Adults, Wellbeing and Health Overview and Scrutiny Committee

Date **Monday 21 March 2022**
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 14 January and of the Special meeting on 25 February 2022 (Pages 3 - 22)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. North East and North Cumbria Integrated Care System Update - Presentation by Michael Laing, Director of Integrated Community Services, County Durham Care Partnership

   A draft Integrated Care Board Functions Checklist is also included within the agenda pack for members information (Pages 23 - 92)

7. County Durham and Darlington Adult Mental Health Rehabilitation and Recovery services - Joint Report by Mike Brierley, Director of Mental Health and Learning Disability, Durham Tees Valley Partnership and Jennifer Illingworth, Director of Operations - Durham and Darlington - Tees Esk and Wear Valleys NHS Foundation Trust (Pages 93 - 108)
8. 2021/22 Q3 Performance Management Report - Report of Paul Darby, Corporate Director of Resources (Pages 109 - 124)

9. 2021/22 Q3 Adults and Health Services Budget Outturn - Report of Paul Darby, Corporate Director of Resources (Pages 125 - 132)
10. 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
11 March 2022

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

Councillor P Jopling (Chair)
Councillor R Charlton-Lainé (Vice-Chair)

Councillors V Andrews, C Bell, R Crute, K Earley, O Gunn, D Haney, P Heaviside, J Higgins, L A Holmes, L Hovvels, J Howey, C Kay, C Lines, C Martin, S Quinn, K Robson, A Savory, M Simmons and T Stubbs

Co-opted Members: Ciesielska and Mrs R Hassoon

Co-opted Employees/Officers: Healthwatch County Durham

Contact: Kirsty Charlton Tel: 03000 269705

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Friday 14 January 2022 at 9.30 am**

Present

Councillor P Jopling (Chair)

Members of the Committee
Councillors V Andrews, R Crute, K Earley, P Heaviside, L A Holmes, L Hovvels, C Kay, C Martin, S Quinn, K Robson, M Simmons and T Stubbs

Co-opted Members
Mrs R Hassoon

1 Apologies

Apologies for absence were received from Councillors Charlton-Lainé, Haney, Howey, Gunn and Savory.

2 Substitute Members

Councillor Hunt was present as substitute for Councillor Howey.

3 Minutes

The Minutes of the meeting held on 19 November 2021 were agreed as a correct record and signed by the Chair subject to amendments to the surname of Councillor Hovells to correct the spelling.

4 Declarations of Interest, if any

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

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

6 Introducing QWELL: Digital Mental Health Services for Adults

The Committee considered a presentation of J Austin, Engagement Lead (County Durham, Sunderland and South Tyneside), Kooth plc. which contained information regarding QWELL: Digital Mental Health Services for Adults (for copy see file of minutes).

Members were advised that QWELL was a free, safe and anonymous service which could be accessed by anyone in County Durham, over the age of 18. It consisted of self-help resources, community support and practitioner intervention where required, which could be through text based support or live chat sessions with Counsellors or Emotional Wellbeing Practitioners. The service was accredited by the British Association of Counselling and Psychotherapy.

The service was operated 365 days of the year and practitioners available between 12-10pm weekdays and 6-10pm on weekends and adults did not need to be referred to use the service, but instead were invited to join if they fell within the cohort that the service was available to.

In response to a question from Councillor Stubbs, the Engagement Lead advised that the service was funded by Durham, Darlinigton and Teeside NHS Learning Disability Service. NE

Councillor Kay advised that he worked with charity, Journey enterprises in Coundon and asked how the organisation could engage with the service and how a parent or carer of an adult with learning disabilities would benefit.

The Engagement Lead advised that that giving users the opportunity to speak to professionals and widely promoting the service, would hopefully increase awareness. Users were able to sign up and access the service and guidance from Kooth plc. had been issued for users.

Councillor Hunt asked what safeguarding was in place if a practitioner suspected an immediate threat and the Engagement Lead advised that the practitioner would try to obtain personal information an in instances that the user did not respond to the request, there was an emergency plan which the clinical team would instigate.

Resolved
That the information within the presentation be noted.

7 2021/22 Q2 Adults and Health Services Budget Outturn

The Committee considered a report of the Corporate Director of Resources, which provided 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 September 2021 (for copy see file of minutes).

J McMahon, Principal Accountant presented the report to Members and it was noted that the forecasts indicated a cash limit underspend of £2.350 million at the year-end against a revised revenue budget of £128.664 million, which represented a 1.8% underspend. In arriving at the cash limit position, Covid-19 related expenditure of £3.026 million offset by Covid-19 related savings of £4.013 million had been excluded. Covid-19 costs were being treated corporately and offset by Government funding so far as possible.

Based on the forecasts, the Cash Limit balance for Adults and Health Services as at 31 March 2022 would be £12.676 million and the capital budget for 2021/22 was £1.210 million. As at 30 September 2021 there had been capital expenditure incurred of £71,000.

Councillor Crute referred to the major area of additional cost in respect of to the £3.026 million for the additional financial support paid to providers which included targeted support being given to residential care homes, and he asked whether this was a trend that was likely to continue in the future. He referred to a policy to be agreed by parliament which would allow self-funders to access residential care homes for local authority rates and asked how this would impact the budget and occupancy. M Laing, Director of Integrated Community Services, County Durham Care Partnership, responded to advise that there would be additional pressure on the budget and it would increase pressures on occupancy levels and staffing. He advised that there were 800 self-funded customers that would be an be given access to care homes at local council rates and the impact on the budget was being assessed and was scheduled to be included in reports to Cabinet and County Council, but it was variable and of concern.

Councillor Kay referred to the recently refurbished Drug and Alcohol Rehabilitation Unit in Horden and queried whether there would be any impact to the one in Bishop Auckland. The Director of Public Health advised that it would remain open and an update on the Drug and Alcohol Service would be provided.

Resolved
That the report be noted.

8 Quarter 2 2021/22 Performance Management Report

The Committee considered a report of the Corporate Director of Resources which provided overview of progress towards achieving the key outcomes of the council's corporate performance framework and highlighted key messages to inform strategic priorities and work programmes and covered performance in and to the end of quarter two, July to September 2021 (for copy see file of minutes).

A Harrington, Strategy Team Leader advised that there had been an issue with regards to the new case management which had resulted in a reduction of the percentage of service users assessed or reviewed in the last 12 months which was due to the increased administrative work placed upon social workers. Forms had been previously pre-populated by data already known and whilst historic records had been transferred, the difference between the systems meant it was not possible to pre-populate care forms with historic data. Social workers were therefore required to complete assessment and review forms in their entirety. Once data was inputted into the new system, forms were then pre-populated formswith known data and therefore once the administrative burden had lightened, performance was expected to improve.

Councillor Earley asked whether the suicide rate had been expected to go up and referring to the Qwell presentation he asked how the message was conveyed to those with mental health issues were reached. There were many things that impacted on mental health and he acknowledged the difficulty of the task. There had also been a reduction in physical exercise for young people and queried whether there would be a campaign relaunch and engagement with the community and voluntary sector to get young people involved in sports and activity.

The Director of Public Health advised that a real time data surveillance system enabled the service to monitor through if u care share. The suicide figures were higher than national average, but still comparable to north east. An-depth review had been done 2-3 years prior, with the recommendations still embedded.

The Director of Public Health advised that should an issue within a local community arise there would be a multi-agency partnership response and the information would be shared with local Councillors. She confirmed that Qwell had useful resources to promote and waws being monitored closely.

With regards to the reduction in levels of physical activity, the Director of Public Health advised that during lockdown there had been a national campaign for exercise at home by Joe Wicks and additional work with schools and parents had been encouraged. She added that the Active Durham Partnership made it easy for families to do physical activity at no cost.

The Chair advised that she had flagged up her concerns with Officers with regard to the increase in suicide rate.

Councillor Hovvels referred to the 24% of children who were eligible for school meals and not claiming them, which she believed would continue to rise in the current economic climate and she asked what the Council were doing to alleviate these pressures. The Strategy Team Leader advised confirmed that wider social issues such as increasing energy and the cost of living were impacting on families, and more specific details would be provided to the Committee.

The Chair advised that she had contacted her local AAP who were already aware of these issues and information had been provided on action being taken within the community. Community services such as schools and GP surgeries were aware of the families most affected by poverty.

The Director of Public Health added that the increase in children living in poverty was a significant concern and the Poverty Action steering group were currently considering national policy to review and update the Poverty Action Plan.

Councillor Crute referred to the capacity in residential and nursing care and although the figures were from the first quarter of the previous year, there had been increase adults age 65 and over admitted to residential care on permanent basis. He accepted that the figures would be distorted due to the impact of the pandemic but there was also a national issue with transfers from a hospital setting and he asked whether an update could be provided and asked if there was a reason that there was no comparative data from other authorities in the region as this would assist with the context.

The Director of Integrated Community Services advised that the service would obtain comparative data but this would be slightly out of date. With regards to capacity, there were unoccupied beds in County Durham which was due to staffing and the inability to get enough members of staff to care for those who had been discharged from hospital. However the figures from the discharge list that morning were more positive, and of those patients in acute beds there were 31 in Durham and Darlington who were waiting to be discharged. Of those patients 15 were actively managed by social care and some would go home with a care package. This was a relatively low number, but the trust were working closel with social services in County Durham and a list was provided at 8am and reviewed by social services Managers at 8.30am and 12.30pm to ensure that if there were any issues, they could be resolved in order for people to be discharged by 5pm. The care sector needed to be supported as there were pressures which were caused mainly by staff absences due to covid isolation, but also that there had been changes to the economy and alternative employment was available.

The Principal Overview and Scrutiny Officer advised that the take up of free school meals had been identified as matter of concern at the Children and Young People's Overview and Scrutiny Committee who were including this on their work programme. In terms of poverty issues, this was a cross cutting theme and a more comprehensive report would be provided to the Corporate Overview and Scrutiny Management Board.

Resolved

That the report be noted.

9 County Durham and Darlington Adult Mental Health Rehabilitation and Recovery services

The Committee received a report of the Director of Mental Health & Learning Disability Durham Tees Valley Partnership and the Director of Operations County Durham and Darlington, TEWV, which outlined a proposal to relocate Primrose Lodge Inpatient Rehabilitation and Recovery unit from Chester le Street to Shildon, which would reduce the community-based rehabilitation beds from 15 to 8 (for copy see file of minutes).

The Committee were invited to comment on the proposal which had been supported by the Durham, Tees Valley Partnership Board and County Durham Clinical Commissioning Executive Group. Following the meeting the CCG, with TEWV support will carry out activities to meet the required level of public consultation.

Councillor Martin advised that a reduction of beds was always a concern, particularly in NHS but the knock-on effect of losing beds caused patients to spill over into services they did not require. At one point 55% of these beds were occupied by patients that did not require this level of support and that equated to eight of fifteen patients that should not have been there. He asked how the service would ensure that this vital resource, would not be taken up by individuals who did not need this level of support in future.

