a short term health & social care service to support adults cared for out of hospital to assist rehabilitation)
- The 0-19 pathway (including school nursing)
- Mental Health and Learning Disability Services
- Community Equipment
- Carers Services
- Social Prescribing
- Post diagnosis Autism Service

We are taking the opportunity to build upon this to define how we want health and social care services to be shaped and delivered across the County to further improve outcomes for local people. Some examples of recent progress include:

- Teams Around Patients (TAP) are now operational across County Durham. TAPs are designed to promote prevention and independence and deliver care in the community in line with local need.
- An Accountable Care Partnership has been established to manage integrated NHS commissioning relating to learning disabilities and mental health.
- A new integrated model has been developed for NHS Community Services to be managed alongside social care services.

To underpin and further develop the integration of services across the health and social care system in County Durham, the post of Director of Integration was established in January 2017 for a two-year period. This role has been instrumental in developing a Memorandum of Understanding and implementing common lines of practice for Teams Around Patients across both CCG areas (Durham Dales, Easington and Sedgefield, and North Durham).

County Durham Integrated care partnership

The Integrated Care Partnership (ICP) is a collaborative arrangement between the NHS and Durham County Council, which has been set up to deliver joined up care, ensuring that delivery is efficient, of high quality and meets the needs of the population. The work of the ICP will be taken forward by an integrated leadership team and governance arrangements with the Health and Wellbeing Board are in place through the County Durham Integrated Care Board.

Better Care Fund

The Better Care Fund brings together NHS and adult social care funding to support integration of health and social care services. In 2017/18 we needed to fulfil new policy requirements to develop spending plans over a two year period rather than a single year, and comply with changes to the national conditions which local areas need to meet to access the funding.

County Durham's Better Care Fund 2017/19 Plan consists of seven programmes which focus on initiatives to enable integration of community based services.

1. Intermediate Care Plus – provides a range of integrated services to promote recovery from illness, prevent unnecessary admission to hospital or permanent admission to residential or nursing care home, facilitate timely and safe discharge and support from hospital and maximising opportunities for independent living.

2. Transforming Care – the Accountable Care Network established a framework for collaboration between partner organisations with regards to integrated care across County Durham including services, workforce training, re-designing of care pathways and improvement in service delivery.

3. Equipment and Adaptations for Independence – the joint funding of the home equipment loans service following service redesign to improve access to equipment and adaptations and make greater use of advancing technologies.

4. Supporting Independent Living – including mental health promotion, prevention and recovery services which focus on the wider determinants of health such as accommodation and employment.

5. Supporting Carers – recognising the contribution that carers make to the health and social care system and economy, we are committed to improving carer support in order to enable them to maintain their caring role and their own health and wellbeing.

6. Social Inclusion –we have worked to increase community capacity and resilience, working with the Voluntary and Community Sector in order to transform preventative and access to universal services, facilities and resources which promote wellbeing and help to avoid the development of needs for health and/or social care services.

7. Care Home Support – we are committed to high quality care home provision which includes dementia liaison services. Our endeavours focus on the competency and capability of homes to provide high quality care which ensures person centred care, dignity and that safeguarding adults standards are met and help avoid unnecessary admissions into hospital.

Prevention

The County Durham Partnership has adopted a focus on prevention and investigating how the work of partner organisations is contributing to improving the wellbeing of the population.

Work is underway to identify and support best practice, maximise funding opportunities and reduce demand on statutory services, through work with Area Action Partnerships, support to access funding streams and enhancing the work of community navigator/peer mentor roles and services.

Durham has been successful in its bid to become one of 15 pilot areas for the national Prevention at Scale offer which involves the Local Government Association providing 20 days of support and advice to deliver at scale a preventative approach that will significantly change health outcomes for local people.

The Health and Wellbeing Board championed mental health as the key cross cutting theme for the project and this was agreed by the County Durham Partnership (including the Health and Wellbeing Board) as a significant priority area to progress. We have identified Suicide Prevention as the focus for this work, with particular strands addressing workforce development and reducing stigma. This work will set the future direction for these services.

Review of Mental Health and Preventative Services

A strategic review of community wellbeing, mental health, public mental health, and preventative services was undertaken, involving extensive engagement with service users, carers, providers and other stakeholders.

This review has highlighted some areas of good practice across the partnership as well as across the life course including:

- Resilience nurses within schools as part of Durham County Council's 0-19 service
- Wellbeing for Life support service
- Dementia friendly communities
- Tees Esk and Wear Valleys NHS Foundation Trust going smoke free
- Director of Public Health Annual Report focusing on Work and Health including mental health and wellbeing
- Capacity building for mental health first aid
- Area Action Partnerships across County Durham many of which focus on mental health and wellbeing
- Men's Sheds networks (supporting men to pursue practical interests)
- Suicide early alert system

The review led to the development of:

- A new life-course preventative mental health and wellbeing approach
- A revised governance structure for the County Durham Mental Health Partnership Board (MHPB)

- Refreshed partnership action plans related to crisis care concordat; adult services; children and young people, suicide prevention and dementia

Wellbeing for Life

The Health and Wellbeing Board has continued to support the Wellbeing for Life Service which provides one-to-one and group support to achieve the changes people want to make in areas like:

- Eating healthier
- Being more active
- Stop smoking
- Alcohol and drug awareness
- Accessing services in the local community

The service has been remodelled and reprocured, based on a comprehensive independent evaluation that was undertaken by Durham University. The evaluation demonstrated the success of the service in improving the wellbeing of local people, whilst allowing us to streamline the new contract to benefit more people in County Durham, and contributes to meeting the Board's vision.

Wider Determinants of Health

Joint working between the Health and Wellbeing Board and County Durham Housing Forum developed a set of five shared priorities based on Kings Fund guidance:

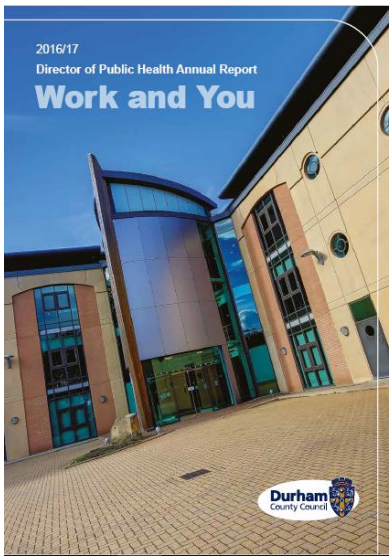
1) Addressing poverty including welfare reform and fuel poverty
2) Early years including identification of neglect and injury prevention
3) Older people with issues such as dementia and age friendly community initiatives, reducing social isolation and falls reduction
4) Vulnerable groups such as those with learning disabilities, a mental illness, and those exposed to domestic abuse
5) Workforce development such as Making Every Contact Count.

A number of projects have been delivered in partnership, focussed on supporting older people, reducing social isolation and improving mental health.

Housing staff have been trained in 'Making Every Contact Count' which equips them to have conversations with the people they come into contact with, which might trigger them to make changes to their lifestyle to improve their health and wellbeing.

A series of Routes out of Poverty training events allowed NHS, Children's Services, Adult Care and Housing staff to jointly work on solutions to case studies.

Cold related ill health work including the Warm and Healthy Homes Programme which targets residents with health conditions, have been recognised nationally as good practice.



Work and You – Director of Public Health (DPH) Annual Report

The last DPH Annual Report focussed on 'Work and You'. People are continuing to stay in work longer and will need good well paid employment to maintain a sense of self-worth and contribute to the local economy. The report sets out how policy makers, employers, clinicians and employees themselves can work together to improve their health and employment outcomes, particularly for workers aged 40-70 years.

The report suggests small changes that businesses can make to work with their local communities and look after the wellbeing of their employees.

Organisations of all sizes are being supported and encouraged to work towards the Better Health and Work Award which helps them to access free workplace training including understanding stress and basic mental health, and supports workplaces to deliver health activities that address key public health improvement priorities.

Support for Carers

The Health and Wellbeing Board recognises the vital part that carers play in the health and social care system and the importance of providing them with support. More carers are registering with carers services than in previous years. This is due to awareness raising work with professionals and schools to identify carers who might not recognise themselves as having a caring role.

Specific work has been undertaken to identify and help people who have a caring responsibility for someone with a learning disability or mental health issue, with booklets produced and training delivered to carers and staff.

Carers who report as unable to work due to their caring role are usually those with the heaviest caring roles. Services have been working with large employers to provide online training to help them understand the pressures faced by carers in employment.

Young Carers are supported to reduce the impact of their caring role on their mental health and wellbeing, educational attainment and social development.

Pharmaceutical Needs Assessment

In line with the statutory responsibilities of the Health and Wellbeing Board, the recommendations of the Pharmaceutical Needs Assessment were agreed which concluded that there are no current gaps in service delivery. As a key HWB partner, Healthwatch collected feedback from the public about how they access pharmaceutical services and their overall views of the services they receive.

The Board has implemented an action plan, which reflects our ambition to develop locally commissioned services to further support targets in the Joint Strategic Needs Assessment. These services will focus on the growing older population, incorporating pharmacy services into Teams Around Patients, the further expansion of pharmacy based public health services and promotion of self-care.

What are our priorities?

County Durham's agreed health and wellbeing priorities for 2017-18 were:

Priority 1

Children and young people make healthy choices and have the best start in life

Priority 2

Reduce health inequalities and early deaths

Priority 3

Improve the quality of life, independence and care and support for people with long term conditions

Priority 4

Improve the mental and physical wellbeing of the population

Priority 5

Protect vulnerable people from harm

Priority 6

Support people to die in the place of their choice with the care and support that they need

Priority 1

Children and young people make healthy choices and have the best start in life

Supporting Children and Young People with SEND

The Health and Wellbeing Board listened to representatives of the eXtreme Group made up of young people with special educational needs and disabilities and signed up to the SEND Promise which pledges the Board will:

- Listen to the needs of the individual
- Support children and young people to access the best possible health care and provide information on the best place to meet their needs
- Fully involve and prepare children and young people during transition from children to adults services

The Board has approved a SEND Joint Commissioning Plan which sets out arrangements for education, health and care services.

Oral Health

The actions within the County Durham Oral Health Strategy are making good progress. Partnership work has been underway with nurseries in the top 30% most deprived communities to implement tooth brushing schemes. There is ongoing work with the Sugar Smart pledge to reduce the availability of sugary snacks in community venues and the better promotion of water as the drink of choice. The Health and Wellbeing Board have also agreed to the next stage of testing the feasibility of expanding the community water fluoridation scheme for County Durham.

Children and Young People's Mental Health

The Health and Wellbeing Board agreed plans to increase the number of initiatives focused on promoting resilience and emotional wellbeing in schools. Partnership work to roll out a resilience programme for 75 schools in County Durham is well advanced. Across the county we now deliver a flexible and responsive service 24/7, 365 days a year, for children and young people experiencing a mental health crisis.

Health Needs Assessment of Young People Who Offend

The Health and Wellbeing Board supported and commended the approach undertaken on the Health Needs Assessment (HNA) of young people who offend in County Durham and the resulting new model for health provision, which sets out the strategic direction to improve health and wellbeing outcomes for these young people.

This involves recruitment of a specialist children's nurse, speech and language therapist, mental health care support workers and drug and alcohol staff to support the work of the County Durham Youth Offending Service.

Priority 2

Reduce health inequalities and early deaths

Gypsy Roma and Traveller (GRT) Health Project

The Health and Wellbeing Board supported an independent evaluation of the GRT Health Team which is now a model of national good practice. The GRT community has the worst health outcomes and lowest life expectancy of any community in County Durham and a number of actions were put in place with the aim of improving this. The work has resulted in:

- Improved trust and access to appropriate health care
- Health issues being discussed more openly in our GRT communities
- A more seamless service between health services and teams in housing, education and the voluntary sector

Cancer Health Equity Audit

The Health and Wellbeing Board agreed to sign up to the development of a strategic action plan to address the identified inequalities in cancer incidence and mortality outlined in the Health Equality Audit. Key findings included:

- Cancer incidence and mortality is higher in more deprived areas
- Female lung cancer has been increasing over time
- Increasing inequality for males and females at different levels across the county

In addition, partner agencies have agreed to consider the findings when planning for cancer services.

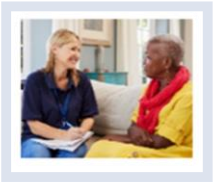
Tobacco

The Health and Wellbeing Board agreed a wider ambition to reduce smoking prevalence amongst adults aged 18 and over in County Durham to 5% by 2030.

Work to achieve this ambition is delivered through the Tobacco Control Alliance of local partners. Smoking prevalence is on the decline with stop smoking services achieving targeted numbers of quitters last year.

County Durham is the lead commissioner of the regional tobacco programme ‘Fresh’, a model which aims to change the broad social norms around the use of tobacco.

Priority 3



Improve the quality of life, independence and care and support for people with long term conditions

Teams Around Patients

The Health and Wellbeing Board supported the creation of 14 Teams Around Patients (TAP) established across County Durham, involving 69 GP Practices. The teams prioritise the top 2% of the most frail and vulnerable older people and those with long-term conditions who are at risk of hospital admissions. The teams agree proactive multi-disciplinary responses, so ensuring that health and social care "discharge capacity" (workforce, beds, equipment, funding) meets daily demand.

Dementia Friendly Communities

The Health and Wellbeing Board agreed the Dementia Strategy which includes the rollout of dementia friendly communities which has continued at a pace. Dementia friendly work has been developed and implemented in Beamish museum, which is seen by many museums as an example of good practice. Work with Dalton Park and Durham City Centre has commenced to make sure their shops, food outlets and cinemas are dementia friendly. Three Housing Associations have linked in with four of the Area Action Partnerships to put in place a two year Coordinator post to support local areas to implement Dementia Friendly Communities.

The Board initiated work with the Alzheimer's Society and the Council's Spatial Policy and Assets Teams to consider the effectiveness of emerging planning policies. Planning policies are being strengthened to ensure that the needs of people living with dementia are considered through the decisions about planning applications, helping to ensure that our neighbourhoods are for life, and extend the active participation of older people with dementia in their local communities.

Adult Autism Self Assessment

The Health and Wellbeing Board agreed the adult Autism self assessment and next steps including further improvements to address waiting times for assessment, redesign the pathway and ensure a smooth transition from children to adults services.

The assessment also identified a number of areas where good progress had been made, including reasonable adjustments to council services, autism awareness training, carers assessments and availability of advocates.

Priority 4

Improve the mental and physical wellbeing of the population

Social Isolation Projects

Each AAP has received £25,000 allocated through the improved Better Care Fund to support community led initiatives that meet local needs. The aim is to focus on prevention and to improve outcomes for older people who are socially isolated by encouraging participation in activities and projects that provide opportunities for people to contribute positively to their local communities.

Working Towards a Healthy Weight in County Durham

Building upon the DPH Annual Report 2015: Obesity - An issue too big to ignore … or too big to mention? the Healthy Weight Alliance (HWA), a sub group of the Health and Wellbeing Board, has produced a strategic plan for a system wide response to halt the rise in obesity by 2022. The focus is on four key areas:

- leading by example;
- give every child the best start in life;
- increasing play; and
- engaging the whole system

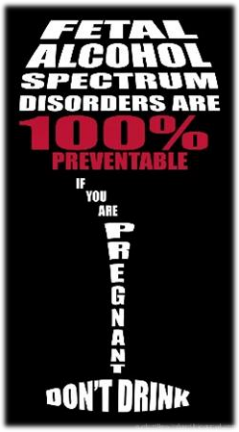
Active Durham

The Health and Wellbeing Board is supportive of the work of the Active Durham Partnership to spread consistent and positive messages about the benefits of physical activity, opportunities and resources and cascading skills to their workforce on a sector basis.

Evidence is being studied to better understand the barriers and needs for older people, women and girls and those living in particular areas of the county. Work is taking place with schools including the development of the Active 30 online resource hub and campaign to help schools enable all of their children to be active for 30 minutes every day.

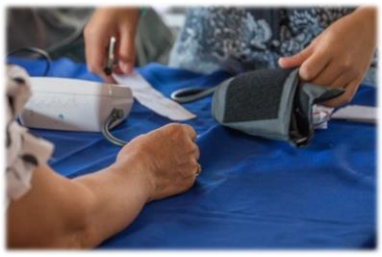
Priority 5

Protect vulnerable people from harm



Foetal Alcohol Spectrum Disorder Group (FASD)

The Health and Wellbeing Board, in conjunction with the Safe Durham Partnership and Local Safeguarding Children Board, agreed to support the work of the Foetal Alcohol Spectrum Disorder Group which was set up to tackle the impact of foetal exposure to alcohol before birth with a focus on prevention and early intervention. The group has campaigned to promote the message that there is no safe level of drinking in pregnancy by integrating with the Better Births initiative and training relevant staff to raise awareness of FASD.



Health Protection Assurance

The Health and Wellbeing Board received assurance that measures are in place to protect the health of the County Durham population. This includes planning for and responding to emergencies that present a risk to public health, making representations about licensing applications and plans for screening and immunisation.

Healthwatch undertook consultation with the public on screening programmes to inform this review.

Health protection in County Durham is strong, particularly in cancer screening, new born screening rates and emergency planning.

Thematic Review of County Durham and Darlington Child Death Overview Panel

The Health and Wellbeing Board received the review of child deaths in the county and considered the findings in terms of learning points, particularly in relation to improving standards within maternity services.

The Board supported the review findings and used its influence to promote the issues with Sustainability & Transformation leads in order to feed into the review of local maternity services.

Priority 6

Support people to die in the place of their choice with the care and support they need

Improving Palliative and End of Life Care

The Health and Wellbeing Board agreed the Improving Palliative and End of Life Care: Strategic Commissioning Plan, which has been refreshed. Actions that are being progressed include a single point of access, specialist pharmacy support, a 24/7 medical model and a model of hospice delivery for the whole county.

A specialist out of hours palliative care advice line has been set up for patients, carers and professionals. This is a telephone service manned by staff with specialist knowledge and skills, which aims to ensure a seamless provision of advice is given on evenings and weekends.

Area Action Partnerships and local hospices are working together to develop specialist bereavement and counselling services for children, young people and families experiencing grief and bereavement.

Macmillan Joining the Dots County Durham

The Health and Wellbeing Board supported the new social model which was developed through the Joining the Dots Project to make sure that all people affected by cancer have the opportunity to receive the best support for their needs. This could be from financial concerns and planning for the future to help with housework and taking care of pets.

Interviews were carried out with people in County Durham affected by cancer to determine support needs and service provision and a group of volunteers have been recruited to progress plans for operation.

The new model will mean that support is tailored to individual needs, support is available on evenings and weekends and key workers will be based in the local community.

Challenges for County Durham

The percentage of mothers smoking at time of delivery is higher than national and regional averages.

The percentage of children aged 4-5 and 10-11 with excess weight are above national averages.

Alcohol specific hospital admissions for under 18's are above national rate.

Breastfeeding at 6-8 weeks is below national and regional rates.

Large inequality in levels of dental disease in 5 year olds across the County.

Successful completions for adults in drug treatment are below target.

The gap in the employment rate for those with a long term health condition is above national and regional averages.

Mortality from liver disease for persons aged 75 and under is increasing and is above the national rate.

Successful completions for adults in alcohol treatment are below target.

The suicide rate is above national and regional averages.

Falls, injuries and hip fractures in the over 65's are above national averages.

Future work of the Health and Wellbeing Board

The Health and Wellbeing Board's work programme for 2018-19 will build on the progress made to date, and will include the following:

Health and Wellbeing Board Strategic Priorities

The HWB Joint Health and Wellbeing Strategy will be reviewed to establish the priorities for the Health and Wellbeing Board beyond 2019, based on the evidence in the Joint Strategic Needs Assessment and the Integrated Needs Assessment, to ensure a continued focus on addressing the county's key challenges, improving the health and wellbeing of people in County Durham and reducing health inequalities.

Health and Social Care Integration

The NHS England 2018/19 planning guidance was clear in articulating the expectation that Integrated Care Systems would need to develop further to enhance the quality of health and social care.

To successfully deliver improvements a number of challenges are faced both locally and nationally, these include:

1. Care Quality – This is impacted by the difficulty in recruiting and retaining staff across a number of areas. Innovative approaches are being explored to encourage nurses to work in County Durham and recruit and retain GPs within Primary Care.

2. Demographics - In recent years, we have experienced major demographic changes across County Durham, such as the increase in proportion of older people. The increased demand on services requires organisations to focus on managing demand and prevention.

3. Finances – We need to find new ways to deliver care for the local population to ensure budgets are utilised to best effect and further shift towards prioritising prevention will be needed.

4. The System – County Durham will see changes to planning footprints and engagement processes and we need to continue to plan at scale for how the needs of our county's population are met for health services.

An extensive piece of work was undertaken to identify what we need to do to take forward a clear and robust Health and Social Care Plan for County Durham, including:

- Formalise existing alliances and partnerships and develop a clear strategy that will enable County Durham to feed into the wider Health and Care agenda across the North East & Cumbria from a position of strength.

- Progress work which has already begun to clearly articulate the ambition for children and young people in terms of integration.

- Develop a local solution for integrated commissioning whilst ensuring that we use collective commissioning capacity to increase efficiency.

- Implement a more formalised governance structure for the integration agenda.

- Implement the new model for NHS Community Services in October 2018.

The Health and Wellbeing Board will continue to monitor joint health and social care planning and commissioning through the Better Care Fund, to alleviate pressures faced by the adult social care sector and NHS. Criteria for funding allocated to AAPs for projects to address social isolation has been finalised and progress will be monitored.

Prevention at Scale

In order to progress Prevention as a vital direction for public services we will apply the skills and knowledge gained from national co-operation and work closely with the Local Government Association to make progress towards tackling stigma surrounding suicide and mental health, and scaling up mental wellbeing across the workforce.

A model is being developed, setting out clearly the strategic direction for this work, which will be taken forward by the Partnership and evaluated by the LGA in November 2018. We will continue to build on this progress and apply learning from the project to other key areas identified in the Joint Health and Wellbeing Strategy.

Mental Health

Following wider stakeholder consultation the Health and Wellbeing Board will agree a refreshed plan to improve the mental health of people in County Durham. The plan will cover the five priority themes:

- Children and young people
- Adults
- Suicide and self harm
- Dementia
- Crisis care

It will also consider five cross-cutting themes:

- Workforce
- Engagement and communications
- Evidence led
- Good governance
- Think Family

A robust performance framework will ensure that the Health and Wellbeing Board and partners can capture and monitor progress over the long and short term.

Children Looked After and Care Leavers

The Health and Wellbeing Board will engage with the Care Leavers Strategic Group to explore the number of female care leavers who are pregnant or mothers and support will be offered through the vulnerable parent pathway. Work is underway to develop a better understanding of the placement and/or risk factors through case review and focus groups, to enable benchmarking and to develop an action plan.

This work will form part of the Health Needs Assessment for Looked After Children and Care Leavers.

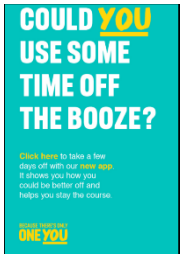
Alcohol Evidence Review

A Minimum Unit Price for Alcohol will be implemented in Scotland from May 2018. The British Government has indicated its intention to develop an alcohol strategy and will ask Public Health England to look at the evidence base again.

The Health and Wellbeing Board received a presentation on the Public Health England Alcohol Review in July 2017 and will continue to monitor further communications from government and impact of the legislation in Scotland and consider its commitment to the alcohol agenda in conjunction with the Safe Durham Partnership.

Co-ordinated Health and Wellbeing Campaigns

We will develop a co-ordinated multi-agency approach to marketing campaigns for the agreed Joint Health and Wellbeing Strategy priorities and facilitate a mechanism by which communication specialists from partner agencies are able to come together to achieve this. The key areas of focus for the forthcoming year will be mental health, breastfeeding, tobacco, alcohol and staying well during the winter.



Pharmaceutical Needs

The HWB will continue to manage the provision of pharmacy services across County Durham and monitor the action plan which was developed from the Pharmaceutical Needs Assessment in March 2018. The action plan identified scope to further develop locally commissioned services to support the growing older population, incorporate pharmacy services into TAPs and promote self-care.

Health and Wellbeing Board Partners

www.durham.gov.uk

www.countydurhampartnership.co.uk

www.northdurhamccg.nhs.uk

www.chsft.nhs.uk

www.durhamdaleseasingtonsedgefieldccg.nhs.uk

www.ddfire.gov.uk

www.healthwatchcountydurham.co.uk

www.cddft.nhs.uk

www.nth.nhs.uk

www.tewv.nhs.uk

www.durham-pcc.gov.uk

www.hdft.nhs.uk

For information or queries about any of the Health and Wellbeing Board's work you can email us at HWB@durham.gov.uk

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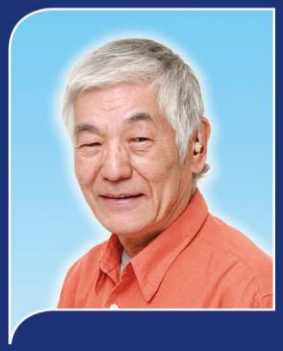
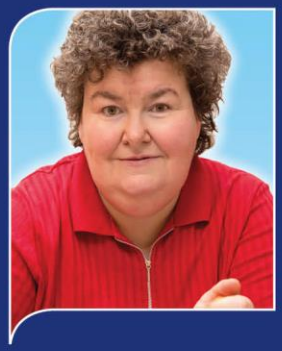
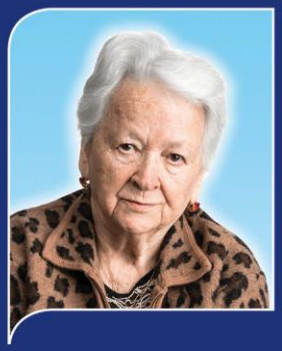
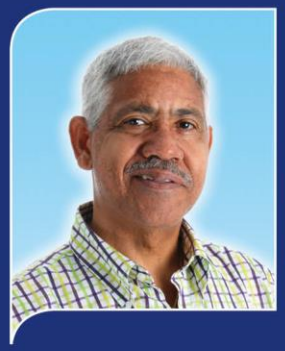
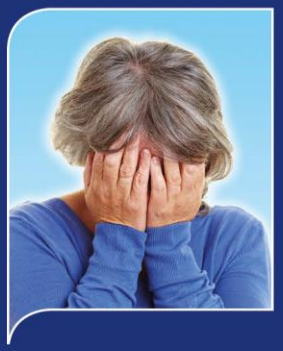
County Durham
SAFEGUARDING ADULTS
INTER-AGENCY PARTNERSHIP

Safeguarding Adults Annual Report 2017/18



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Message from the Chair

As Independent Chair of the Durham Safeguarding Adults Board (SAB), I am pleased to present the annual report for 2017-2018, and in recognising the contribution of partners and wider partnership working that has taken place over the last year.

Jane Geraghty
SAB Independent Chair

In 2018-2019, Lesley Jeavons, Director of Integrated Care will take up the role of Safeguarding Adults Board Chair, and we extend a warm welcome to her as the work of the board continues.