In addition, Councillor Martin asked whether transferring funding from the provision of beds to employ more staff to assist people within the community could reduce the number of patients that required a bed, whether there was any proof from any other authority that this would be efficient as he wanted to be assured that this would not damage mental health services across County Durham.

The Director of Operations County Durham and Darlington, TEWV, confirmed that this was not a case of removing funding and redistributing it elsewhere, it was an attempt to reducte the length of stay, which would divert patients from acute wards and create capacity. The provision was countywide provision so although people in Chester le Street may view it as a loss, the service was relocating.

The Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that the national framework was focused on the avoidance of crisis and investment in outreach support, to keep people safe at home with early intervention and tools such as Qwell assisted in thie approach. Inevitably there were people that would need beds, however these beds were for people who were coming out of crisis and beds in west park that were fit for purpose, but sustaining additional investment and resources was shifting to support holistically as per strategy and national framework.

Councillor Andrews confirmed that she was not adverse to more care delivered in community but she queried whether there would be any issues with recruitment in the current crisis as there had been a loss of beds in Shildon due to inability to recruit staff. The Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that staff were in post.

In response to a question from Councillor Quinn the Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that the building was already owned by TEWV and it was considered that this proposal would be in place between April and June however this was not specific as service users would need to be consulted.

Councillor Quinn requested that the Town Council be made aware of the changes as they would receive queries from residents.

R Hassoon noted the changes within the team were extensive and asked what the changes meant for clients. The Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that services would be provided in communities, by community rehab team but some would remain clinic based depending on the need and service required.

Ms Hassoon noted that the service was countywide but asked whether the same provision was available with regards to visitors and in response the Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that the service would be replicated and visitors supported as they were in Chester le Street.

Councillor Stubbs referred to the modelling that had been carried out on the reduction of beds and asked when it had been carried out and whether it been revalidated. The Director of Mental Health & Learning Disability Durham Tees Valley Partnership advised that it had been done 18 months prior and had been reviewed based on the number of admissions over 18 months that were linked to covid and not appropriately placed. This had been considered and procedures were in place to attempt to prevent those admissions and it would continuously be reviewed.

The Principal Overview and Scrutiny Officer advised that the recommendation to request support for the proposal from the Committee and outline the level of public consultation required and timescale to complete was not within the Committee's remit. Members were advised that they may consider any feedback following engagement with the public, at the meeting on 21 March, and comment on the proposal.

Resolved

That the report be noted and a further report outlining the results of the stakeholder feedback undertaken in respect of the proposals be submitted at the Committee's meeting scheduled for 21 March 2022.

10 Director of Public Health County Durham Annual Report 2020/21

The Committee considered the Director of Public Health, County Durha Annual Report 2020/21 (for copy see file of minutes).

The Director of Public Health confirmed that under the National Health Service Act 2006, one of the statutory requirements of the Director of Public Health was to produce an annual report about the health of the local population and the local authority had a duty to publish the report.

The government had not specified what the annual report might contain and has made it clear that this is a decision for individual Directors of Public Health to determine.

The Director of Public Health Annual Report for 2021 focused on the following:

- Foreword
- Health and wellbeing across County Durham
- Approach to wellbeing
- County Durham – our health roadmap
- COVID-19 – response and recovery
- Update on strategic priorities
- Specific focus on 3 remaining strategic priorities; Promoting positive behaviours; High quality drug and alcohol services; Better quality of life through integrated health and care services
- Revisiting the Taylors with a focus on real life case studies
- Update on recommendations from 2020
- Recommendations for 2021 based on the three priority areas of focus

Councillor Kay queried the higher than average rate of obesity in children in County Durham which also had higher rates of child poverty as children in poverty were assumed to be underweight. The Director of Public Health confirmed that children in poverty were more likely to be overweight due to the challenges for parents to provide good healthy food. If a family was struggling financially or with time to prepare food, often the easiest and cheapest option was to provide food that was less healthy. This had led to work around poverty such as holiday activities which would include the offer of healthy food.

Councillor Kay referred to test and trace and asked what had became of track and trace and whether there was a difference. The Director of Public Health advised that what was originally called track and trace had been renamed as test and trace and was a national system, which were all operated by the Uk Health Security Agency and some of the test and trace services were delivered locally. In

response to a further question the Director of Public Health advised that there Public Health England had been disbanded to different parts of the system which were Health Security Agency but the costs associated still remained.

The Chair confirmed that in her opinion, the obesity crisis had to be solved by the government - supermarkets encouraged junk food offers and it was understandable that parents went for the cheap and convenient food.

Councillor Quinn advised that obesity weight management courses were offered through GP's and commented that bariatric people suffered at end of life although would still try to lose weight. She suggested that obesity and poverty were also linked to hot food takeaways and people with the least amount of money would still go to takeaways rather than making healthy homemade food.

The Director of Public Health advised that the North East Clinical Lead had appointed a Manager to look at the different tiers of the service and quality standards as there was a variation across the North East.

Councillor Martin welcomed the emphasis on reducing the figures for smoking, which was almost a factor towards poverty for those who had an addiction. He asked whether there was an explanation why figures increasing and whether there was a similar increase in smoking during COVID-19 as there had been with alcohol.

The Director of Public Health confirmed that people had returned to smoking during the pandemic and young people had taken up smoking. Fresh North East had kept advocacy work at local, regional and national level but attention may have been elsewhere during the pandemic and it was time to refocus on tobacco as it was an addiction that hopefully people could be prevented from starting in the first place.

The Chair referred to the potential health impacts of vaping as many people had taken this up as an alternative to smoking and she queried whether any studies had been undertaken. The Director of Public Health advised that vaping was 95% safer than cigarettes however it was essential to ensure that young people did not take up vaping and would consider targeting, marketing and how vaping was being promoted.

Councillor Robson referred to time at school due to COVID-19 and the impact on physical exercise. At times people were discouraged and he suggested that encouraging more exercise and increasing physical education sessions or inviting clubs into schools to encourage children to join. The Director of Public Health praised the work done in schools worked during the pandemic, to try and keep to the key curriculum and physical activity was included. There was a physical activity strategy being developed, which included various exercises that could be done at home such as walking out with family to sports and was ambitious in terms of what the service wanted to see. County Durham had great opportunities, which

did not come at a high cost and this was something that needed to be considered when emerging from COVID-19 impacts.

Councillor Hunt added that smoking drop-ins were all stopped during the pandemic with the only access being online and queried what was being done to get smoking clinics back up and running. With regards to vaping, Councillor Hunt suggested that it was a new trend for young people and was not something that should not be encouraged.

The Director of Public Health advised that a new service was being transitioned during the pandemic and they did deliver the programmes but many were online. There was also the additional pressures on pharmacies and GP surgeries to deliver the vaccination programme, which were still being delivered most but they were starting to liaise again on some of the pre COVID-19 programmes.

The Director of Public Health advised that she would take the concerns regarding young people and vaping and consider this with colleagues in order to build this into the plan and she acknowledged the role of the Committee in raising important issues such as this.

Councillor Earley added that he was pleased to see the policy that prohibited planning consent for hot food takeaways in the vicinity of schools contained in the County Durham Plan. There were already such high numbers of takeaways that when Members were considering town centres, other uses should be encouraged instead of constant proliferation of unhealthy uses.

The Director of Public Health advised that there was an environment that did not just consist of takeaways but an increase of unhealthy food delivered to doors. When considering Towns and Villages, healthy places and mental health should be considered with public health input. Corporate Directors were looking at priorities underpinning prioritites, but practical examples like hot food takeaway policy but what does it look like in terms of towns and villages

The Chair noted that there were programmes about cooking but people tended not to and there was an issue in getting children to grow up with the ability to cook and in her opinion had to come from within schools and this was an issue that needed to be prioritised by the government.

Advertising tobacco had been made illegal and had also been changes to advertising alcohol, but legislation was required across all levels of unhealthy choices.

Councillor Quinn thanked the Director of Public Health for using the Taylor family as a community champion which would hopefully continue the good work done by the Durham County Council.

Resolved

11 Local Outbreak Management Plan Update

The Committee received a report of the Director of Public Health which provided an update on the Local Outbreak Management Plan, the Health Protection Assurance Board and the current local COVID-19 activity. In addition, the report included an update on the Government's Autumn and Winter Plan, Contain Framework and Plan-B guidance (for copy see file of minutes).

In providing the most recent COVID-19 infection rates, the Director of Public Health confirmed that over 12000 positive cases had been reported during the previous week, which were not translating into same the same level of hospital admissions that the same number of case rates would have resulted in 2021, which was confirmation that the vaccination programme had been significant in reducing hospital admissions.

The Director of Public Health advised that over 86% of people eligible had been given their first dose of thee vaccine, 80% had been given the second dose, and 63% had been given the third booster.

Guidance was continuously changing and the day before the meeting the government had shared new self-isolation guidance. County Durham had a significant level of vaccination stock which had been prioritised and utilised in hight risk settings, care homes, prisons, NHS, in order to keep services running however the national supply was starting to come through. There had been changes to testing, with PCR testing having been suspended.

The Direector of Public Health advised that the infection was circulating in schools but the service was trying to get young people age 12-15 years, vaccinated.

Councillor Stubbs acknowledged the success of the vaccination programme with only 103 patients in hospital in County Durham and he referred to the message being widely conveyed over social media. He asked whether patients' vaccination status was checked on admission to hospital and the Director of Integrated and Community Service , County Durham Care Partnership advised that vaccination status was checked on admission and of the 103 patients admitted only half were admitted with COVID-19 as a primary cause.

Those who were most ill and those in ITU were unvaccinated and people who were unvaccinated were more risk of being ill with COVID-19.

In response to a further comment from Councillor Stubbs who did not thing that the message was getting across, the Director of Integrated and Community Service

advised that this was the message that was being conveyed to the public, the unvaccinated were much more likely to be really, really ill.

R Stray, Communications and Engagement Manager, County Durham & Darlington NHS Foundation Trust advised that over the previous 2-3 weeks the message reported was with regards to the importance of having the first two doses and the booster as soon as eligible. This was reported on social media, internally, the Director mo had been interviewed on BBC Look North.

Councillor Andrews referred to the two strains of COVID-19 Delta and Omicron and queried whether the public were aware that they were both running alongside one another. The Director of Public Health confirmed that Omicron was the dominant variant and even if the booster protected from serious illness, it could still be a really awful virus. The NHS were proactive and reinforcing the message that the effects of this strain was not mild, even for those who were vaccinated and it could still be a serious illness.

Resolved

That the report be noted.

DURHAM COUNTY COUNCIL

At a meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Friday 25 February 2022 at 9.30 am**

Present

Councillor P Jopling

Members of the Committee
Councillors R Crute, O Gunn, D Haney, P Heaviside, L Hovvels, C Kay, S Quinn, K Robson and J Cosslett (substitute for L A Holmes)

Co-opted Members
Mrs R Hassoon

1 Apologies

Apologies for absence were received from Councillors V Andrews, Cc Bell, J Higgins, L Holmes, C Martin, A Savory and T Stubbs.

2 Substitute Members

Councillor J Cosslett was present as substitute for Councillor L Holmes.

3 Declarations of Interest

There were no declarations of interest.

4 Any Items from Co-opted Members or Interested Parties

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

5 Question from a member of the Public

The Chair advised the Committee of the procedure to follow with regards to a question from a member of the public. She confirmed that Mr Cunningham would be invited his question and representatives of County Durham and Darlington NHS Foundation Trust would respond. There would be no debate on the matter and the response would be included in the minutes of this special meeting.

Mr Cunningham asked the following question with regards to the Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR);

- It is my assertion that there has been a disconnect between the County Durham and Darlington NHS Trust, and its University Hospital of North Durham medical and surgical teams: and the patients, family members and legal Trustees of those patients: in the specific area of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy towards those patients whose lives are deemed 'best served' by the surgical and medical staff's decisions to apply those same DNACPR notices without adequate and informed discussion of that notice with patients and / or concerned family members or legal trustees.

  I searched through the recently published minutes of the Adults, Wellbeing and Health Overview and Scrutiny Committee for any sign that a shortcoming in the University Hospital North Durham structure in Medical / Patient End-of-Life conversations was being researched, or corrected; but found nothing.

  The Court of Appeal's ruling on Tuesday 17th June 2014 stated :- *"You have the right to be involved in discussions and decisions about your health and care, including your end of life care, and to be given information to enable you to do this. Where appropriate, this right includes your family and carers."*

  Mr Cunningham advised of his personal experience with the DNACPR procedure.

  Given that apologies and expressions of sincere condolence were eventually stated by the Hospital, as well as promises made to me that staff would be reminded of the importance of Empathy and Sympathy by January 2022 when discussing proposed DNACPR notifications, has the Council's Adults, Wellbeing and Health (AWH) Scrutiny Committee been recently made aware of any changes to both 'Best Practice'; as well as abiding with published changes to the Law, in the specific area of advice and discussions of DNACPR Notifications to patients, family members and Trustees?

Dr D Oxenham, Specialist Palliative Care Consultant, gave a presentation which provided a detailed description of the complexities surrounding the DNACPR procedure and the associated form used in such circumstances was circulated to Members (for copy see file of minutes).

Members were advised of the history surrounding cardiopulmonary resuscitation (CPR) and that it was originally developed to help a minority of young, adult patients, who developed a sudden cardiac arrest. It had changed over time to an

expectation of treatment for all causes of death, however it was ineffective in individuals who were ill and had multiple co-morbidities, or in catastrophic causes such as a massive haemorrhage.

The Specialist Palliative Care Consultant advised of the limited success rate of CPR and how it's effectiveness was reduced by frailty and information was provided which confirmed that even those who had received it with mild frailty had not survived. There was a "deciding right initiative" in place in the North East and Cumbria whereby authority was given for the process under the Mental Capacity Act 2005 and this process had been adopted by NHS England as good practice nationally. The Specialist Palliative Care Consultant confirmed that Clinicians were given full training and a competency assessment was undertaken by all Clinicians who were involved in these discussions.

These decisions were often difficult and distressing for individuals as CPR did not work as well as expectations and this made it difficult to communicate decisions. Members were advised that although there were discussions with patients and their families, the decision was ultimately based on medical assessment, and there was not a choice for patients to opt-in. The Specialist Palliative Care Consultant confirmed that CPR was a procedure that was distressing for the patient and would only be performed if it was deemed to be of benefit.

The Specialist Palliative Care Consultant admitted that there were times of miscommunication, however the Trust were committed to make improvements where possible and ensured that policy and practice was as good as it possibly could be and where improvements could be made, they would be.

6 999/111 Service provision by North East Ambulance Service NHS Foundation Trust- System processes, demand, capacity and performance.

The Committee considered a report of the Corporate Director of Resources, which provided background information regarding the 999/111 services currently provided by North East Ambulance Service NHS Foundation Trust (NEAS) and a detailed presentation by M Hunter, Emergency Operations Centre Manager (for copies see file of minutes).

The Emergency Operations Centre Manager advised that NEAS delivered a number of services including 999; 111; Clinical Assessment Service; Patient Transport Service; and the Dental Clinical Assessment Service.

NHS Pathways was designed to clinically assess patients and triage them to the correct service with a defined timescale identified for the patient. It was developed and maintained by a group of Clinicians and constantly reviewed.

Call handlers were dual trained in both 111 and 999 operations and in order to take live calls would have to undertake a four week, full-time training course and achieve a minimum pass score. Calls were regularly audited with each member of staff having five random calls monitored.

The 111 service was linked up with GP Practices, 17 Dental Hubs, Emergency Departments, 18 Urgent Treatment Centres, Clinical Assessment Service, Out of Hours GP Services and could dispatch an ambulance as if it were a 999 call. Triaging patients reduced footfall in Emergency Departments and health advisors could advise services of the arrival time, as well as giving a summary of the triage for each patient.

The Emergency Operations Centre Manager gave details about call numbers at the end of December 2021. The number of ambulances dispatched was at 17% and this was higher than the national average, which 10-15% but did not take into consideration the actual number of patients that received an ambulance. Patients who received an ambulance was closer to 7% as there were occasions resulting in lower category outcomes after reassessment by Clinicians and patients were downgraded o asked to attend a nearby service. Patients also sometimes declined an ambulance.

The demand was similar the previous year, however the 111 service performance had taken a downward turn due to a change in call patterns. Historically 111 had been an out of hours service, however demand had increased as a result of patients being unable to contact their own GP. Some days there had been a 45% increase in calls received.

During the early days of the pandemic, the national message portrayed was to ring 111 and GP practices essentially shut up shop and directing patients to 111. In conjunction, NHS England were running a campaign called 111 First, which encouraged patients to call 111 as an alternative to attending an Emergency Department. The message became that of “ring 111 for everything” and was being used as an alternative to contacting GP’s.

The service had been overwhelmed during an historically quieter period and there were also increased 999 calls. The dual training had given some protection to the service and all calls had been directed to 999 operators. This was an issue for some other localities with operators that were not dual trained.

The service became further impacted by record increased levels of Health Advisor absence. There were 350 Health Advisors, but and there were periods where up to 35% of staff were absent with COVID-19 or isolating. The Management Team had also been affected with 80% absent at one time and the 25 team leaders were operating at 50% but throughout the pandemic, the centre continued to offer the service. As a result of this substantial reduction in staff, calls had taken longer to answer.

The Emergency Operations Centre Manager confirmed that in addition to COVID-19 infections there was an increase in mental health absences, strongly suspected to be due to fatigue, coupled with being on the receiving end of extremely challenging calls, some of which were abusive. He advised that staff would be increasing from 350 to 500 over the following 6 months and recruitment was taking place.

Having considered ambulance services in other areas the Emergency Operations Centre Manager advised that the number of patients accessing 111 was double and could be that 111 was more established in the North East as this is where the pilot had been ran for three years, or it could be that patients had more difficulty accessing primary care.

Members were advised that in 2022 the service had turned a corner with demand and the abandonment rate was also reducing. It was important to share the month on month decrease as the worst point and most critical period was October with 60%, November 50%, dec 42%, January 33% and to date 19%. The service were committed to answer all calls and get the figure to 0%.

In terms of calls answered NEAS were 25th out of 35 and the speed had reduced to 6.5 6.5 minutes.

Overall this demonstrated that improvements were being made and the service were taking this seriously. Improvements had been mostly due to a large scale recruitment campaign for additional 152 Health Advisors for the 111/999 service and the service was on target with continued recruitment throughout the rest of 2022. An additional 53 staff had been recruited in February. There were also plans to recruit Apprentices and offer training and qualifications.

A third contact centre was being opened in Teesside as the service had outgrown the two that they operated from currently.

In addition, NEAS had liaised with dental services which had enabled the service to double the amount of dental appointments needed. The Dental Service was a strategy that was unique to NEAS; in other parts of the country, callers were advised to contact their local dentist but the North East 11 service were able to offer appointments within one of the 17 dental hubs.

The Emergency Operations Centre Manager advised that the impact on staff was also something that NEAS wanted to address and they would be offering a gift to all staff at the end of March to recognise their hard work and what they had been through over last two years. In addition, a Health and Wellbeing Officer was being recruited and the provision of quiet rooms for staff to use after challenging calls.

Councillor Kay referred to the dental hub which he had not been aware of and asked if he would be signposted to one of the 17 hubs if he contacted 111 in acute pain. The Emergency Operations Centre Manager advised that a patient was triaged which would determine how urgent and severe the concern was. The triage would determine how urgently a patient needed to be seen, usually between a period of between 2 hours to 3 days, however there were 500 available per week, in order to manage urgent dental concerns. If a triage resulted in time scale of 12 to 24 hours, a patient would be asked to attend a dental hub and all information was able to be transferred electronically, there was no need for a patient to contact dental service.

Councillor Kay commended the service but advised that many service users would be unaware and asked how this was being communicated and promoted to the public. The Emergency Operations Centre Manager advised that dental access was a problem nationally and he had worked closely with a dental clinician for three years, part of the project was to create an electronic system but this would be a long progress.

In the short term, 111 was about to launch pilot service where at the very outset of the call an automated message would route the caller to the appropriate local service. This would transfer patients to call handlers trained in dental calls and signpost them. With regards to marketing, the service had deliberately not been promoted and they would be reluctant to as of the 466 appointments that were offered, the utilisation was 98-99% on a weekly basis. At the point of asking for more dental appointments they were ony offering 250. Dental problems equated to 10-15% of 111 calls, it had been the forgotten element of 111 and NEAS were at the forefront in driving some different ways of working. If a patients need was great enough, they tended to call 111 despite not advertising the service.

Councillor Gunn thanked the Emergency Operations Centre Manager for the presentation and reminded him that it had been required for scrutiny due to major concerns regarding the ambulance service causing nervousness and anxiety. She congratulated the service on what they had been able to do and understood the issues regarding capacity and the limitations with amount the funding they had, however Members had a responsibility to residents and she asked how Members could provide residents with confidence in the ambulance service, as they were anxious - and not just older people, but people of all ages.

The Emergency Operations Centre Manager advised that it was important to note that prior to the pandemic, NEAS delivered exceptionally well and 111 had continually been in the top 6 of the best providers in the country. It had slipped a little in last two years, but residents should be assured by the fact that they had delivered and were on the road to recovery again.