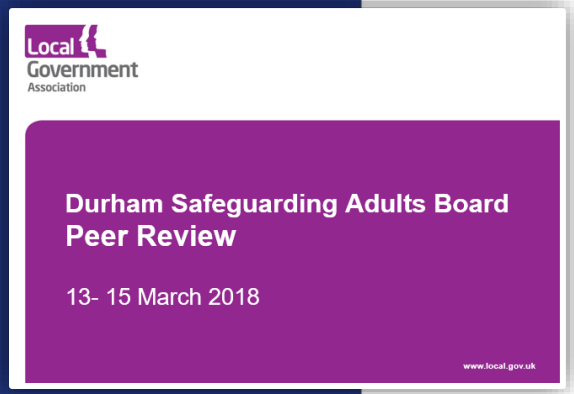
As with each year in my role as Chair, I hope that this report provides a picture of the work undertaken as a board and the progress made since our last report in 2016-2017. The Durham Safeguarding Adults Board continues to operate with openness and transparency, demonstrated by its commitment to commission a peer review in the last year.

Challenges remain for all partners of the SAB working within a climate of continual financial restraint. Yet I am pleased to report that the commitment of partners remains strong, working together throughout the year with reflection upon our direction, identifying new and innovative ways of working and service delivery with a key focus upon prevention. Heightening awareness and building community resilience to keep people safe is key for the SAB, and to continue to empower individuals and communities alike in being able protect themselves.

This is no more evident than in the success of our annual event last year, which focussed upon financial abuse and related issues. The event in conjunction with the Safe Durham Partnership promoted a clear message of how working collectively can support the prevention agenda. I would like to express my thanks to everyone involved, and to the local, regional and national organisations who helped to make the event such a success. I would also like to extend those thanks to the service providers, the voluntary sector and the adults and carers in receipt of services who attended the event and for their valued input.

Consultation activities led by Lay Members over the last year has helped to build good working relationships with both adults and carers. This will continue to inform the work of the board, ensuring that we hear the 'voice' of adults and carers in everything we do.

Financial abuse event 31st October 2017 Opened by Assistant Chief Constable Dave Orford – Durham Constabulary



A continued challenge for the SAB is the exploration of performance data. This year, the SAB revisited its performance reporting, identifying a number of areas to take forward, including developing further enhanced analysis of the data. This was echoed in findings from the peer review, to know the SAB is on the right track and moving in the right direction is reassuring.

I would like to close by thanking all partners of the SAB, lay members and the Adult & Health Services Portfolio Holder for their active support and positive contributions to the work of the board, and for their continued commitment.

Jane Geraghty
Independent Chair (up to March '18)

Introduction

The Durham Safeguarding Adults Board in line with the Care Act 2014 has a statutory duty to publish an Annual Report including the achievements of the SAB and its members against its strategic priorities.

The annual report will be publicised on each core member's website and will be available to other agencies.

The Care and Support statutory guidance tells us that our annual reports should consider what the SAB has done locally and to draw conclusions from the following areas:

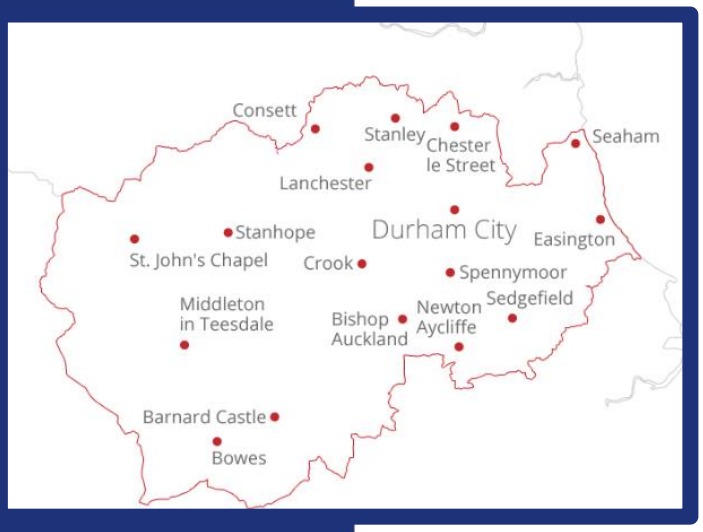
- evidence of community awareness of adult abuse and neglect and how to respond
- analysis of safeguarding data to better understand the reasons that lie behind local data returns and use the information to improve the strategic plan and operational arrangements
- what adults who have experienced the process say and the extent to which the outcomes they wanted (their wishes) have been realised
- what front line practitioners say about outcomes for adults and about their ability to work in a personalised way with those adults
- better reporting of abuse and neglect
- evidence of success of strategies to prevent abuse or neglect
- feedback from local Healthwatch, adults who use care and support services and carers, community groups, advocates, service providers and other partners
- how successful adult safeguarding is at linking with other parts of the system, for example children's safeguarding, domestic violence, community safety
- the impact of training carried out in this area and analysis of future need; and
- how well agencies are co-operating and collaborating

It is the intention of this annual report to outline what the SAB has done in Durham to meet the above. Drawing upon a range of data and information from agencies to illustrate the effectiveness of safeguarding arrangements in Durham.

A Local Picture

In 2017, there were approximately 524,400 people of all ages living in Durham covering 862 square miles.

There are 316,700 adults aged between 18 – 64 years in Durham.



There are 12,400 adults aged over 85 years in Durham.

There are 1,912 adults over the age of 85 years living in a care home.

In 2017, there were approximately 9,943 adults with a learning disability, and 6,492 adults with dementia living in Durham.

Data sources: www.pansi.org.uk www.poppi.org.uk

Our Work

Since moving to a statutory footing, the SAB has a key role to assure itself that our partners and our local safeguarding arrangements are working harmoniously to protect adults in our area. We do this through our Board activity. The SAB continues to be supportive of the County Durham Sustainable Community Strategy for an **Altogether Better Durham**.

The SAB has a key focus to safeguard an adult's right to live in safety, free from abuse and neglect. Our vision encompasses working together to prevent the risk of abuse or neglect, and if it does occur to respond swiftly to achieve the best outcome possible for those adults.

Hearing the voice of adults who may be experiencing abuse and what they would like to happen to keep them safe is at the heart of safeguarding adults in Durham, it is a key priority for 2017 – 2020.

We consulted with adults who told us we could improve our surveys, we completed this work in 2017-2018. Social Care Staff told us how we could support them to gather the views of adults and carers who had accessed safeguarding services. As a result, we have developed an information pack to share information about safeguarding and other services with adults who have experienced abuse or neglect.

The external peer review recognised a key message from the SAB is that everyone sees there is a person at the centre.

The SAB meets twice yearly for development, these sessions help the SAB to reflect on what is doing well and where it needs to make improvements.

In October 2017, the SAB recognised it needed to explore the impact of training, in December 2017 we started work to revise our training evaluations.

In January 2018, the SAB agreed improving upon our performance measures in developing meaningful multi-agency quantitative and qualitative data. The external peer review supports this area of development with a key message that the SAB is on the right path.

What some board members said at development sessions:

Strengths…

> Good governance and partnership working

> Strong commitment to hear adult/carer voice

Areas we could improve…

> Hearing the voice of the wider workforce

Messages from Service Users, Carers and Advocates

Over the last year, the SAB has continued its commitment to ensure we hear the 'voice' of adults and carers who access safeguarding services.

Last year we shared our plans for increasing engagement opportunities through our user/carer forum led by a Lay Member. In 2017-2018 we held a 'Seek Your Views' event, and completed a consultation activity with adults and carers on how we could improve upon our survey activities.

We asked adults and their support workers who attended the Seek Your Views event to tell us about their understanding of abuse, and what they felt might tell them that abuse was taking place.

> *Name Calling*

> *Bullying*

> *Using my money and not letting me use it*

healthwatch County Durham

Throughout the year, we have continued to engage with a diverse group of adults and carers in helping us to improve. Healthwatch Durham are supporting the board in gaining views of adults and carers who have experienced safeguarding services. The board will receive an evaluation of their work in 2018-2019.

The Board commissioned an external peer review to gain a view of how well it is doing.

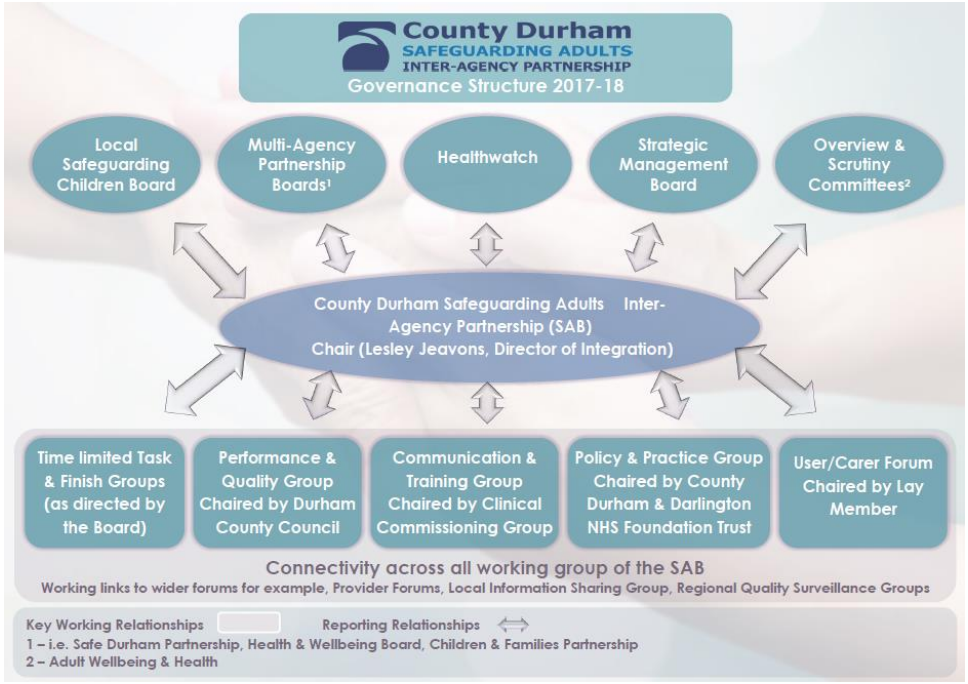
The team were impressed by the website and the publications produced with the input of users and carers and recognised that the board has pro-active links with providers, advocates and practitioners.

> *The public sector is most fortunate to have dedicated staff of his calibre supporting vulnerable adults.*
>
> **Source: Family member/Appropriate representative**

SAB Working Arrangements

As a statutory strategic partnership, with a key focus upon prevention of abuse of neglect the SAB oversees and leads safeguarding of adults for Durham. The SAB achieves its strategic role through collaborative working with SAB partners, mindful of the voice of adults and carers in all that it undertakes.

As part of its annual activity to strengthen arrangements, the SAB revisits its governance arrangements. In 2017-2018, the SAB issued its revised governance structure and agreed to streamline for 2018-2019.



Over the last year, the SAB has also completed a range of activity in meeting its statutory requirements, which include:

- Completed revision to the Terms of Reference of its working groups, outlining the role of partners and the accountability and escalation arrangements, and identified further work in its development session of January 2018.
- Continued to monitor compliance and attendance of partners, with two reports to board.
- Completed 20 consultations with SAB partners for specific actions or documents, including Training Needs Analysis, work plans, vice-chairing arrangements.

- Completed two consultations with adults, carers and providers to improve surveys.
- Contributed to the revision of the Safeguarding Framework. A document outlining linkage to the wider thematic partnerships including the Safe Durham Partnership, the Health & Wellbeing Board and Children and Families Partnership.
- Revised its self-assessment tool for completion in 2018-2019.
- Issued the first GP self-audit in January 2018.
- Continued to challenge partners of the SAB and document responses and corrective actions through the SAB risk and challenge log.
- Commissioned an external peer review in March 2018.

SAB membership

The Care Act 2014 specifies that each SAB should have three core members, the local authority, clinical commissioning groups (CCGs) and the police. The SAB is made up of a wider membership, individual partner statements are outlined at the end this report.

In 2017-2018, the SAB appointed a third lay member to the SAB. Lay members act as critical friends to the board.

SAB Meetings

3 The SAB agreed in July 2017 that it would meet 3 times per year

2 and hold 2 development sessions.

The Independent Chair continued to meet with partners throughout 2017 – 2018 to support the collaborative working of the SAB.

Chair engagement with partners

13

Meetings

- *Well attended SAB*
- *Positive partnership working & engagement*
- *Lay Member(s) contribute and take an active role in the Board*

Source;
Peer Review Team March 2018

> **Area Action Partnerships pick up prevention agenda and are engaged and supported by the Board**
>
> Source;
> Peer Review Team
> March 2018

Our overarching vision is *'to support adults at risk of harm to prevent abuse happening, and when it does occur, to act swiftly to achieve good outcomes'*. This is only achievable by effective partnership working and an interface through **County Durham Partnership (CDP)** to a broader vision of an "Altogether Better Durham". Best illustrated by a real shift to working towards wider preventative initiatives and building community resilience through a 'Good to Great' programme, and linking with the **14** Area Action Partnerships (AAPs).

The **Safe Durham Partnership (SDP)** tackles crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and seeks to reduce re-offending. The SAB strengthened its links with the SDP, through related abuse agendas such as modern slavery, and raising awareness of the links to financial abuse such as cyber-crime.

The **Health & Wellbeing Board (HWB)** promoting integrated working between commissioners of health services, public health and social care services, for the purposes of improving the health and wellbeing of the people in the area. SAB is committed to taking forward any actions of the Joint Health and Wellbeing Strategy to support its objectives. The **Environment Partnership** – improves, transforms and sustains the environment to support the economy and the wellbeing of local communities. The **Economic Partnership** works to make County Durham an area where people want to live, work, invest and visit; whilst enabling residents and businesses to achieve their full economic potential. The **Children and Families Partnership (CFP)** is working towards ensuring effective services are delivered in the most efficient way to improve the lives of children, young people and families in County Durham. SAB continues to share issues of note.

Durham Local Safeguarding Children Board

The SAB works closely with its colleagues within the Local Safeguarding Children Board, creating a familial approach to safeguarding in Durham. This is strengthened by working together where cross-cutting themes exist, such as modern slavery.

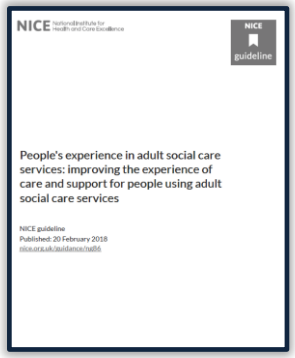
National and Local Updates

As part of the SABs continual improvement activity, it regularly receives any national and local updates relating to research, consultation and legislative changes. Below are just some of the examples that have informed the SAB in 2017-2018.

Deprivation of Liberty Safeguards (DoLS) - The Law Commission undertook a consultation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS), publishing its findings in March 2017 along with a proposed draft bill. The proposals relate to DoLS for adults who cannot make decisions about how their care or treatment is provided or how they are kept safe. Currently DoLS applies to Care Homes and Hospitals, the new proposals include supported living, shared housing and private housing. The new proposals are supportive of adults living in more than one place, and receiving or moving between more than one place for care and treatment. There is also a proposal that the new Liberty Protection Safeguards include those 16 years and over. The SAB continues to monitor the draft bill progress.

Making Safeguarding Personal (MSP) – Since 2010, there have been a number of key developments to promote a personalised approach to safeguarding adults, this is known as Making Safeguarding Personal. The Local Government Association and the Directors of Adult Social Services (ADASS) jointly published a number of resource toolkits. These resources aim to support the SAB partners, commissioners and providers to embed and promote an outcome based focus in safeguarding practice. The tools also highlight the importance of prevention and this is in keeping with the SAB plans.

National Institute for Health & Care Excellence (NICE) – In January 2018 the SAB received an update in respect of NICE guidelines relating to 'People's experience in adult social care services: improving the experience of care for people using adult social care services', these guidelines were published in February 2018 and link to safeguarding policy.



Board Assurance 2017-2018

Following a board development session in March 2017, the board refreshed its one page plan, streamlining its priorities and separating statutory responsibilities for 2017-2018. Throughout the year, the board continued to strengthen its assurance mechanisms. Some examples of partner assurance outlined below.

- Durham County Council – Safeguarding and Access Service - Changes to the requirements to report the death of a person subject to a Deprivation of Liberty Safeguards (DoLS) authorisation to the Coroner (April 2017)
- Durham County Council – Channel Panel Update Presentation (April 2017)
- Her Majesty's Prison & Probation Service – Partner Assurance Report (October 2017)
- North East Ambulance Service – Partner Assurance via Annual Report (January 2018)

In addition, the board received a Multi-Agency Public Protection Arrangements Update in July 2017. Key messages about lessons learnt and managing risk delivered, and following the learning from a Local Safeguarding Children Board (LSCB) instigated Child Serious Case Review. The board previously supported learning from this case by raising the profile of the adult board through learning lessons events coordinated by the LSCB.

Following a Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD), the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England commissioned a programme of work known as the LeDeR programme. The board received its latest update focussing upon ensuring links to the SAB for assurance of local reviews. It included identifying learning and meeting any gaps to embed learning within the wider workforce with a number of actions to take forward. The board will receive progress updates twice a year.

The board also received a number of audit reports throughout 2017-2018 and other reports to offer assurance including the multi-agency response to modern slavery, its prevention and collaborative working.

Source: Peer review team March 2018

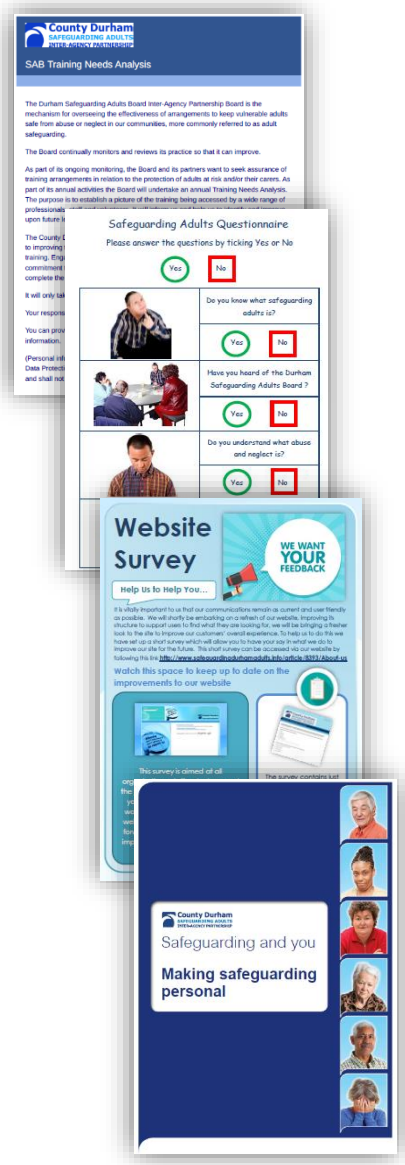
What we have Achieved in 2017-2018

The Board set eight priorities for 2017-2018, the below intends to set out an illustration of just some of the key achievements of the SAB against those priorities, and the impact of that work.

External Peer Review – the board agreed to undertake an external peer review in its performance framework to gain a measure of the board progress. **Impact**: "The peer team concluded from what was read, heard and seen that the SAB is in a strong position with positive working relationships and professional and respectful challenge when needed. Since the Care Act in 2014 there have been really positive changes in the way the SAB works and there is a clear sense that everyone is there to make a difference". **(Source: Peer Team Summary feedback)**

SAB Annual Event – a joint event with the Safe Durham Partnership to raise awareness of financial abuse and related issues. **Impact**: This event raised awareness across wider stakeholders, providers, adults and carers in receipt of services. It has contributed to a strengthened working relationship with wider partnerships, and service. It is supporting the prevention agenda in the promotion of community resilience.

Modern Slavery Briefings – Introduced in October 2017 to raise awareness of modern slavery and sexual exploitation, and the signs and indicators. **Impact**: These specialist sessions delivered jointly with the police have enabled the wider workforce to update their knowledge of modern slavery and sexual exploitation. It has helped to support partner agency staff such as Nurses and Social Workers and wider organisations such as housing providers in understanding how to make appropriate reports.



Training Needs Survey – a training survey shared with all partners of the board, and wider organisations for a second year. It included impact measures on understanding person centred outcomes in safeguarding. **Impact**: There was an increased 25 per cent response rate on the previous year with 514 submitted surveys. It has helped the SAB identify the support needed for wider agencies in the promotion of person centred safeguarding.

Safeguarding Week 2017- Following an invite from the LSCB, the SAB raised awareness of safeguarding adults and related issues through the LSCB safeguarding week. **Impact**: With over 860 staff from partner agencies attending events during that week there was a clear message shared that 'Safeguarding is Everyone's Responsibility'.

Awareness Raising Events – The SAB and partners raised awareness at a variety of forums throughout the year, including Holocaust Memorial Day, Fulfilling Lives (led by Learning Disabilities People's Parliament) and World Social Work Day, International Nurses Day. **Impact**: With attendance of over **300** professionals, volunteers and service users and carers, the safeguarding adults profile is raised and in particular, how to report a concern.

Website Updates – Updated throughout the year and posted to the SAB website included SAB training information, Annual reports and easy read version, website survey and SAB newsletters. **Impact**: A total of **34,420** page views, and **22,551** unique page views of the SAB website, this includes reporting a concern.

Training Programmes – A wide variety of training is accessible to staff and volunteers across the wider workforce, it includes face to face training, workbooks and e-learning packages. **Impact: 20,359** of the wider workforce received some form of safeguarding training over the last year, supporting prevention and early intervention, and continual update of staff/volunteer skills and knowledge.

Mrs C is a vulnerable adult who has dementia. Care workers pop in to her home twice a week to help her shower. **Mrs C's** grandson moved in with her recently. Her grandson often has friends over, to play computer games, sometimes they stay for a long time. **Mrs C's** care worker noticed she was becoming withdrawn and spent a lot of time in her bedroom and was worried about her. **Mrs C** has always enjoyed watching television.

Mrs C's care worker telephoned Social Care Direct. A social worker contacted **Mrs C**.

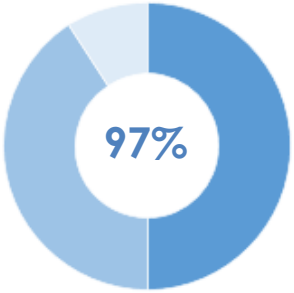
Mrs C told the social worker that she wanted her grandson to continue living with her, and that she liked the company. **Mrs C** received support to speak her grandson about not having friends over quite so much. **Mrs C's** grandson explained that he was worried about leaving his grandmother home alone. Other family members agreed to help by visiting so when **Mrs C's** grandson wanted to be with friends, she would not be alone. **Mrs C** is much happier and is enjoying time with her family.

Mr Y is a man who lived alone with some support from family members and agency support from home carers. Adult Social Care received some concerns relating to the company providing home care to **Mr Y**. As a result, a multi-agency response to gather information about the concerns took place. **Mr Y** was unable to give his views or the outcomes he would like to achieve from safeguarding support. A family member acted as his representative to support him.

Through conversations with **Mr Y's** family and his representative, safeguarding plans to support **Mr Y** and keep him safe from further risk were put in place. Concerns about a staff member from the company providing his care resulted in that person being removed from their working role. This has prevented further risk to **Mr Y** and others. **Mr Y** continues to live independently with the support of his family and home care.

> "Everyone sees there is a person at the centre"
>
> **Source: Peer Review team March 2018**

At a Glance 2017- 2018



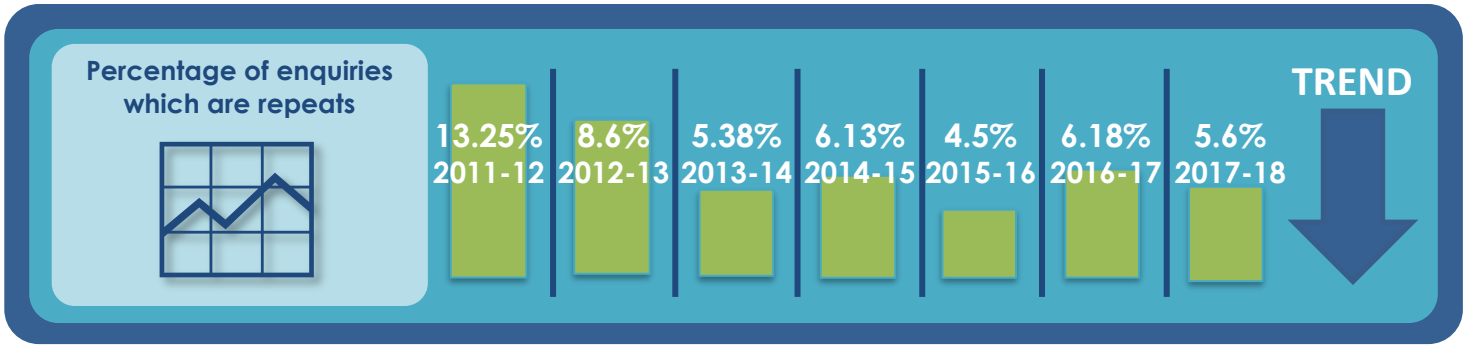
Desired outcomes

Expressed by service users were fully or partially achieved following safeguarding involvement

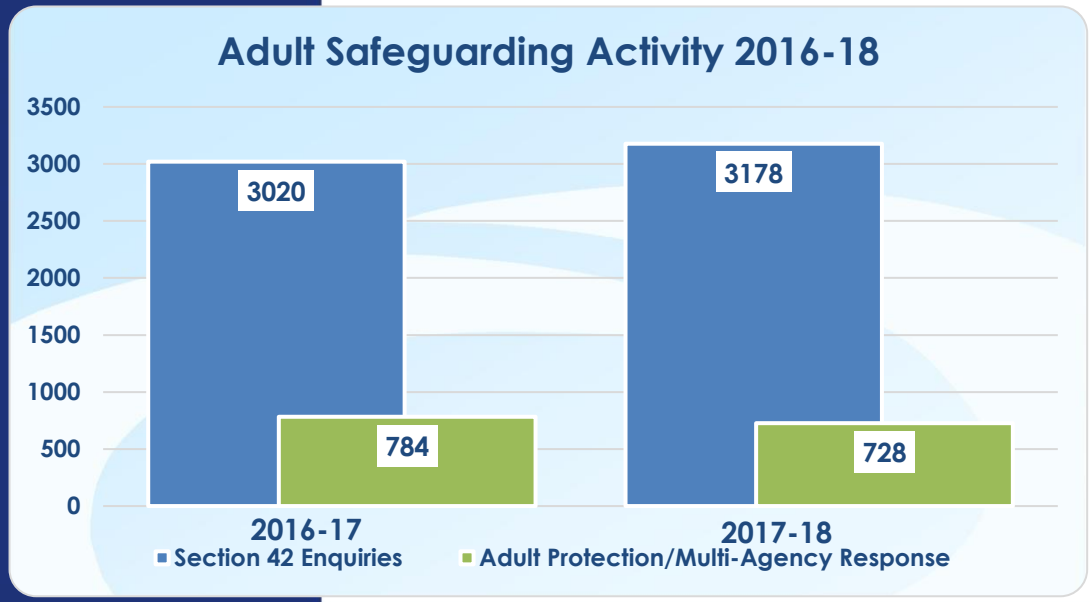
Advocate

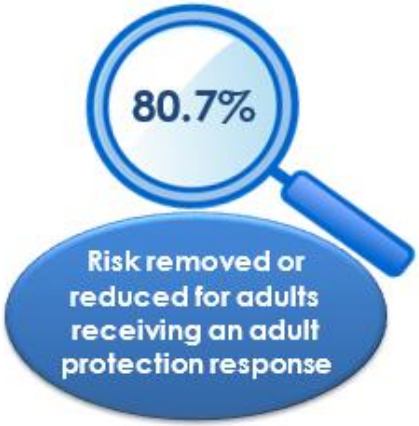
Adults supported by family, friends or advocates during Safeguarding

Enquiries made under Safeguarding should always consider the mental capacity of adults. The Care Act tells us that when any such enquiries are undertaken, advocacy support should be offered to adults when needed. An adult's ability to contribute to decisions about their protection should always be recorded.