The Chair asked whether the dental service was going to be enhanced again so that residents could be made aware that it existed and M Cotton, Assistant Director

of Communications NEAS, reminded Members that the 111 service was commissioned as an urgent care service for when patients required urgent treatment that was not 999. It had been developed around assessing the clinical need for caller. He explained that over the previous two years the model had been confused. What was being suggested was that 111 was promoted as an alternative route to other services when it was not set up to do that. The concern in promoting the service was that it was not an advice line but an urgent care right and if promoted for otherwise, it would become a service for low priority treatment and increase the number of calls. It had been confirmed that 98% of appointments were utilised and if advertised that would increase and in turn, affect call handling times.

The delivery of the service and what others would like it to deliver was something for wider discussion, but not for NEAS as a provider.

In response to a question from Councillor Robson with regards to the number of calls on psychiatric matters the Emergency Operations Centre Manager confirmed that a significant number of calls were received regarding mental health episodes and the service had good links with crisis teams and offered a transfer process, so if the outcome of triage recommended that a patient needed to be seen by a mental health professional or crisis team, they could refer that patient. All calls were taken through triage, as some patients did not require crisis team intervention and could speak to in-house Clinicians instead.

Councillor Charlton-Lainé complimented NEAS for being independently proactive in making improvements. She understood the reasons that pathways could not be advertised, but with regards to the time, she wanted to speak about her on personal experience. She asked having called 111 and been assessed and given a time scale, did the patient need to be seen within that time and did it take into account that the patient may be sat in the emergency department for longer periods.

The Emergency Operations Centre Manager confirmed that this was an ongoing issue and that terminology had changed and most dispositions would be that a patient had to contact a service within time frame and once contact within clinical environment had been made, the recommendation from pathways had been met. With regards to urgent treatment centres, the appointment booking centres worked well and they tried to work around emergency departments to assist with arrival times, however he had heard anecdotally, that due to general footfall from other patients, there were increased pressures in the Emergency Department which impacted on waiting times.

The Chair appreciated the presentation and suggested that a further update be provided in 6 months.

Councillor Quinn advised that she had been made aware of the dental service via social media. She referred to waiting times for drop offs at hospital and was alarmed at how many ambulances were queuing outside of Darlington Hospital and people waiting to be discharged who could not go home as still waiting for ambulances coming in.

P Liversidge, Chief Operating Officer, NEAS, advised Members that there were still a lot of infection control measures as there was a level of protection required to reduce infection. Handover delays were improving and workforces were getting back to normal. Delays were improving and the Trusts were working collectively to deal with patients in the community and create new pathways of care to avoid Emergency Departments.

Councillor Quinn reiterated the importance of hygiene which in her opinion should continue, as during early lockdown stages it was proven in reducing the spread of infection.

Councillor Hovvels advised that the presentation had demonstrated how much progress had been made and she wanted to place on record, her appreciation to the staff who had continued to deliver all services, during an extremely difficult time. She also welcomed the offer of a gift to thank staff.

The Principal Overview and Scrutiny Officer advised that there had been a request for NEAS to provide a heat map or analysis of pattern of service requests within County Durham and they were considering the request. The Assistant Director of Communications advised that he was investigating how the data could be provided and the information would be circulated to the Committee in due course.

Resolved

That the report and presentation be received.

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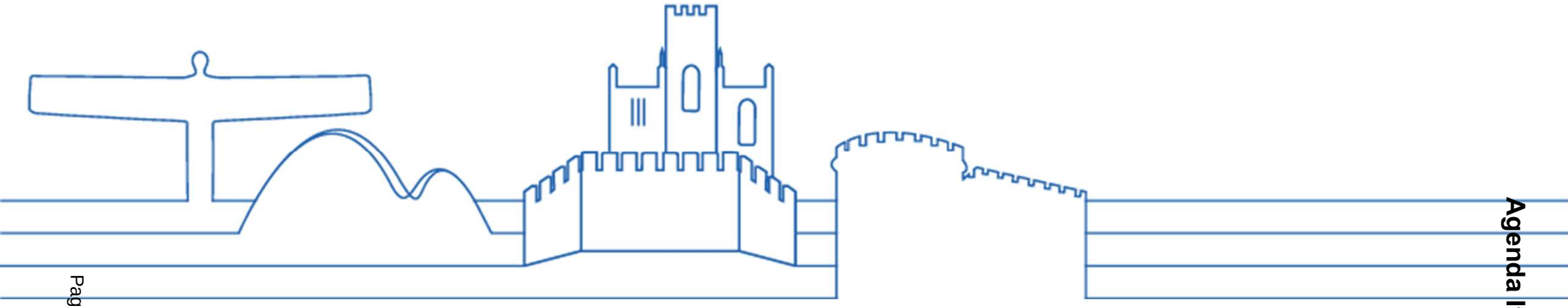
DRAFT

Towards an Operating Model for NHS North East and North Cumbria Integrated Care Board



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Presentation outline

- What is an operating model?
- Our objectives
- Design principles agreed through JMEG
- Functions and Decisions Map
- System working example: commissioning
- Place Based Partnerships, role and governance
- ICB Area and matrix management concept
- System Flow Chart
- Next steps

Slide 2

BN(CDC1 Dies this slide need to be in now ?
BAILEY, Nicola (NHS COUNTY DURHAM CCG), 18/02/22

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Suggested Operating Model Framework

- Values and principles
- People and local communities at the centre of what we do
- Governance and membership of the ICB
- Operating arrangements i.e. ICP, sub ICP, ICB system, geography above place and place
- Functions and where they are delivered
- Next steps, stress, scenario testing etc
- Review and agree governance handbook
- Phase 2 structure work underway
- Shadow ICB in place April to July- focus on board development and readiness to operate from July.

What is an operating model?

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One definition:
An operating model is a visual representation of how an organisation delivers value to its internal and external customers. Operating models are created to help employees visualise and understand the role each part of an organisation plays in meeting the needs of other components [What is an operating model? - Definition from WhatIs.com (techtarget.com)]

Some key questions for us:

1. How do we set our objectives as an integrated care system?
2. How do we make decisions – and who makes them?
3. How we deploy our people and resources to make these decisions happen?
4. How do we assure ourselves that we are meeting our objectives?

Our objectives

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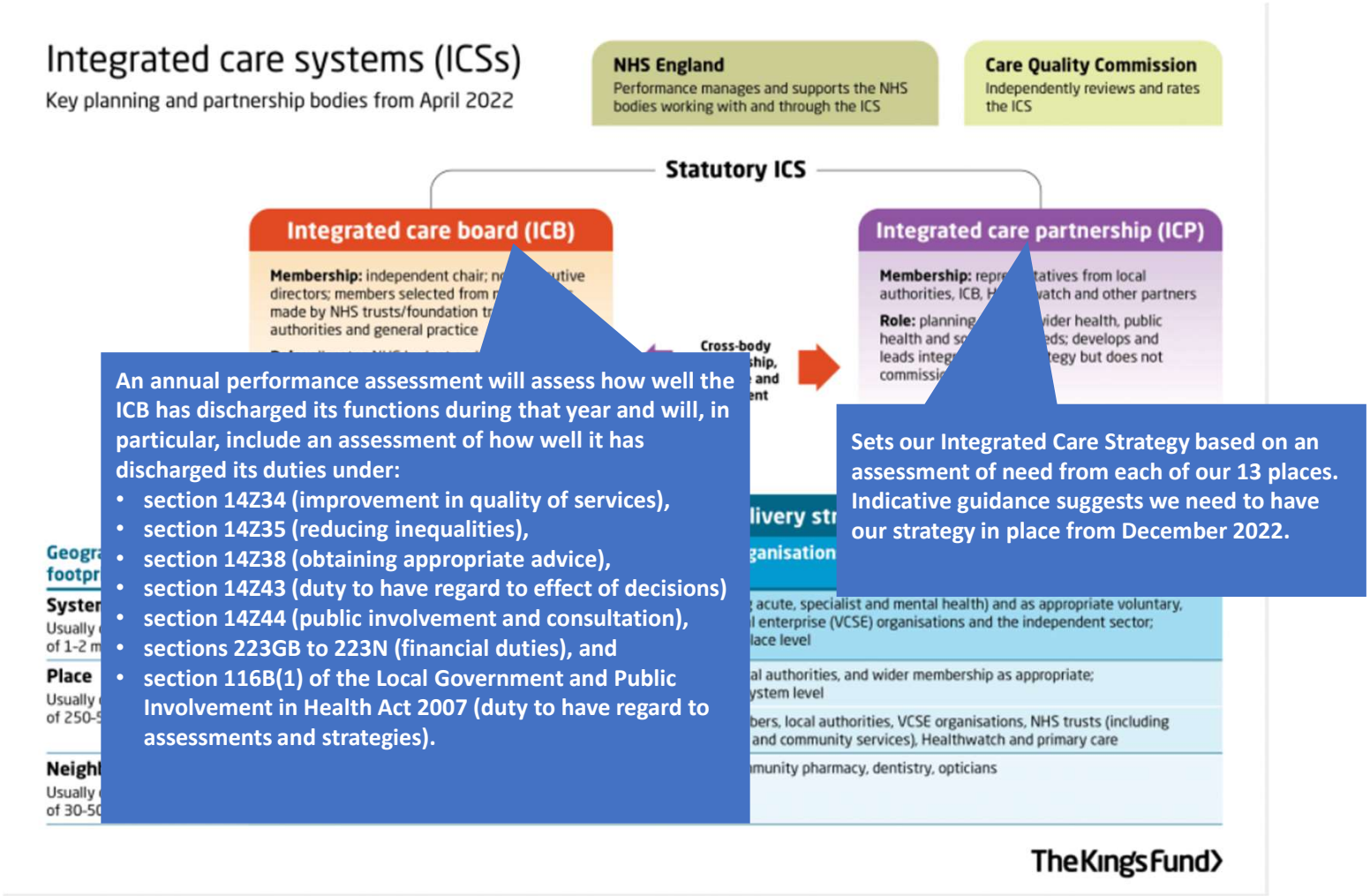

Guiding principles for ICB development agreed by JMEG

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- Secure **effective structures** that ensure accountability, oversight and stewardship of our resources and the delivery of key outcomes
- Create **high quality planning arrangements** to address population health needs, reduce health inequalities, and improve care
- Ensure the **continuity of effective place-based working** between the NHS, local authorities and our partners sensitive to local needs
- **'Stabilise, transition, evolve'** throughout 2022-23 – ahead of adoption of formal Place Board models by April 2023
- **Recognise our ICP sub-geographies** as a key feature of our way of working across multiple places
- Design the right mechanisms to drive developments, innovations and improvements in **geographical areas larger than place-level**
- Highlight areas of policy, practice and service design where **harmonisation of approach** by the NHS might benefit service delivery
- Maintain high and positive levels of **staff engagement and communication** at a time of major change and upheaval

Developing an operating model: DRAFT design principles/givens

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1. Maximise opportunity for standardisation in the interests of efficiency
2. Subsidiarity based on a consideration of Principle 1 above
3. Arrangements must be affordable and within running costs
4. Ensure simplicity and clarity on accountabilities to the ICB

Key questions for our operating model:

- Should we just define the ICB's objectives, but leave the delivery arrangements to each Director of Place-Based Delivery?
- If we do this how do the Exec team develop ways of working across the ICB?
- Or, do we develop a more uniform model of place and 'cross-place' working to ensure consistent approaches to delivery across our ICS?
- Or something else ?