Since 2011-2012 a concerted effort has been made to ensure repeat instances of abuse are maintained at the lowest possible levels. This is an indicator of the effectiveness of safeguarding interventions, of person centred practice and of achieving good outcomes. For 2017-2018, repeat instances accounted for 5.6 per cent of invoked referrals. The SAB receives audit information annually of all repeat instances.





For 80.7 per cent of safeguarding enquiries receiving a multi-agency response action was taken and the risk was either reduced or removed, this is in keeping with the national average of 2016-2017 of 87 per cent.

Last year we said we would carry out work in a number of areas, to support the board to continue to make progress. These included:

Improving upon our performance reporting to ensure it is fully reflective of multi-agency working and incorporates prevention and early intervention. During the year, the SAB has worked towards making improvements to its performance reporting. A number of actions identified at the board development session in January 2018 are being taken forward including linking with performance leads across the partners. The Peer Review also identified this an area of development for the board.

We said we would improve upon gaining the 'voice' of user/carers to inform our work and identify improvements. The peer team highlighted this was an area of strength for the board, and noted that resources and publications are developed with users and carers.

> *"User and Carer Sub-Group is making progress and has come a long way."*
>
> **Source: Peer Review team March 2018**

> *"Good cross-agency working on trafficking and modern slavery."*
>
> **Source: Peer Review team March 2018**

We said we would identify the prevalence and need of adults who may be victims of sexual exploitation or trafficking. This was to support the development of appropriate pathways to support adults at risk of sexual exploitation or trafficking. This work is near to completion with an 'At a Glance' Toolkit developed in conjunction with Darlington Safeguarding Adults Board.

Safeguarding Adult Reviews

The SAB must within its annual report provide details of any Safeguarding Adult Reviews (SARs) undertaken, the lessons learned and actions to be taken as a result of a SAR. This means the SAB must identify whether or not cases where someone has died or suffered significant harm would require a Safeguarding Adult Review. The main purpose of reviews is to learn lessons that will help to prevent any risks happening again for adults at risk.

During this year, **2** referrals reviewed by a SAR Panel determined that the criteria was met for one case to instigate a SAR, and for another case whilst the criteria was not met, it was agreed there may be valuable learning from the case. Both cases are ongoing, the learning and any actions taken will be publicised within 2018-2019 annual report.

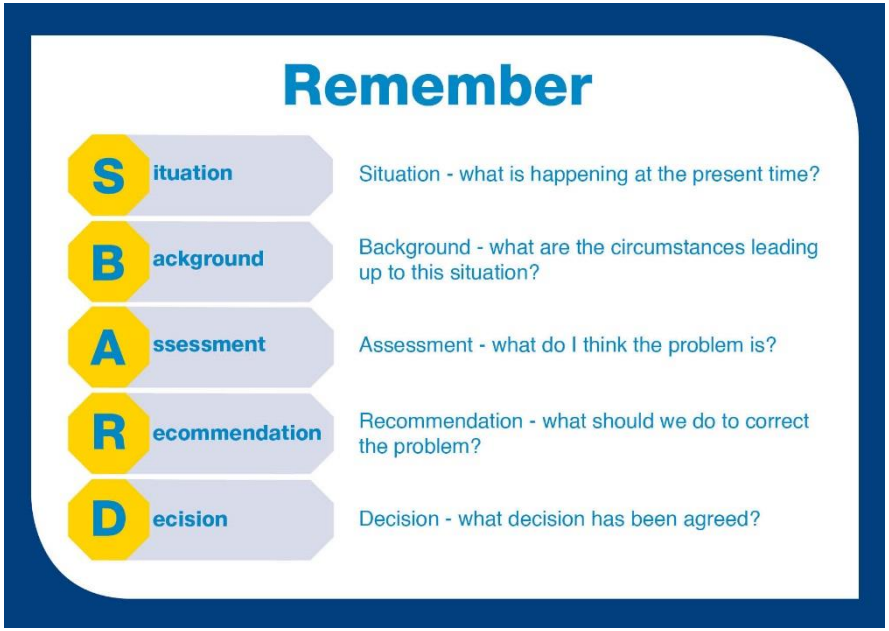
The SAB agreed to explore a wide range of learning opportunities as part of its continual improvement, including the development of a thematic tool drawing upon learning from:

- Adult Protection Cases) and Reflective Analysis
- Case file audits
- Organisational Learning – (for example learning from NHS Serious Incidents)
- Near Miss processes
- Provider self-audits and emerging themes
- Safeguarding Adult Reviews
- Domestic Homicide Reviews
- Mental Health Homicide Reviews
- Child Serious Case Reviews, (Safeguarding Practice Reviews - Consultation Working together to Safeguard Children, December 2017)
- Confidential Inquiries

In 2017-2018 the SAB identified a learning need for board members and wider practitioners in relation to Safeguarding Adult Reviews and in particular the differing methodologies available, the SAB is holding SAR workshop events in May 2018 to meet this need.

The SAB noted raising the profile of SARs and how to refer cases should continue, and the recent peer review highlighted a suggestion for the SAB to explore the low numbers of SARs. It is reassuring to note that our areas of development correlate to that of the peer review findings.

The Care and Support statutory guidance informs that SABS should be mindful of parallel review processes. SABs should consider the exploration of joint reviews to prevent duplication. In our 2016-2017 report we noted a key recommendation from a Mental Health Homicide Review relating to communication between agencies in situations of specific risk for adults in receipt in services. The recommendation suggested the LSAB explore how it could achieve a more robust approach to cross-agency communications.



The SAB held workshops with a group of pilot participants outlining the learning from the review and the reasons for an intended pilot. Consultation on the development of resources to support the pilot participants took place. Resources and guidance packs shared with participants.

With the support of NHS England a pilot is underway with selected agencies, including a provider and two GP practices as well as Social Care. The pilot is using a well-adopted framework for improving communication. In July 2018, the SAB will hear the pilot findings including analysis of its impact.

Looking Ahead and Summary

Collectively the SAB wishes to continue its journey with innovation and creativity in support of its vision. This includes working in smarter ways across partnerships and reducing duplication of effort.

The SAB held its development sessions in October 2017 and January 2018. These sessions provide the SAB with an opportunity to reflect upon its progress and review its 'plan on a page' and related priorities.

The SAB agreed to revise its priorities for the period 2018 to 2021, and to adopt a streamlined approach by reducing the priorities from eight to four.

A key emphasis for the SAB moving forward into 2018 is performance monitoring, with a view to bringing strengthened narrative and analysis of data across all the statutory SAB agencies. The recent peer review team gave added validity to this area of development. Improving upon performance reporting will offer the SAB further assurance of the effectiveness of its arrangements through completion of development session actions and related learning from the recent peer review.

Other areas identified include strengthened engagement with Healthwatch, including the exploration of research opportunities to inform the work of the SAB and identification of future priorities.

> *Partners see the Board as inclusive*

> *Real desire to make a difference*

> *The Board is on the right path*

Sources: Peer Review team March 2018

> *Very good session, two key themes worked well, probably the best session we've had, more interactive, and maybe a feeling of a more mature group.*

> *SAB should have more days like this and strive for excellence.*

Source: Board member October 2017

Partner Statements

Durham County Council

Adult Care

Durham County Council continues to fulfil its responsibility under the Care Act 2014 to protect adults with care and support needs from abuse and neglect. There have been a number of initiatives and improvements to the service in order to achieve these goals. The local authority are the lead agency for safeguarding and the Adult Protection Lead Officer team are responsible for coordinating the safeguarding response at an operational level. The team of seven lead officers was increased to eight, to address an increase in adult protection referrals and to ensure that the quality of safeguarding was maintained. Regular meetings were arranged with the chair of the Safeguarding Adults Board to promote and maintain links between the operational and the strategic aspects of safeguarding.

A procurement process has commenced to replace the current ageing adult care IT system to bring the local authority up to date with modern IT facilities. This will ensure safeguarding records are better managed and overall issues are more easily identified, such as multiple victims and emerging issues relating to care provision.

A Training Bulletin has been introduced to be disseminated quarterly in order to promote continuous learning amongst local authority staff and inform them of latest practice issues regarding topics such as Mental Capacity Act and advocacy.

A new advocacy provider, Rethink, now provides all advocacy services to the local authority, replacing the previous advocacy service providers and providing a more consistent approach to advocacy to fulfil Care Act, Mental Capacity Act or Mental Health Act requirements.

The Safeguarding Team has been working closely with other local authority departments, such as trading standards, environmental health and housing to ensure there is a more comprehensive and integrated response to safeguarding issues. This joint working has been improved by the introduction of new referral forms, leaflets and training.

The local authority celebrated World Social Work Day on Tuesday 20 March. Social workers from Adult and from Children's Services came together in County Hall for the event, which created the opportunity to recognise the variety of crucially important tasks they perform in helping some of our most vulnerable residents.

Housing Solutions

Housing Solutions provide a strategic and operational role in the delivery of key local housing services including:

- Homelessness or risk of homelessness and Homeless Prevention
- Advice on the range of accommodation options available through Durham Key Options, Private Rent, Housing Associations, Supported accommodation, Emergency hostels and Refuges and Gypsy, Roma and Traveller sites;
- Family Intervention Project, Integrated Offender Management Project, HOPE Project, Project Beta, Remain Safe Project, Welfare Reform Project
- Disrepair, Empty Properties and Regeneration
- Private Landlord Accreditation Scheme
- Loans and Grants
- Energy issues
- Home Improvement Agency
- Rights and responsibilities as a tenant or an owner occupier

Some key achievements this year include:

- Development of Near-Miss procedure
- Development of Safeguarding champions- dedicated safeguarding rep in all service areas raising awareness and knowledge.
- Annual staff safeguarding self- assessment audits
- Mandatory mental capacity act training and MSP briefings
- Development of Modern Slavery procedure
- Implementation of MSP through Personal Housing Plans and initial needs assessments
- Development of Rough Sleeper strategy (Multi-agency)-including sweeps of Durham City engaging and empowering vulnerable rough sleepers
- Project Beta- dedicated keyworkers supporting offenders from prison to accommodation
- MAPPA- dedicated officers in attendance and engagement in housing support
- County Durham Housing Providers Safeguarding Partnership- Housing solutions facilitate key speakers and training to wider partners
- Potential of a Rough Sleeper outreach worker

An area of good practice is the development of a questionnaire with the help of vulnerable adults (Rough Sleepers) to share their experiences and collate views. We provided advice and support to those choosing to sleep rough identifying the need for a dedicated outreach worker. Our challenges for 2018-2019 include:

- Clients with a Dual Diagnosis
- Appropriate suitable temporary accommodation
- Housing clients with complex needs

Clinical Commissioning Groups

NHS North Durham Clinical Commissioning Group

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

CCGs are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of or experiencing abuse or neglect. North Durham (ND) and Durham, Dales, Easington and Sedgefield (DDES) CCGs are committed to the safeguarding agenda and work closely with provider organisations to ensure that robust systems and processes are in place.

The CCGs support the work of the SAB in working towards achieving its strategic plan by active contribution and participation. It has further supported the SAB by means of contributions for staffing resources for the period 201/2018.

Over the last year the CCGs have worked with the local authority safeguarding staff in relation to the executive strategy process, Section 42 enquiries and adult protection investigations.

The CCGs continue to work with primary care colleagues to raise awareness through primary care practice development sessions which have been held throughout 2017/2018. Topics included;

- Consent/Capacity/Confidentiality
- Prevent/Stay Safe
- Coroner's update
- Domestic Abuse Support Services
- Sexual Assault Referral Centre
- Modern Day Slavery/Human Trafficking
- Adult Reviews and Lessons Learned

In addition the CCG safeguarding team have received training around Safeguarding Adults process and research methodologies and processes.

The CCG Safeguarding team continue to monitor commissioned providers compliance in relation to the Prevent agenda.
The Designated Nurse acts via a Memorandum of Understanding as a conduit between the North East Ambulance Service and the Local Safeguarding Adults Board.

A challenge for 2018/19 is to continue ensure the requirements of the "competencies for health staff" guidance is fully implemented across the health sector following publication.

Durham Constabulary

Durham Constabulary is a Service that continues to deliver excellent Policing to the Communities of Durham and Darlington. The Force has been praised for the way it inspires confidence in Victims and communities by protecting neighbourhoods, tackling criminals and solving problems.

Durham Constabulary have a designated Detective Superintendent heading the Safeguarding department.

There has been growth in the last 12 months and the Department now has two dedicated Detective Chief Inspectors allowing for additional cover to both manage active investigations and also the Strategic direction of the Organisation.

Staff from Durham Constabulary understand that Safeguarding is 'Everybody's business' and to support this all members of staff receive regular structured and ad-hoc inputs as part of continuous development to ensure we deliver an excellent service to the Public.

Detectives that have a dedicated role in the Safeguarding Department are 'Omni-competent' in all types of investigations requiring specialist knowledge.

Durham Constabulary has been praised in the way that it 'Problem Solves' issues and there is a true understanding with staff around the need to work with partners with prevention being a key focus.

In conjunction with PCVC Office we continue to carry out Victim surveys to understand ways to improve our response to victims.

- Our victim-focussed investigations continue to gain praise. We listen to victims, identify their vulnerabilities early and supported them through the process.
- Good practice and highlighted by HMIC as excellent, is the victim and ASB 7 day ring-backs we conduct with service users, enabling us to identify good practice or areas for improvement and implement change at an early stage.