North East and North Cumbria Integrated Care Board - functions and decisions map

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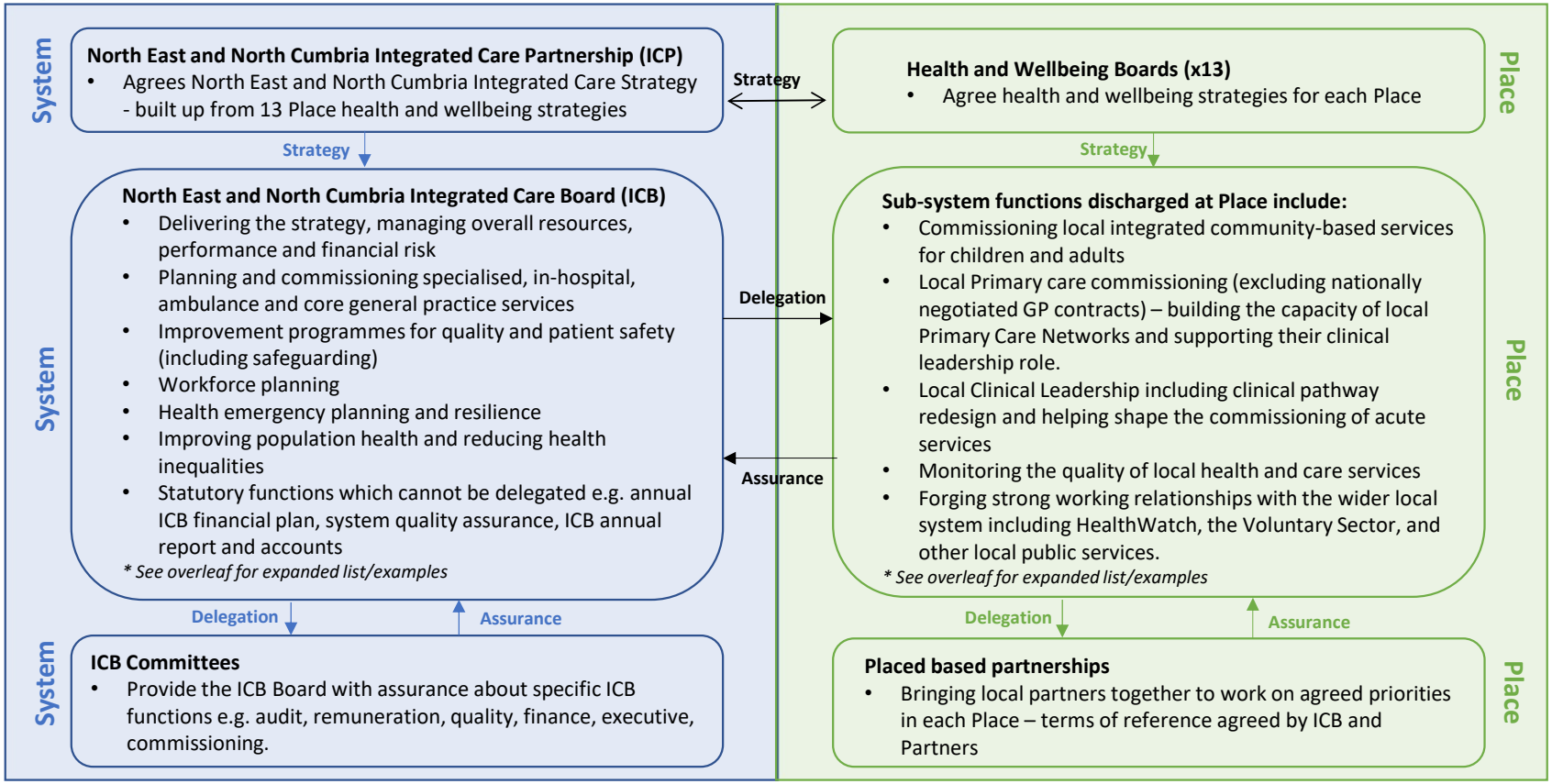

North East and North Cumbria Integrated Care Board - functions and decisions map

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ICB functions discharged at system level

- Setting strategy
- Managing overall resources, performance and financial risk
- Planning and commissioning specialised, in-hospital, ambulance and core general practice services
- Improvement programmes for quality and patient safety (including safeguarding)
- Workforce planning
- Horizon scanning and futures
- Harnessing innovation
- Building research strategy and fostering a research ecosystem
- Driving digital and advanced analytics as enablers
- Health emergency planning and resilience
- Improving population health and reducing health inequalities
- Strategic communications and engagement
- Statutory functions which cannot be delegated e.g. annual ICB financial plan, system quality assurance, ICB annual report and accounts

Sub-system functions discharged at Place*

- Building strong relationships with communities
- Service development and delivery with a focus on neighbourhoods and communities
- Commissioning local integrated community-based services for children and adults (including care homes and domiciliary care).
- Local Primary care commissioning (excluding nationally negotiated GP contracts) – building the capacity of local PCNs and supporting their clinical leadership role.
- Local Clinical Leadership including clinical pathway redesign and helping shape the commissioning of acute services
- Monitoring the quality of local health and care services – including support to care homes, e.g. infection prevention and control.
- Forging strong working relationships with the wider local system including HealthWatch, the Voluntary Sector, and other local public services.
- Monitor Place based delivery of key enabling strategies.

In addition, there are formal place-based joint working arrangements between the NHS and Local Authorities which will also be part of the ICB delegated functions; they include:

- Participation in Health & Wellbeing Boards to develop Joint Strategic Needs Assessments and Joint Health & Wellbeing Strategies
- Joint initiatives to promote health, prevent disease and reduce inequalities
- Joint commissioning and leadership of local services:
  - Continuing Health Care
  - Personal Health Budgets
  - Community mental health, learning disability and autism
  - Children and young people's services (including transitions, Special Educational Needs and Disabilities, Looked After Children)
- Service integration initiatives and jointly funded work, e.g. the BCF & Section 75.
- Fulfilling the NHS's statutory advisory role in adults' & children's safeguarding.
- The provision of updates to local Scrutiny Committees and Lead Members on local health and care services.

** Some of these functions may have a policy or plan developed at a geography above Place for ICB consistency but the function would be delivered and nuanced at Place*

System level working example: Commissioning by the ICB

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Proposals developed by the Commissioning workstream:

- Commissioning is a tool to deliver the ICB's priorities (hence our ICB commissioning sub-cttee)
- ICB commissioning should be simpler than current arrangements
- We should do things once where possible, and avoid duplication
- Our commissioning resources should be used flexibly to support pressure points
- Our clinical networks should support performance and pathway improvement
- We can build on and refine what already works well - e.g. the lead commissioner model
- One contract per provider, with a clear nominated lead
- ICB rules should determine that contracts are handled as close to provider footprints as possible
    - Specialised Services and Ambulance Services at system level
    - Acute and community contracts across relevant places (ICP area level?)
    - BCF and smaller scale VCSE contracts managed at place
- Commissioning, performance and quality management could happen on the same footprints

Key question: Does this mean high value contract negotiation is done locally and at 'area' level – with sign off at the ICB Commissioning Committee?

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Place-based working: Expectations in the Integration White Paper

- While strategic planning is carried out at ICS level, **places will be the engine for delivery** and reform
- Introducing a **single person accountable for delivery** of a shared plan at a local level – agreed by the relevant local authority and ICB
- Expectations for **place-level governance and accountability** through 'Place Boards' or similar to be adopted by Spring 2023.
- **Place governance should provide clarity of decision-making**, agreeing shared outcomes, managing risk and resolving disagreements between partners
- These arrangements should **make use of existing structures** and processes including Health and Wellbeing Boards and the Better Care Fund.
- All places will need to develop ambitious plans for the scope of services and spend to be overseen and section 75 will be reviewed to **encourage greater pooling of budgets**
- ICS will support **joint health and care workforce planning at place level** to meet the needs of local populations, expanding multidisciplinary teams
- **ICSs will provide support and challenge to each place** as to the assessment of need and local outcome selection and plans to meet both national and local outcomes.
- **The CQC will consider outcomes agreed at place level** as part of its assessment of ICSs
- **Place Boards will require shared insight** and a holistic understanding of the needs of their local population, listening to the voices of service users

Each of our places has:

A **Health and Wellbeing Board** – a statutory committee of each local authority, responsible for assessing local health and care needs (JSNA) and developing a local strategy (JHWBS)

A **non-statutory local partnership forum** of NHS and LA executives –responsible for operationalising the JHWBS, developing local integration initiatives, and overseeing pooled budgets and joint financial decisions (S75, BCF).

Each Place-Based Partnership/Board/Committee will be accountable for the delivery of objectives set out by the ICB. Some of already have the design features and representation to move seamlessly into the new system – but some may need to evolve.

CCG	Local Authority	Partnership Forum
Cumbria	Cumbria County Council	North Cumbria ICP Leaders Board
		North Cumbria ICP Executive
		(Whole of) Cumbria Joint Commissioning Board
		(Whole of) Cumbria Health and Wellbeing Board
Newcastle Gateshead	Newcastle City Council	Collaborative Newcastle Executive Group
		City Futures Board (formerly Health & Wellbeing)
	Gateshead Council	Gateshead Care (System Board and Delivery Group)
		Gateshead Health and Wellbeing Board
Northumberland	Northumberland County Council	Northumberland System Transformation Board
		BCF Partnership
		Northumberland Health and Wellbeing Board
North Tyneside	North Tyneside Council	North Tyneside Future Care Executive
		North Tyneside Future Care Programme Board
		North Tyneside Health and Wellbeing Board
Sunderland	Sunderland City Council	All Together Better Executive Group
		Sunderland Health and Wellbeing Board
South Tyneside	South Tyneside Council	S Tyneside Alliance Commissioning Board & Exec
		South Tyneside Health and Wellbeing Board
Durham	Durham County Council	County Durham Care Partnership
		County Durham Health and Wellbeing Board
Tees Valley	Middlesbrough Council	South Tees Health and Wellbeing Board
	Redcar & Cleveland Council	Adults Joint Commissioning Board
	Hartlepool Council	Hartlepool BCF Pooled Budget Partnership Board
		Hartlepool Health and Wellbeing Board
	Stockton-on-Tees Council	Stockton BCF Pooled Budget Partnership Board
		Stockton-on-Tees Health and Wellbeing Board
	Darlington Council	Darlington Pooled Budget Partnership Board
		Darlington Health and Wellbeing Board

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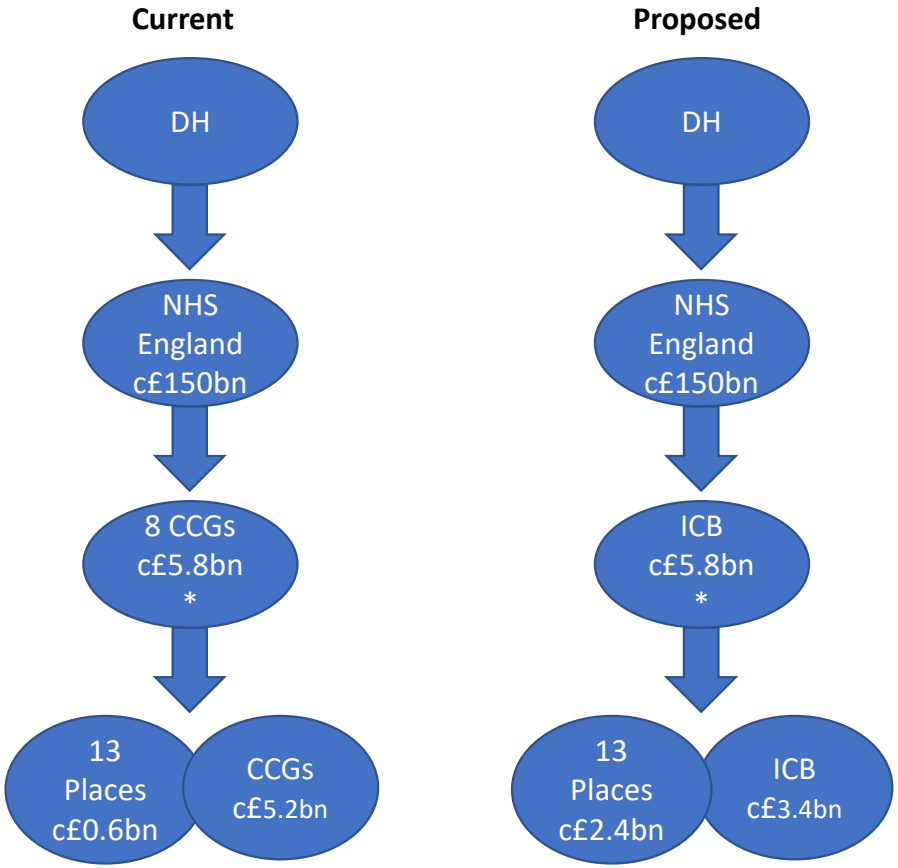
Financial delegations to place agreed by FLG and JMEG

- The Finance Leadership Group recommended increasing the current allocation of resources overseen at Place
- Currently joint financial arrangements at place tend to focus predominantly on the *Better Care Fund* and those services closely aligned with it – e.g. the joint-funding of care packages, safeguarding, and elements of community and primary care.
- From 1 July 2022, Place-Based Partnerships will be responsible for all long-term care packages, community-based services, local primary care services and VCSE provision.
- Place Based Partnerships will therefore need robust governance to manage a more significant level of resource.

These are indicative allocations at this point



ICB Exec placed based delivery concept

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Role

- Responsible for delivering both the ICB's strategic priorities and those agreed at place – tackling variation, driving up quality and improving outcomes

Guiding principles for consideration

- Efficient and cost neutral deployment of our CCG staff
- Harmonising approaches and being as efficient as we can across the ICB while maintaining the strength of place-based working
- Do we need to look at how we manage our resources equitably across our whole ICB ?
- Do we need to ensuring a more consistent model of NECS support for each ICB Area ?

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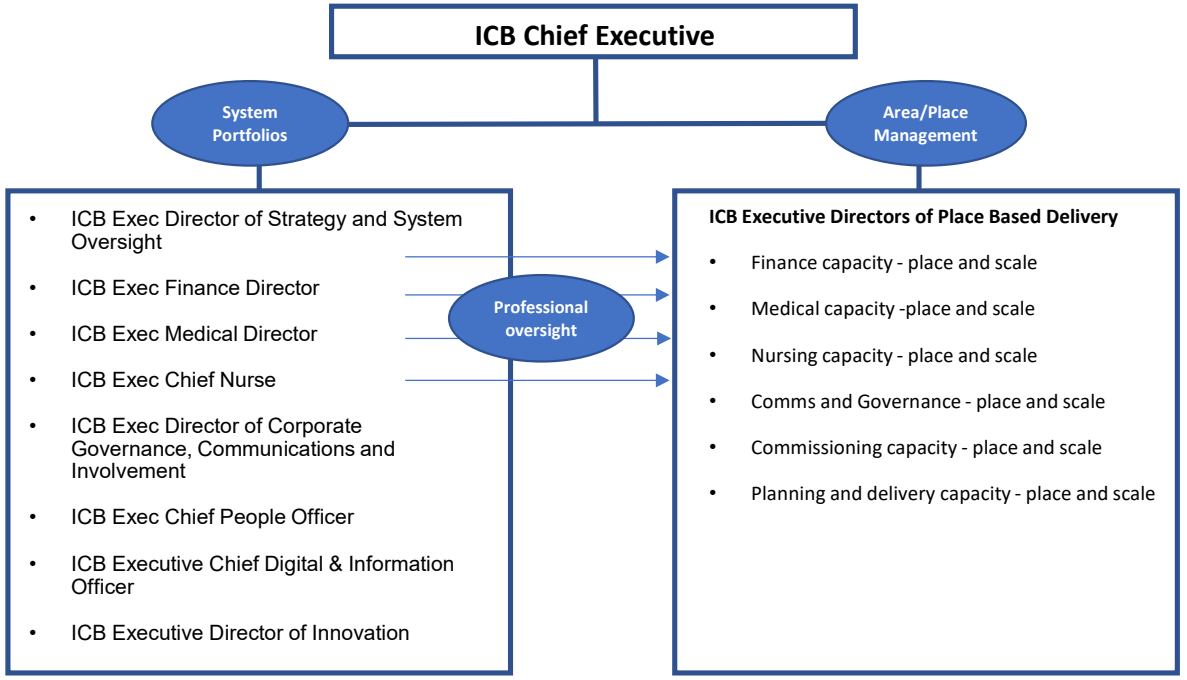
Matrix Management?



NB Area Director portfolios TBC

System Flow Chart

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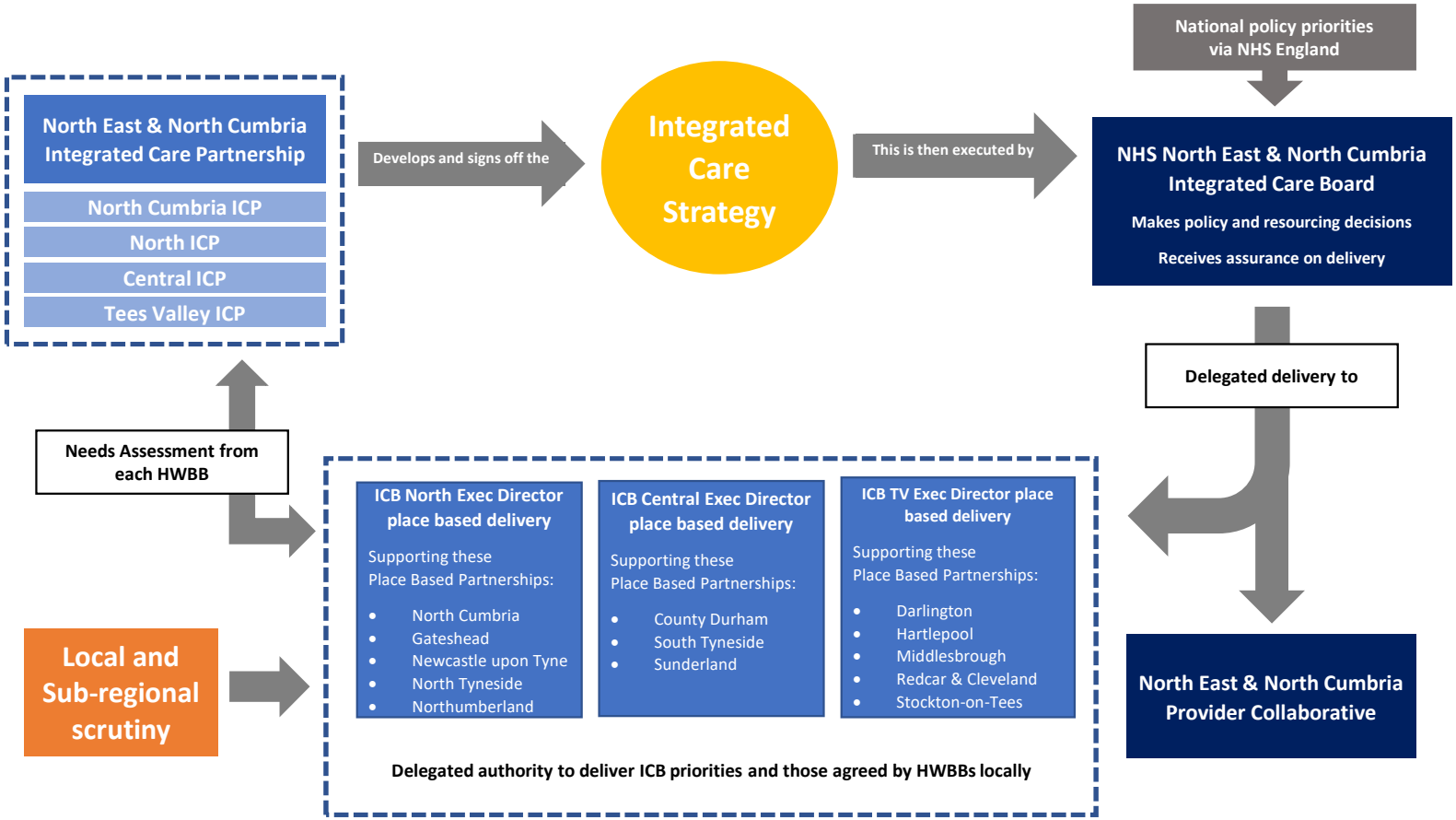