- Our response to vulnerable adult missing from homes that ensures we identify early vulnerability and identify support agencies to reduce likelihood of going missing in the future (Herbert Protocol / ERASE)
- Our management of Modern Day Slavery / Human Trafficking investigations has received praise following a recent Audit from the lead Force

Our challenges for 2018 – 2019 include, managing increasing demands in times of austerity and the ever changing face of Policing, especially around the Digital enabler element.

Tees, Esk and Wear Valleys NHS Trust

Tees, Esk and Wear Valleys NHS Foundation Trust provides a range of community and in patient specialist Mental Health and Learning Disability services across a large geographical area.

Our vision is to be a recognised centre of excellence with high quality staff providing high quality services that exceed expectations. Providing excellent services working with the individual users of our services and their carers to promote recovery and wellbeing.

The Trust attends and is an active participant in the work of the Safeguarding Adults Board and associated sub groups.

Trust safeguarding activity is monitored internally by the Safeguarding and Public Protection Sub group of the Quality Assurance Committee which reports to the Trust Board.

The Trust is also monitored by the Clinical Commissioning Groups via the Clinical Quality Review Group meetings in relation to safeguarding.

At the end of 2017/18 compliance rates of Trust staff meeting the mandatory training requirements for Safeguarding Adults Level 1 training was 93% and Level 2 training compliance was 93%.

The safeguarding Level 1 mandatory training programme has been revised and now incorporates safeguarding adults and safeguarding children training. Also Level 2 refresher training programme has been developed.

Mental Capacity Act Training is mandatory for Trust staff. To further improve adherence to the legislation and monitor compliance, the use of Mental Capacity Champions across the Trust who have been trained at a higher level on MCA/DoLS, and they will attend regular MCA forums.

Making Safeguarding Personal (MSP) questionnaires are offered to all patients willing to feedback their experience of safeguarding adult procedures. The results from 2017/18 MSP survey work demonstrated that patients felt informed and involved, and that safeguarding support and outcomes were appropriate.

The Trust Multi-Agency Risk Assessment Conference Advisors have produced a Domestic Abuse training programme which is available for Trust staff through the education and training portfolio

The Trust supports campaigns and events throughout the year and actively promotes safeguarding adults alongside the Local Authority

It is expected that NHS England will publish the SGA intercollegiate guidelines in early summer it is unknown what impact this will have on the current Trust resources.

Further embed Specialist safeguarding supervision into the Trusts clinical supervision compliance monitoring system.

Further embed 'Think Family' into all aspects of safeguarding work including training, support and advice and when working with vulnerable adults.

Participate alongside partner agencies in implementing national initiatives to identify and report and manage Modern Day Slavery cases

County Durham and Darlington Fire and Rescue Service

County Durham and Darlington
Fire and Rescue Service

As a fire and rescue service (FRS) we have a statutory responsibility to proactively reduce risk in the community and provide an emergency response service. To ensure we are effective in making people safer, we use a range of information to identify residents who may be vulnerable or at greater risk and target our resources to support them. We also work with businesses, providing support, advice and enforcement if necessary to ensure they comply with their duty under the Fire Safety Order. This work can result in our crews interacting with people who have social care and safeguarding needs and helps to deliver against our vision to have the ''safest people, safest places" wherever people live, work or visit within County Durham and Darlington.

SAB Priority – Care Act/Legislation Compliance, Awareness, Prevention and Partner Engagement

Delivering against our duty under safeguarding is included in the Service's community safety strategy and this has been supported by a review of our policy and procedure to ensure they comply with the Care Act 2014, the locally agreed policy and procedures and that they take cognisance of the Mental Capacity Act 2005. A key achievement this year has been to refresh and upgrade safeguarding training to all our staff. Our staff have completed training in 'making every contact count' and Level 1 'alerter' training to ensure they can identify and refer those that may need help and support; this is predominantly delivered through our targeted Safe and Wellbeing visits. Our central community safety team have been trained to Level 2 'managing the alerter' to ensure appropriate action is taken when a safeguarding report is received from our staff; they have also attended Mental Capacity training sessions organised by the SAB business unit.

SAB Priority – Learning Lessons and Improvement

Due to increased knowledge and awareness, the FRS have referred a case to a Safeguarding Adults Review (SAR) panel, which has been taken forward under a learning lessons review, we have also supported information gathering for other referred cases.

SAB Priority – Partner Engagement

During the delivery of our visits to businesses, to undertake fire safety audits, we identified two potential cases of modern slavery at separate premises. The Fire Service referred to the Police, and it resulted in follow up joint inspection visits, which led to appropriate action being taken in both cases.

We would like to build on our current practises by:

- Introduce a quality assurance process to confirm staff understanding of safeguarding and referral procedures;
- Organising further training with the Police and DCC to increase knowledge and practices in relation to modern slavery and human trafficking;
- Raise awareness of safeguarding within our communities through interaction at fire station open days.

Safeguarding Adults Board – Strategic Plan on a Page 2018-2021

County Durham SAFEGUARDING ADULTS INTER-AGENCY PARTNERSHIP

OUR VISION

"We will support adults at risk of harm to prevent abuse happening; and when it does occur we will act swiftly to achieve good outcomes"

Sub-Group	Practice and Implementation	Engagement and Communication	Performance and Governance	Learning and Improvement
Priorities	Prevention and Early Intervention	User/Carer Voice and Awareness Raising	Performance, Quality and Governance	SAR Learning and Training
Key Objectives Development Areas	1. Identify opportunities to prevent abuse, neglect or exploitation through links to commissioners and organisations. 2. Reduce opportunities for abuse, neglect or exploitation and promote resilience and empowerment across communities. 3. Strengthen working with Area Action Partnerships and wider partnerships on prevention agenda.	1) Increase opportunities to engage with adults and carers and wider communities. 2) Include measures of impact of effective outcomes in board reporting. 3) Increase opportunities to build a culture across all organisations that places adults with care and support needs at the centre of safeguarding intervention.	1) Streamlining governance arrangements mindful of SAB direction. 2) Explore and improve the performance monitoring with partner inputs for both quantitative data and qualitative information. 3) Review performance reporting and thresholds for quarterly escalation to board.	1) Identify learning from local, regional and national Safeguarding Adult Reviews (SARs) to inform improved practice. 2) Development of innovative approaches to training across the partnership. 3) Devise processes to effectively capture and evaluate training.
Suggested Outputs	• Provide information and advice in accessible ways for communities. • Full review of policies and procedures (incl. commissioners) • Improved monitoring of types of abuse to inform prevention strategies. • Wider partnership engagement. • Website development.	• Consultation/engagement across wider and diverse communities. • Survey activities and case studies. • Increased involvement with Healthwatch. • Performance measures for engagement events. • Rebrand Making Safeguarding Personal information for adult's carers and wider communities.	• Governance/Terms of Reference signed off by board. • Cycle of audits agreed by SAB. • Performance data that fits with priorities includes partnership data in existence and partner data. • Board attendance and contributions to the board captured through compliance.	• Evidence of compliance with the Care Act 2014 requirements. • Learning and development events. • Agreed training strategy. • Improved training evaluation. • Emerging themes identified. • Training Needs Analysis (themed)
Example Indicators	Examples: Monitoring reported concerns, types of abuse (analysis, including organisational concerns)	Examples: Survey data, website data, and qualitative information illustrating voice of adults and carers.	Examples: Compliance reporting, risk logs, completed audits, outcomes data.	Examples: Training & Learning Event attendances, TNA data, Training Impact and Evaluation measures.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

1 October 2018

Quarter One 2018/19 Performance Management Report

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

Purpose of the Report

1 To present progress towards achieving the key outcomes of the council's corporate performance framework for the Altogether Healthier theme for the first quarter of the 2018/19 financial year.

Summary

2 Health continues to be a challenging area for the county. Smoking remains one of the biggest causes of death and illness in the UK. It increases the risk of developing more than 50 serious health conditions, some of which are fatal or can cause irreversible long-term damage to health. Smoking prevalence has decreased in County Durham in the last year and is now not significantly different to regional and national figures. Commissioned smoking cessation services perform well and have exceeded contracted targets. However, mothers smoking during pregnancy remains a challenge with the Durham Dales, Easington and Sedgefield clinical commissioning group area having the highest rate (21.9%) in the North East and third highest nationally. A recent health equity audit shows that smoking prevalence is linked to areas of higher deprivation. Breastfeeding has long-term benefits for babies, lasting right into adulthood and also benefits the mother. Breastfeeding prevalence amongst new mothers is significantly lower in County Durham than the rest of the North East and nationally. Older people admitted to residential and nursing care on a permanent basis has increased in the last year and we are not achieving our Better Care Fund target.

Performance Reporting Arrangements for 2018/19

3 Our performance management framework provides us with a valuable insight into the extent to which we are achieving our objectives and how effectively the council and its partners are meeting the needs of our residents. It enables us to regularly assess, report on and scrutinise performance to support the continuous improvement of our services.

4 It brings together key planning, monitoring and evaluation processes through an integrated suite of documents, including the Sustainable Community Strategy, Council Plan, Service Plans and the Medium Term Financial Plan, and demonstrates the contribution made at various levels of the organisation to our priority themes.

Overview of performance

5 Altogether Healthier is one of six priority themes that forms the basis of our PMF. This report sets out the key messages relating to this priority theme structured around the following two areas of focus:

- Are our services improving the health of our residents?
- Are people needing adult social care supported to live safe, healthy and independent lives?

6 A comprehensive table of all performance data is attached as Appendix 2.

ALTOGETHER HEALTHIER

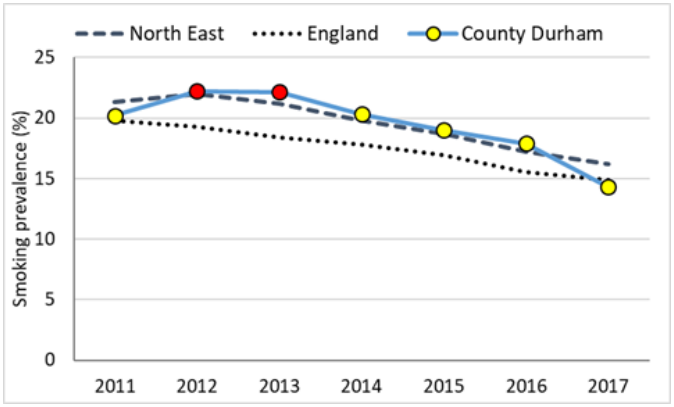
1. Are our services improving the health of our residents?

Smoking Quitters

2,497 people quit smoking with support between 1 April 2017 and 31 March 2018, exceeding the target of 2,401.

Quit with Bella is a stop smoking app: the world's first artificial intelligence powered stop smoking coach, using knowledge from hundreds of experts to provide a personal, friendly and expert service. https://www.smokefreelifecountydurham.co.uk/Quit.aspx

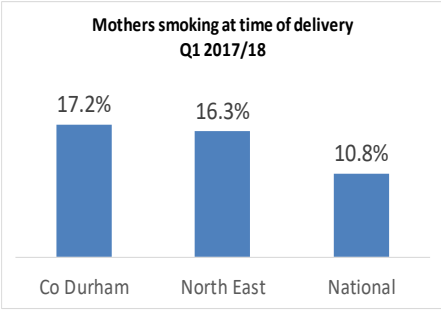
Smoking Prevalence



	Statistically significantly higher than England
	Not statistically significantly higher than England

Mothers Smoking at Time of Delivery

- worse than same period last year (16.7%);
- worse than England (10.8%) and North East (16.3%);
- DDES CCG has the highest rate (21.9%) in the North East and third highest nationally;



Solution 4 Health Stop Smoking Service (SSS)	
227	pregnant women set a quit date with the SSS in 17/18;
148	65% women managed to quit (self-reported), compared to 55% in 2016/17;

Prevalence of breastfeeding at 6-8 weeks

28.2% (Apr-Jun-17)
29.2% (Apr-Jun-18)

Although performance has increased slightly, levels are still low and it is still an issue.

Website www.durham.gov.uk/beststartinlife launched with key information to help parents and families make an informed choice about breastfeeding.

Are our services improving the health of our residents?

7 Of the 13 indicators that support this area, percentage of mothers smoking at time of delivery has deteriorated since last year, missed target and is performing below national and regional averages. Male life expectancy at birth has deteriorated since last year and is below national average, male healthy life expectancy has also deteriorated since last year and is below national and regional averages. Prevalence of breastfeeding at 6-8 weeks; female life expectancy; female healthy life expectancy; excess weight in adults and the suicide rate are all performing below national and regional averages.

8 Between April 2017 and March 2018, 2,497 County Durham residents stopped smoking with support from the Stop Smoking Service (SSS). This has exceeded the SSS 2017/18 contract target of 2,401 smoking quitters.

9 Estimated smoking prevalence (persons aged 18 and over) is 14.3% for 2017 which has decreased from 2016 (17.9%) and for the first time, is not significantly different to both national (14.9%) and North East (16.2%) averages.

10 For 2017/18, 17.2% of mothers (844 out of 4,908) were smoking at time of delivery (SATOD) which is a decrease in performance from 2016/17 (16.7%). Challenging SATOD targets have been set for County Durham which reflect the government's Tobacco Control Plan to significantly reduce smoking rates for the population of England by 2022, paving the way for a smoke-free generation, which specifically aims to lower the smoking in pregnancy rate. The 2017/18 target of 15.9% has, however, not been achieved. Performance is worse than both national (10.8%) and regional (16.3%) rates.

11 Durham, Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group (CCG) has the highest rate (21.9%) in the North East and is the third highest of all CCGs in England. The reducing smoking in pregnancy incentive scheme currently being implemented in DDES aims to address this issue. Early data are showing good retention in the Stop Smoking Service (SSS) amongst these women. However, the challenges of reducing smoking in pregnancy is evident, as 61% of those recruited to the scheme live with a smoker. The full evaluation of the incentive scheme will be available late summer 2018.

12 Overall, between April 2017 and March 2018, 227 pregnant women set a quit date with the SSS of whom 148 women quit (self-reported). This equates to 65% quitting, which is an increase from 2016/17 (55%).