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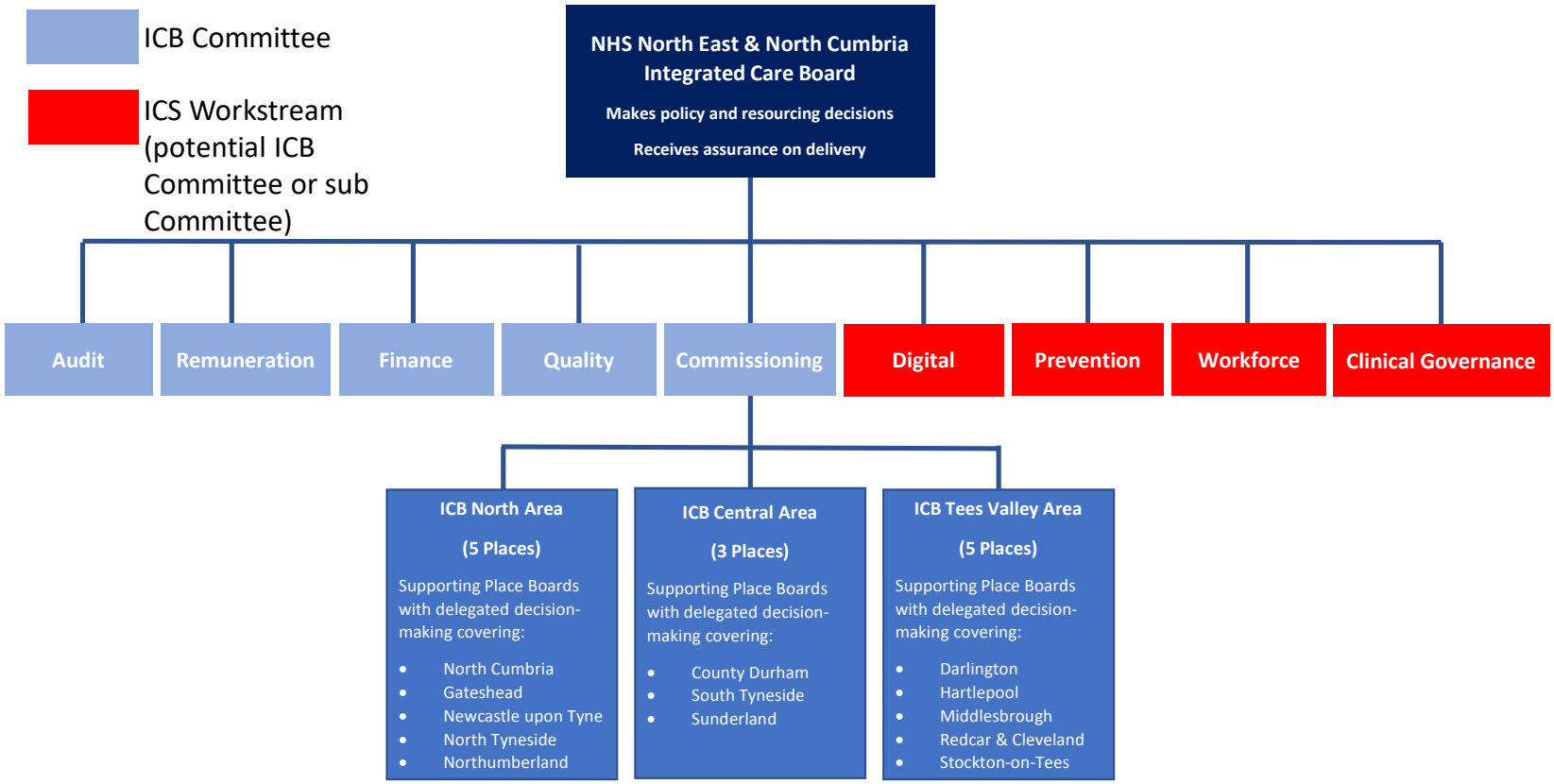
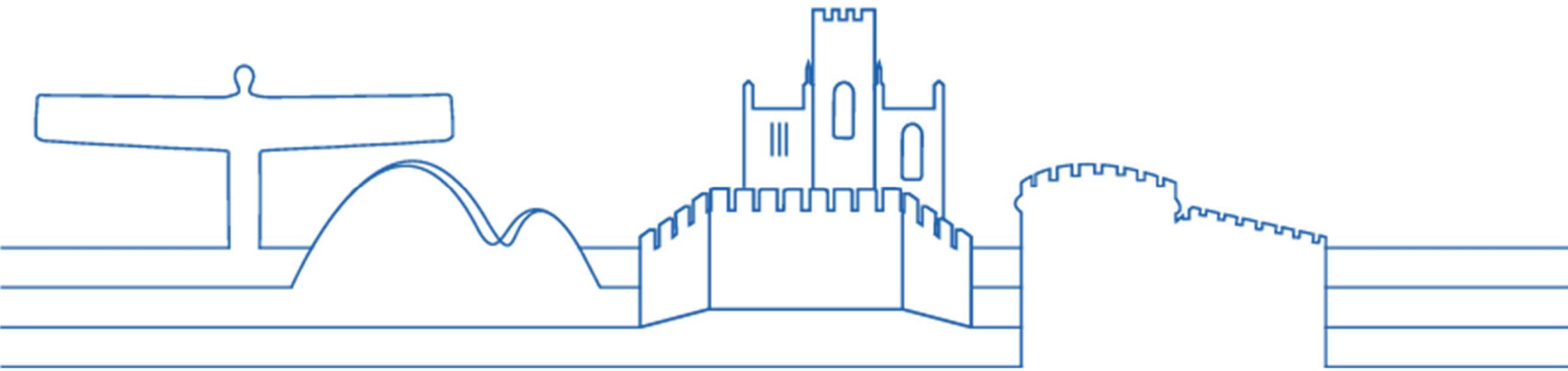
Accountability to the ICB



Proposed engagement



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Some key questions to consider

- Given the proposed split of system and place-based functions agreed by JMEG, what key functions need to be managed within the ICB's corporate services?
- Based on the proposed functions and their allocation at place and system do you foresee any major safety, reputational or delivery issues
- Do you feel the mapping covers all of the functions you would expect to see in the area you work in and if not what is missing
- Do you think the proposed ICB committee structure is logical, what areas do you feel we may need to consider using sub committees for eg Primary care delegated
- What opportunities are there to further strengthen our place-based working arrangements with our partners? For example, pooling budgets, or joint workforce planning.
- Given the expectation in the Integration White Paper for place-based leadership and governance, what place-based infrastructure would be required to support this and can this only be delivered at place or across places
- How can we build on existing lead commissioning arrangements within our ICS? And could certain commissioning functions be carried out within our ICS sub-regions, and if so what?

Engagement with leadership groups

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- ICB team to share proposals with;
  - Joint CCG Committee (for CCG chairs)
  - CCG COOs group
  - CCG Executive committees
  - ICS Workstreams
  - Key partners and stakeholders
  - ICS Management Group

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Engaging CCG governing bodies and staff

- To be led via Accountable Officers
- Governing bodies to be formally presented to with feedback collated.
- Accountable Officers to brief staff verbally and then provide a link to a questionnaire
- All staff to have the opportunity to feedback via the questionnaire created via Comms
- Questionnaire to be available by 1st March
- Comms will provide a syndicated email for Accountable Officers to use as they see fit

Engaging Local Partner PCNs, GPs, FTs, LAs,

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- Accountable Officers to engage local partners to garner feedback
- To include PCNs, GPs, FTs, LAs, Healthwatch, Voluntary Sector
- Briefings should be set up
- A link to a questionnaire will be provided to be issued to partners for completion

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Feedback

- To be collated and reported on
- Recommendations made on any changes required
- Report to be shared with the Programme Board 25th March
- To be presented to 1st ICB Shadow Board

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Next steps?

- Engage with our colleagues on the detail of the proposed operating model in February and March (questionnaire to be available first week in March)
- Test the proposed model against a range of scenarios, including:
  - serious quality and financial performance issues
  - major service reconfiguration
  - high cost care packages
  - reducing health inequalities
- Review our Scheme of Reservation and Delegation to ensure alignment with operating model
- Review ICB committee roles and structures, and the governance of our ICS workstreams, with our Exec Directors as they are appointed.
- Conclude CCG staff mapping, and consider how our staff are best deployed to support the final agreed model
- Review current NECS SLA, and consider rebalancing how this support is best deployed across our system

Appendix 8
Five principles for placing effective clinical and professional leadership

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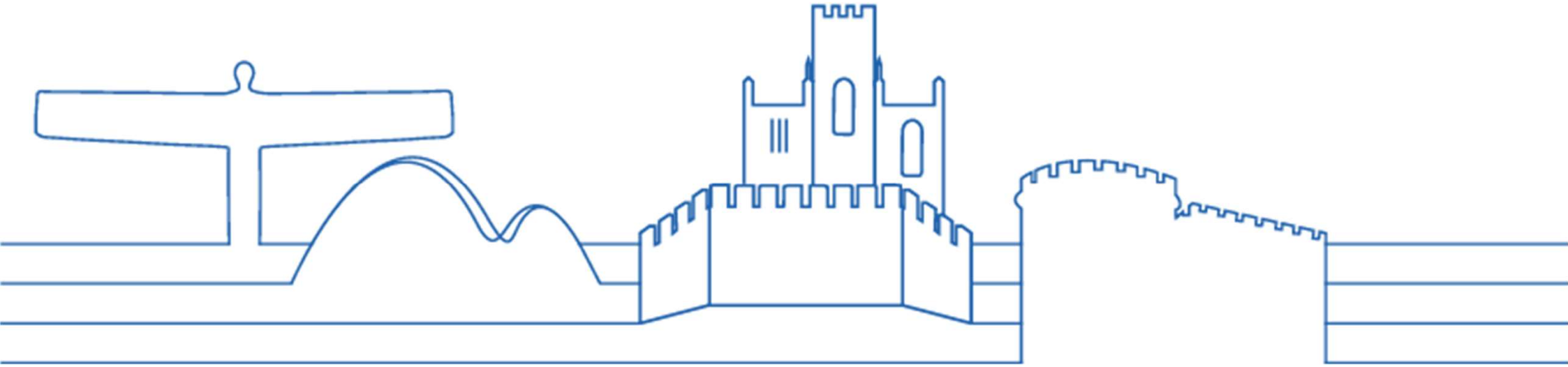
1. Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.
2. Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.
3. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.
4. Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (eg managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).
5. Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

Views? Questions?



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ICB Functions notes for consideration

*‘Place’ for North Cumbria is North Cumbria CCG. However, in some instances when working at ‘Place’ with the Local Authority then ‘Place’ is Cumbria wide and involves a place based strategic partnership with Morecambe Bay CCG. This is different to the Strategic Partnership definition for CCGs/Places within the NENC ICB footprint in the table above.

**North Cumbria CCG has collaborative working practices with Lancashire, Merseyside and Greater Manchester CCGs / ICBs in respect of Ambulance Commissioning including 999, PTS and 111. There are also similar collaborative working practices for FT and IS provider commissioning and contracting arrangements, including joint procurement exercises (e.g. Tier 4 weight management). This will necessitate ICB collaboration for North Cumbria only between NENC ICB and North West ICBs.