13 A Health Equity Audit (HEA) of County Durham NHS Stop Smoking Service 2018 has been carried out to assess whether the County Durham NHS SSS is having an impact on health inequalities and also to provide a comparison with a previous HEA conducted in 2014. The findings and recommendations of the

2018 HEA, together with areas for further investigation, have been presented to the SSS and the Tobacco Control Alliance. A summary of key findings are as follows:

- Smoking prevalence has been decreasing over time for England, the North East and County Durham;
- County Durham is significantly worse than England for most indicators related to smoking, as set out in the Local Tobacco Control Profiles;
- Levels of smoking in pregnancy remain high;
- The number of babies born to mothers who smoke is higher in the more deprived areas;
- There is a higher rate of pregnant women who smoke referred to the SSS, accessing the service and quitting, from the more deprived areas;
- There is a higher rate of people setting a quit date and quitting smoking who live in the more deprived areas of County Durham;
- The County Durham SSS has been successful in reducing the equity gap, seeing a consistent increase in the relative index of inequality for access and quit rates. This indicates that the service is contributing to a reduction in health inequalities;
- GP, pharmacy and specialist settings have higher rates of access and quitters in the more deprived areas. Services are continuing to perform well in terms of reducing inequalities.

14 Between April and June 2018, the percentage of mother's breastfeeding at 6-8 weeks is 29.2% (359 out of 1,230 mothers), which is an increase from the same period in 2017 but below latest data for both national and regional averages.

15 A breastfeeding call to action paper has been presented to Public Health Senior Management Team to support the active promotion of breastfeeding across the county, which includes a multi-agency communication plan and a review and relaunch of the breastfeeding friendly business scheme in June 2018. In conjunction with national breastfeeding week (20-26 June 2018) a new website www.durham.gov.uk/beststartinlife has been launched, with key information to help parents and families make an informed choice about breastfeeding. Parents can also access information to help them prepare for and stay healthy in pregnancy, along with advice and guidance on becoming a parent and baby's first year.

ALTOGETHER HEALTHIER

2. Are people needing adult social care supported to live safe, healthy and independent lives?

85.9% (548) of people were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (Jan-Mar 2018).
Target met, but performance lower than same period last year (88.5%).

86.9% of people received an assessment/ review within the last 12 months (Jun 2017 to Jun 2018) this is slightly down on the 12 months prior (87.2%).

97.7% of individuals achieved their desired outcomes from the adult safeguarding process, better than same period last year (95.7%).

Daily delayed transfers of care beds per 100,000 population

3.2	(May 2017)		Better than averages for England (9.3) and the North East (8.2). DCC is ranked 20th in England.
4.9	(May 2018)		

Number of bed days commissioned

899,637	2017/18 (actual)	The number of bed days commissioned is still on track to reduce for the fourth year in a row, although there has been a slight increase at quarter one (223,683) when compared to last year (218,918).
894,732	2018/19 (estimate)	

Adults aged 65+ per 100,000 population admitted to care on a permanent basis (Apr-Jun)

191.0	(Apr- Jun 2017)		Target 154.9
199.5	(Apr-Jun 2018)		

Are people needing adult social care supported to live safe, healthy and independent lives?

16 Of the eight indicators that support this area, older people at home 91 days after discharge from hospital into reablement/rehab; service users receiving an assessment or review in last 12 months; delayed transfer of care beds have all deteriorated since last year. Adults (65+) permanently admitted to residential or nursing care has missed target and deteriorated since last year. Carer satisfaction with support and services, and service users who report they have enough choice are below regional average and user satisfaction with care and support has deteriorated since last year and is below national and regional averages.

17 Through quarter one of 2018/19 there were 217 adults aged 65+ admitted on a permanent basis to residential or nursing care. This equates to a rate of 199.5 per 100,000 population. This is an increase of 8.5 per 100,000 from the 191.0 (203 admissions) recorded over the same period in 2017/18. This is a Better Care Fund (BCF) indicator with an annual target of 726.2 admissions per 100,000 population. The quarter one target of 154.9 per 100,000 has not been achieved.

18 Despite the rise in permanent admissions and the missed BCF target through quarter one, the number of bed days commissioned is on track to reduce in 2018/19 for the fourth year in a row. There were 223,683 bed days commissioned through quarter one, with a forecast of 894,732 across 2018/19, a 0.5% decrease from the 899,637 recorded through 2017/18.

19 All residential / nursing admissions continue to be scrutinised by team managers at an admissions panel to ensure consistency.

20 From January to March 2018, there were 638 discharges from hospital in reablement / rehabilitation services. Of those, 548 remained at home 91 days after their discharge (85.9%). This is a reduction in performance from the same period in 2017 when 88.5% remained at home.

21 This is a BCF indicator with an annual target of 85.9% which has been achieved through quarter one.

22 In quarter one of 2018/19, 97.7% of individuals (304 of 311) achieved their desired outcomes from the adult safeguarding process. This is the best quarterly performance recorded since the indicator began to be tracked in 2016/17.

23 Throughout May 2018, there were an average of 4.9 delayed transfers of care per day per 100,000 population. This is an increase from 3.2 in May 2017. Despite this increase, Durham continues to perform extremely well in delayed

transfers of care. The 4.9 average is better than the national average of 9.3 and the North East average of 8.2 over the same period. Durham was the 20th best performing local authority in England for delayed transfers of care in May 2018.

Risk Management

24 Effective risk management is a vital component of the council's agenda. The council's risk management process sits alongside our change programme and is incorporated into all significant change and improvement projects.

25 There are no key risks in delivering the objectives of this theme.

Recommendations and reasons

26 That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising therewith.

Contact: Jenny Haworth Tel: 03000 268071

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 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 performance indicators 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 Performance Indicators

There are two types of performance indicators throughout this document:

(a) Key target indicators – targets are set as improvements can be measured regularly and can be actively influenced by the council and its partners; and

(b) Key tracker indicators – performance is tracked but no targets are set as they are long-term and/or can only be partially influenced by the council and its partners.

A guide is available which provides full details of indicator definitions and data sources for the 2017/18 corporate indicator set. This is available to view either internally from the intranet or can be requested from the Strategy Team at performance@durham.gov.uk

KEY TO SYMBOLS

	Direction of travel	Benchmarking	Performance against target
GREEN	Same or better than comparable period	Same or better than comparable group	Meeting or exceeding target
AMBER	Worse than comparable period (within 2% tolerance)	Worse than comparable group (within 2% tolerance)	Performance within 2% of target
RED	Worse than comparable period (greater than 2%)	Worse than comparable group (greater than 2%)	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.

More detail is available from the Strategy Team at performance@durham.gov.uk

Key Target and Tracker Indicators

ALTOGETHER HEALTHIER										
1. Are our services improving the health of our residents?										
Ref	**PI ref**	**Description**	**Latest data**	**Period covered**	**Comparison to**					
					Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**
66	AHS 12	% of mothers smoking at time of delivery	17.2^	2017/18	15.9 **RED**	16.7 **RED**	10.8^ **RED**	16.3^ **RED**		
67	AHS 13	Four week smoking quitters per 100,000 smoking population [number of quitters]	3306.8 [2,497]	2017/18	3,180 [2,401] **GREEN**	3076.1 [2,903] **GREEN**				
68	AHS 7	Male life expectancy at birth (years)	78.0	2014/16	Tracker N/a	78.1 **AMBER**	79.5 **AMBER**	77.8 **GREEN**		
69	AHS 8	Female life expectancy at birth (years)	81.3	2014/16	Tracker N/a	81.2 **GREEN**	83.1 **RED**	81.5 **AMBER**		
70	AHS 9	Female healthy life expectancy at birth (years)	59	2014/16	Tracker N/a	57 **GREEN**	63.9 **RED**	60.6 **AMBER**		
71	AHS 10	Male healthy life expectancy at birth (years)	59.1	2014/16	Tracker N/a	59.7 **AMBER**	63.3 **RED**	59.7 **AMBER**		
72	AHS 14	Excess weight in adults (Proportion of adults classified as overweight or obese)	67.5	2015/16	Tracker N/a	New PI N/a	61.3 **RED**	66.3 **AMBER**		

ALTOGETHER HEALTHIER										
1 Are our services improving the health of our residents?										
Ref	PI ref	Description	Latest data	Period covered	Comparison to					
					Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different
73	AHS 11	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population	12.6	2014-2016	Tracker	15.7	9.9	11.6		
					N/a	GREEN	RED	RED		
74	AHS 38	Prevalence of breastfeeding at 6-8 weeks from birth	29.2	Apr-Jun 2018	Tracker	28.2	43.6	32.7		Oct-Dec 2017
					N/a	GREEN	RED	RED		
75	AHS 40	Estimated smoking prevalence of persons aged 18 and over	14.3	2017	Tracker	17.9	14.9	16.2		
					N/a	GREEN	GREEN	GREEN		
76	AHS 41	Self-reported wellbeing - people with a low happiness score	6.9	2016/17	Tracker	11.5	8.5	8.7		
					N/a	GREEN	GREEN	GREEN		
77	NS 21	Participation in Sport and Physical Activity: active	63.1	Nov 16–Nov 17	Tracker	59.5	61.8			
					N/a	GREEN	GREEN			
78	NS 22	Participation in Sport and Physical Activity: inactive	25.3	Nov 16–Nov 17	Tracker	28.0	25.7			
					N/a	GREEN	GREEN			

^provisional data

ALTOGETHER HEALTHIER										
2. Are people needing adult social care supported to live safe, healthy and independent lives?										
Ref	**PI ref**	**Description**	**Latest data**	**Period covered**	**Comparison to**					
					Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**
79	AHS 18	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	199.5	Apr–Jun 2018	154.9 RED	191.0 RED				
80	AHS 20	% of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	85.9	Jan–Mar 2018	85.9 GREEN	88.5 RED	82.5 Not comparable	85.3 Not comparable		2016/17
81	AHS 16	% of individuals who achieved their desired outcomes from the adult safeguarding process	97.7	Apr–Jun 2018	Tracker N/a	95.6 GREEN				
82	AHS 17	% of service users receiving an assessment or review within the last 12 months	86.9	Jun 2017-Jun 2018	Tracker N/a	87.2 AMBER				
83	AHS 21	Overall satisfaction of people who use services with their care and support	63.6	2016/17	Tracker N/a	69.5 RED	64.7 AMBER	66.9 RED		
84	AHS 22	Overall satisfaction of carers with the support and services they receive (Biennial survey)	43.3	2016/17	Tracker N/a	New PI N/a	39.0 GREEN	45.7 RED		
85	AHS 19	Daily Delayed transfers of care beds, all per hospital per 100,000 population age 18+	4.9	May 2018	Tracker N/a	3.2 RED	9.3 GREEN	8.2 GREEN		
86	AHS 23	% of adult social care service users who report they have enough choice over the care and support services they receive	73.1	2016/17	Tracker N/a	New PI N/a	67.6 GREEN	73.4 AMBER		

Other additional relevant indicators

A. TOGETHER BETTER FOR CHILDREN AND YOUNG PEOPLE										
1. Are children, young people and families in receipt of universal services appropriately supported?										
Ref	**PI ref**	**Description**	**Latest data**	**Period covered**	**Comparison to**					
					Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**
35	AHS 1	Under 18 conception rate per 1,000 girls aged 15 to 17	21.3^	2016/17	Tracker	25.9	18.5^	24.8^		
					N/a	GREEN	RED	GREEN		
36	AHS 2	% of five year old children free from dental decay	74.2	2016/17	Tracker	64.9	76.7	76.1		
					N/a	GREEN	RED	RED		
37	AHS 3	Alcohol specific hospital admissions for under 18s (rate per 100,000)	56.2	2014/15-2016/17	Tracker	67.5	34.2	64.8		
					N/a	GREEN	RED	GREEN		
38	AHS 4	Young people aged 10-24 admitted to hospital as a result of self-harm	400.8	2016/17	Tracker	420.8	404.6	425.3		
					N/a	GREEN	GREEN	GREEN		
39	AHS 5	% of children aged 4 to 5 years classified as overweight or obese	24.1*	2016/17 academic year	Tracker	24.3	22.6	24.5		
					N/a	GREEN	RED	GREEN		
40	AHS 6	% of children aged 10 to 11 years classified as overweight or obese	37.7*	2016/17 academic year	Tracker	37.0	34.2	37.3		
					N/a	AMBER	RED	AMBER		

ALTOGETHER SAFER										
3. How well do we reduce misuse of drugs and alcohol?										
Ref	**PI ref**	**Description**	**Latest data**	**Period covered**	**Comparison to**					
					Period target	**12 months earlier**	**National figure**	**North East figure**	**Nearest statistical neighbour**	**Period covered if different**
95	AHS 31	% of successful completions of those in alcohol treatment	33.6	Dec 2016-Nov 2017 with reps to May 2018	28.0 GREEN	29.0 GREEN	38.6 RED	30.8 GREEN		
96	AHS 32	% of successful completions of those in drug treatment - opiates	6.0	Dec 2016 - Nov 2017 with reps to May 2018	6.0 GREEN	6.2 AMBER	6.6 RED	5.2 GREEN		
97	AHS 33	% of successful completions of those in drug treatment - non-opiates	30.6	Dec 2016 - Nov 2017 with reps to May 2018	26.4 GREEN	28.7 GREEN	36.7 RED	27.4 GREEN		

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Adult Wellbeing and Health Overview and Scrutiny Committee

1 October 2018

Revenue and Capital Outturn 2017/18

Report of Paul Darby, Head of Finance and Transactional Services

Purpose of the Report

1. To provide the committee with details of the 2017/18 revenue and capital budget outturn position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget for the year, based on the final position at the year end (31 March 2018) as reported to Cabinet in July.

Background

2. County Council approved the Revenue and Capital budgets for 2017/18 at its meeting on 22 February 2017. 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:

   - *AHS Revenue Budget - £132.942 million (original £151.581 million)*
   - *AHS Capital Programme – £0.326 million (original £0.318 million)*

3. The original AHS revenue budget was revised in year to incorporate a number of budget adjustments, as summarised in the table below:

Reason For Adjustment	**£'000**
Original Budget	151,581
Transfer From Contingency - Additional Inflation	313
Transfer To Contingency - Winterbourne	(272)
Transfer from Contingency - Care Fees	3,593
Transfer To Contingency - Civica	(150)
Transfers to other services	(7,620)
Use of (+)/contribution to AHS reserves (-)	(14,963)
Use of (+)/contribution to Corporate reserves (MTFP) (-)	460
Revised Budget	**132,942**

4. The use of / (contribution) to AHS reserves consists of:

Reserve	£'000
AWH – Cont. to Social Care Reserve	(15,843)
Public Health Reserve – Cont. from Reserve	885
EHCP Reserve – Cont. to Reserve	(5)
Total	**(14,963)**

5. The summary financial statements contained in the report cover the financial year 2017/18 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 AHS 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 AHS service had a cash limit underspend of £2.651 million against a revised budget of *£132.942 million* which represents a 2.0% underspend. This compares with the forecast cash limit underspend at December of £2.757 million. The outturn is therefore broadly in line with the position forecast at quarter 3.

7. The tables below show the revised annual budget, actual expenditure in 2017/18 and the year end variance. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for AHS; and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	Actual 2017/18 £000	Variance £000	Items Outside Cash Limit £000	Cont. To / (From) Reserves £000	Cash Limit Variance £000	Memo: QTR3 Cash Limit Variance £000
Employees	47,116	45,263	(1,853)	10	(425)	**(2,268)**	(2,418)
Premises	2,267	2,370	103	(131)	(19)	**(47)**	209
Transport	3,004	2,565	(439)	0	0	**(439)**	(299)
Supplies & Services	4,799	4,279	(520)	0	(81)	**(601)**	(339)
Third Party Payments	241,942	243,576	1,634	0	(237)	**1,397**	2,469
Transfer Payments	11,380	10,976	(404)	0	0	**(404)**	(484)
Central Support & Capital	28,283	29,596	1,313	(831)	1,224	**1,706**	1,454
Income	(205,849)	(208,528)	(2,679)	0	684	**(1,995)**	(3,349)
Total	**132,942**	**130,097**	**(2,845)**	**(952)**	**1,146**	**(2,651)**	**(2,757)**

Analysis by Head of Service Area

	Revised Annual Budget £000	Actual 2017/18 £000	Variance £000	Items Outside Cash Limit £000	Cont. To / (From) Reserves £000	Cash Limit Variance £000	Memo: QTR3 Cash Limit Variance £000
Central/Other	7,585	8,677	1,092	(1,200)	171	**63**	(50)
Commissioning	6,446	6,137	(309)	86	(90)	**(313)**	(115)
Environment, Health & Consumer Protection	4,684	4,084	(600)	591	21	**12**	(99)
Head of Adults	111,856	110,532	(1,324)	(410)	(679)	**(2,413)**	(2,493)
Public Health	2,371	667	(1,704)	(19)	1,723	**0**	0
Total	**132,942**	**130,097**	**(2,845)**	**(952)**	**1,146**	**(2,651)**	**(2,757)**

8. The table below provides a brief commentary of the outturn cash limit variances, analysed by Head of Service. 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	£406,000 under budget on employees, mainly due to effective vacancy management. £180,000 over budget in respect of premises/transport/supplies and services. £207,000 net under budget on care related activity.	(433)
Safeguarding Adults and Pract.Dev.	£74,000 under budget due to effective management of vacancies. £9,000 under budget on transport. £102,000 under budget on supplies and services.	(185)
Ops Manager OP/PDSI Services	£152,000 under budget due to effective management of vacancies. £201,000 under budget in respect of premises/transport/supplies and services. £40,000 net over budget on direct care-related activity.	(313)
Ops Manager Provider Services	£1.357 million under budget on employees in respect of early achievement of future MTFP savings. £125,000 under budget on non-staff costs in respect of early achievement of future MTFP savings.	(1,482)
		(2,413)
Central/Other		
Central/ Other	£84,000 under budget on employee-related costs £168,000 over budget on non-staff related costs. £21,000 additional income mainly in respect of salary recharges.	63
		63

Service Area	Description	Cash limit Variance £000
Commissioning		
Commissioning	£122,000 under budget on non-staff costs. £191,000 under budget on Third Party Payments.	(313)
		(313)
Environmental, Health & Consumer Protection		
Head of Env Health and Consumer Protection	£47,000 over budget on employee budgets. £22,000 over budget on non-staff costs. £27,000 over achievement of income	42
Environment Protection/Other	£99,000 over budget on employee budgets. £108,000 under budget on non-staff costs. £37,000 under achievement of income.	28
Consumer Protection	£52,000 under budget on employees mainly in respect of future MTFP savings. £16,000 under budget on non-staff costs. £128,000 under recovery of income.	(60)
Health Protection	£29,000 under budget on employee budgets. £52,000 under budget on non-staff costs. £37,000 over achievement of income.	(118)
		12
Public Health		
Cancer Vulnerable Groups and Sexual Health and Domestic Violence	High usage of emergency contraception and associated drug costs (+£156,000) saving on pharmacy service (-£25,000) Savings on Harbour Contract (-£14,000) and General Prevention Activities (-£4,000).	113
Drugs and Alcohol Health Checks and Smoking Cessation	Community Health checks contract terminated early (-£172,000) premises related costs (-£200,000) NRT voucher scheme (-£106,000) offset by additional GP Health Checks (+£65,000) and supervised consumption (+£47,000).	(366)
Public Health CVP Services Oral Health Obesity and Physical Activity	Fluoridation saving (-£25,000) uncommitted budget re Harrogate contract not allocated (-£183,000) Receipt correction re 16/17 (-£13,000) social marketing (-£31,000) emotional wellbeing and parenting (-£35,000) offset by 0-19 Contract (+£60,000) and other activities (+£7,000).	(220)
Public Health Grant and Reserves	Contribution to reserves of £1,247 million from underspends and uncommitted budgets in Children's Services and Public Health Team including vacant posts, staff recharges, travelling and supplies and services. Additionally early ending of a number of contracts e.g. Living Mindfully and Community Health Checks.	1,247
Public Health Team	Vacant posts (-£205,000) training (-£24,000) staff travelling (-£42,000) supplies and services (-£54,000). Uncommitted budget (-£333,000) additional income from secondments (-£229,000) offset by £53,000 for professional fees.	(834)
Social Determinants/Well being and Adult Mental Health	Early termination of Living mindfully contract (-£77,000) and savings on Wellness Contract (-£5,000) offset by overspends on Crees (+£12K) volunteer drivers (+£10,000) bereavement support (+£110,000) and workplace health (+£10,000).	60
		-

Service Area	Description	Cash limit Variance £000
AHS Total		**(2,651)**

9. In summary, the service grouping has maintained spending within its cash limit. It should also be noted that the outturn position incorporates the MTFP savings built into the 2017/18 budgets, which for AHS in total amounted to £6.353 million.

Capital Programme

10. The AHS capital programme comprised four schemes, LD Provider Services, Drugs Commissioning, Drug and Alcohol Premises Upgrade and Public Health.

11. The AHS capital programme was revised in year to take into account budget reprofiling from 2016/17 following the final accounts for that year. Further reports taken to MOWG during the year included revisions to the AHS capital programme. The revised capital budget totalled £0.326 million in 2017/18, with summary financial performance shown below.

AHS	Actual Expenditure 31/03/2018 £000	2017-18 Budget £000	(Under) / Over Spending £000
LD Provider Services	17	17	0
Public Health – Drugs Commissioning DACT	0	32	(32)
Public Health – Drug & Alcohol Premises	0	200	(200)
Public Health – General	77	77	0
	94	**326**	**(232)**

12. Unspent budgets have been requested to be carried forward to 2018/19.

Recommendations

13. It is recommended that the Adults Wellbeing and Health 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**

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 AHS. 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. Income and expenditure is in line with the necessary statutory regulations.

Adult Wellbeing and Health Overview and Scrutiny Committee

1 October 2018

Quarter 1: Forecast of Revenue and Capital Outturn 2018/19

Report of Paul Darby, Head of Finance and Transactional Services

Purpose of the Report

1. To provide the Committee with details of the forecast outturn budget position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of June 2018 as reported to Cabinet in September.

Background

2. County Council approved the Revenue and Capital budgets for 2018/19 at its meeting on 21 February 2018. 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:

- *AHS Revenue Budget - £126.513 million (original £130.822 million)*
- *AHS Capital Programme – £0.232 million (original £0.232 million)*

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

Reason For Adjustment	£'000
Original Budget	130,822
Transfer to REAL of EHCP	(4,761)
Transfer to REAL – Integrated Transport	(170)
Transfer to TAP	(1)
Use of (+)/contribution to AHS reserves (-)	(453)
Use of (+)/contribution to Corporate reserves (ERVR) (-)	1,076
Revised Budget	**126,513**

4. The use of / (contribution) to AHS reserves consists of:

Reserve	**£'000**
Contribution to AWH - Social Care Reserve	(805)
Use of Public Health Reserve	352
Total	**(453)**

5. The summary financial statements contained in the report cover the financial year 2018/19 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 AHS 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 updated forecasts show that the AHS service is now reporting a cash limit underspend of £3.096 million against a revised budget of *£126.513 million* which represents a 2.4% underspend.

7. The tables below show the revised annual budget, actual expenditure to 30 June 2018 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 the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget	**YTD Actual**	**Forecast Outturn**	**Variance**	**Items Outside Cash Limit**	**Cash Limit Variance**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Employees	38,669	10,474	37,167	(1,502)	0	(1,502)
Premises	1,918	43	1,973	55	0	55
Transport	2,309	282	2,023	(286)	0	(286)
Supplies & Services	4,304	781	4,438	134	0	134
Third Party Payments	257,585	36,593	252,552	(5,033)	0	(5,033)
Transfer Payments	10,649	1,911	10,495	(154)	0	(154)
Central Support & Capital	26,802	19,709	29,512	2,710	0	2,710
Income	(215,723)	(34,478)	(214,743)	980	0	980
Total	**126,513**	**35,315**	**123,417**	**(3,096)**	**0**	**(3,096)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Items Outside Cash Limit £000	Cash Limit Variance £000
Central/Other	8,904	(11,893)	8,755	(149)	0	(149)
Commissioning	6,599	4,859	6,421	(178)	0	(178)
Head of Adults	109,756	29,259	106,987	(2,769)	0	(2,769)
Public Health	1,254	13,090	1,254	0	0	0
Total	**126,513**	**35,315**	**123,417**	**(3,096)**	**0**	**(3,096)**

8. The table below provides a brief commentary of the forecast cash limit variances against the revised budget, analysed by Head of Service. 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	£95,000 under budget on employees due to effective vacancy management. £15,000 under budget in respect of premises/transport/supplies and services. £323,000 net under budget on care provision.	(433)
Safeguarding Adults and Pract.Dev.	£67,000 under budget mainly in respect of staffing and transport costs.	(67)
Ops Manager OP/PDSI Services	£107,000 under budget due to effective management of vacancies. £192,000 under budget in respect of premises/transport/supplies and services. £1.208 million net under budget on direct care-related activity.	(1,507)
Ops Manager Provider Services	£762,000 under budget due to early achievement of MTFP savings.	(762)
		(2,769)
Central/Other		
Central/ Other	Net position mainly in respect of employee-related costs.	(149)
		(149)
Commissioning		

Service Area	Description	Cash limit Variance £000
Commissioning	£178,000 under budget mainly in respect of employees and third party payments .	(178)
		(178)
Public Health		
Cancer Vulnerable Groups and Sexual Health and Domestic Violence	Residual payments relating to various sexual health contracts which have now been brought together under a single contract for 2018/19 (+£25,000).	25
Drugs and Alcohol Health Checks and Smoking Cessation	No material variance.	0
Public Health CVP Services Oral Health Obesity and Physical Activity	Uncommitted budget (-£245,000) and a small over budget on the Early Years Researcher (+£2,000)	(243)
Public Health Grant and Reserves	Amount to balance the cash limit variance (+£806,000) made up principally of the uncommitted budgets in CVP Services and the Public Health team together with savings from vacant posts. These uncommitted budgets are under review as part of the Public Health prioritisation exercise.	806
Public Health Team	Vacant posts in the new structure partially offset by spend on professional fees (-£93,000). Savings on the Regional Maternity survey (-£7,000) and Uncommitted budget (-£488,000).	(588)
Social Determinants/Well being and Adult Mental Health	No material variance.	0
		-
AHS Total		**(3,096)**

9. In summary, the service grouping is on track to maintain spending within its cash limit. It should also be noted that the forecast outturn position incorporates the MTFP savings built into the 2018/19 budgets, which for AHS in total initially amounted to £5.644 million of which £209,000 related to savings in EHCP and which has therefore transferred to REAL.

Capital Programme

10. The AHS capital programme comprises two schemes both of which are in Public Health; Drugs Commissioning, Drug and Alcohol Premises Upgrade.

11. Further reports will be taken to MOWG during the year where revisions to the AHS capital programme are required. The capital budget currently totals £232,000.

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

AHS	Actual Expenditure 30/06/2018 £000	Current 2018-19 Budget £000	(Under) / Over Spending £000
Public Health – Drugs Commissioning DACT	-	32	(32)
Public Health – Drug & Alcohol Premises	-	200	(200)
	-	**232**	**(232)**

13. Officers continue to carefully monitor capital expenditure on a monthly basis. There has been no expenditure incurred to date. At year end the actual outturn performance will be compared against the revised budgets and service and project managers will need to account for any budget variance.

Recommendations:

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

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

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 AHS. 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. Income and expenditure incurred is in line with the necessary statutory regulation.