***Additional note – Wider Collaborative working relating to Public Health Commissioning / Planning on behalf of North Cumbria is undertaken by the Local Authority and NHSE and is co-ordinated via the North West Public Health network for Cumbria and Lancashire and will necessitate ICB collaboration for North Cumbria only between NENC ICB and Lancashire ICB.

ICB FUNCTION 1

Developing a plan to meet the health and healthcare needs of the population (all ages) within their area, having regard to the Partnership's strategy.

Strategic Planning	Place	Area	NENC	Provider Collaborative
• Strategic Planning with LA and wider Place Partners	X			
Strategic Partnership functions provided within the NENC ICS • Integrated Planning across the Strategic Partnerships – strategic planning, PMO functions, PHM strategy, Outcomes Frameworks - defining outcomes and resources for Places/Neighbourhoods to design and deliver according to population needs. • Triangulation of Workforce, Activity and Financial Planning • PHM expertise drawing together Place-level intelligence (health economics and behavioural insights) • Strategic Financial Planning, Resource Allocation & Delegation • Management of Strategic Capital Developments and Strategic Change Programmes - Service Re-organisation 'at scale' and socio-economic strategies that add value at Strategic Partnership level • Oversee the development of Place-Based Arrangements • Oversee the transition of CCG functional alignment and Place delegations • Oversee the transition of Direct Commissioned Service functional alignment with PCNs, Place-Based Partnerships and strategic-change programmes Align system cultures and behaviours to support people function to develop and implement effective OD strategies		X	X	

NENC ICS functions, where items are best provided once at ICS level • System strategic planning – development of the ICS Plan • ICS overview of Population Health needs assessment and priorities • Strategic Commissioning and Finance – defined resources for defined population outcomes, including services delivered to 1-2.5m populations e.g. 18 specialised services ICS Wide strategic workforce planning			**X**	
Provider Collaborative Includes: **• Acute, community, mental health and primary care collaboratives and place based integrated provider collaboratives (includes both horizontal and vertical collaboratives)** • Acute strategic planning			**X**	

ICB Function 2

Allocating resources to deliver the plan across the system, determining what resources should be available to meet population need in each place and setting principles for how they should be allocated across services and providers (both revenue and capital). Financial rules will apply to ensure delivery of key national commitments, such as the Mental Health Investment Standard and the primary medical and community health services funding guarantee

Finance	Place	Area	NENC	Provider Collaborative
• Financial Service ○ Single ledger and bank account, ledger management and budget management with budget holders ○ Annual accounts and annual reporting processes including external audit ○ Balance sheet arrangements and cash management ○ Financial Services ○ Audit			**X**	
• Overarching consolidated financial planning & overall financial risk management across the ICS			**X**	
• Strategic Finance - allocations to place and strategic partnership, scheme of delegation & accountability agreements with Place			**X**	

Financial Planning and co-ordination function, finance expertise to develop and agree financial plans linked to triangulated operational plans • Resource allocation function across partnership, including SDF • Financial risk management arrangements across geography • Co-ordination of system wide 'at scale' transformative savings programmes • Resources to support agreed programmes and budgets • Transformational financial savings programme management – support to Places		**X**	**X**	
• Delegated authority to plan for, manage and report against specific and relevant place-based budgets (e.g. all out of hospital services) for the relevant geography, including savings plans • Accountability for delegated budgets to ICS leadership • Section 75 with CYC arrangements to formalise arrangements for integration and holding of these budgets • Integrated CHC finance functions with adult social care • Financial support and resource to develop and support primary care response • Financial support and resource to develop wider out of hospital provision and embed population health management principles, including SDF. Place based financial planning	**X**			

ICB Function 3

Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
Also see areas under Function 5

Partnership and Collaborative Development	Place	Area	NENC	Provider Collaborative
• Provider Collaborative Development				

ICB Function 4

Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations.

Corporate & Governance – Governance*	Place	Area	NENC	Provider Collaborative
• Development of governance structures at Place level • Named risk leads • Secretariat Function • Contributors to Annual Report / Annual Governance Statement • Implementation of Risk Management Strategy • Implement Governance and IG policies / procedures Implementation of COI/SBC policies and procedures plus named senior lead to support ICS	X			
• Some governance input to support joint/subcommittee structure	X	X	X	

• Named Director Lead • Development and maintenance of: • Constitution & governance handbook • ICS level governance structures • Terms of reference • ICS level SoRD and OSoD • Risk Management Strategy • ICS level GBAF and Risk Register • Governance and Information Governance policies and procedures, incl COI and Standards of BC • Development of GBAF and Risk Register templates for SP level implantation • ICS level Board Secretary / Secretariat Function Management • Annual Report and Annual Governance Statement • Development of a governance network • Legal review			**X**	

*Governance and performance is dependent on legislation and the constitution governance will need to be reviewed for levels of delegation and where responsibility sits

ICB Function 5

Arranging for the provision of health services in line with the allocated resources across the ICS through a range of activities including:

a) putting contracts and agreements in place to secure delivery of its plan by providers
b) convening and supporting providers (working both at scale and at place) to lead major service transformation programmes to achieve agreed outcomes
c) support the development of primary care networks (PCNs) as the foundations of out-of-hospital care and building blocks of place-based partnerships, including through investment in PCN management support, data and digital capabilities, workforce development and estates
d) working with local authority and voluntary, community and social enterprise (VCSE) sector partners to put in place personalised care for people, including assessment and provision of continuing healthcare and funded nursing care, and agreeing personal health budgets and direct payments for care.

Acute	Place	Area	NENC	Provider Collaborative
• Clinician to clinician Outpatient referral interface and local pathways • Clinician to clinician diagnostic interface and local pathways • Clinician to clinician emergency and urgent care interface • Specific local acute pathways for local health improvement • Urgent care commissioning (working across acute and primary care) including Urgent Treatment Centres and integration with GP Out of Hours • Acute elements of complex care pathways (such as Frailty, complex Mental Health etc) • Intermediate care and rehabilitation (acute, step-down, and home-based) • Palliative Care including Hospices	X			

• Acute hosted community services including District Nursing, Community Therapy, Community Hospitals ? pc contracting interface with providers				
• Coordination of acute planning and contract management outcomes with Place • Urgent and Emergency care operational planning and response (inc. AEDBs) • Referral Support Services • Coordination of local Clinical Assessment Service within NHS 111	X	X X		
• Main acute contracting (inc Independent Sector) • Performance monitoring against compliance with constitutional and national standards • Improving access for planned care • Strategic capital development planning • Acute commissioning statements and treatment thresholds • Network level pathways delegated to care networks (e.g. Cancer, Stroke) • 999 Emergency Ambulance commissioning • NHS 111 commissioning		X		
• Strategic planning of acute configuration • Strategic planning of improving access • Strategic development of workforce models and ICS level workforce planning			X	X

Integrated Delivery & Development -Deliver an Integrated Community Service Model	Place	Area	NENC	Provider Collaborative
• Establish leadership and operational working arrangements across health, social care and voluntary sector organisations that facilitates teams to work together in a multi-disciplinary way to build care around the person Design and deliver integrated solutions to respond to key local and national requirements, including: • Ageing Well – including Enhanced Health in Care Homes and anticipatory care • 2 hour crisis response service, receiving referrals from GPs, 111, YAS, hospital SDEC services (e.g. frailty) • Integrated frailty model including patient stratification, assessment, care planning and signposting • Discharge to assess services to expedite earlier discharge through Discharge Command Centres, effective reablement, rehabilitation and support services • Respiratory – Develop and deliver pulmonary rehabilitation and long Covid services utilising transformation funding Home First delivery models	X	X	X	
Lead and support the development of place-based organisational relationships/partnerships focussed on: • Defined population/ Equity of outcomes/ Agreed priorities/Identified resources • Shared principles and standards for developing integrated models • Establish appropriate planning and delegation processes to facilitate the development and approval of place-based plans to delegate funding • Single Discharge Co-ordinator across health and care Commission services and infrastructure best undertaken at a a number of levels form place to NENC: • overseeing care market development with LA • designated beds for the covid response • CHC • care homes / domiciliary care • other agreed system-wide community services (e.g. Medequip, wheelchair service, podiatry) • appropriate voluntary sector services • Identifying system level workforce trends and requirements	X X X X X	X X X X	 X	

Integrated Delivery & Development - Deliver an Integrated Community Service Model (continued)	Place	Area	NENC	Provider Collaborative
• Define system-level requirements and priorities for community & voluntary sector • Facilitate whole system planning and ultimate sign-off for community plans and assure delivery to NHSE • Clarify and delegate funding envelopes / framework for places to draw down transformational funding, e.g. Ageing Well, Diabetes, Long Covid and Pulmonary Rehabilitation funding, and cash-limited national discharge funding • Commission services and infrastructure best undertaken at ICS level, e.g. YAS /111 / CAS • Effective interface with NHSE commissioning teams / influence national policy frameworks • System level clinical and professional leadership: • Ageing Well • Urgent and Emergency Care • Discharge • Respiratory Clinical Network • NENC level workforce initiatives to support recruitment/retention in places			X	
• Patient and stakeholder engagement • Service design and problem-solving to address strategic priorities • Service transformation and delivery • Relationship building and co-production between partners • Shared budget management/shifting resources between organisations • Develop integrated workforce solutions, including shared roles and innovative workforce models • Monitoring delivery/KPIs/activity/outcomes	X	X		

Needs additional narrative to define

Mental Health – MH, LD and Autism Contracting	Place	Area	NENC	Provider Collaborative
• Input into discussion around placed based delivery models which informs contract requirements with other organisations including the voluntary sector	X			
• Contract Negotiation, Contract Monitoring, Input into procurements	X	X	X	
• Contract Register, Contract Documentation, Contract payments			X	
Mental Health – MH, LD & Autism Individual Funding Requests				
• Local clinical and commissioning/provider input to support access to local services	X			
• Policy, and ongoing panel administration and equity of access			X	
Mental Health – MH, LD & Autism Partnership Support				
• Oversight / Coordination/ Management / Administration • Finance Support/ Agreement of Priorities and use of funding (MHIS) • Working with TEWV/CNTW as Lead Provider		X		
• Feeds into wider Partnership process to update / escalate / inform			X	

Mental Health – MH, LD & Autism Planning				
• trajectories and priorities • narrative	X		**X**	
• Coordination / Completion			**X**	
Mental Health – MH, LD & Autism Quality Assurance				
• Coordinate and feeds in local issues		**X**		
• Oversight and assurance processes			**X**	

Mental Health – Adult and Older People Transformation and Delivery	Place	Area	NENC	Provider Collaborative
Commissioning and Transformation support provided to place to deliver: • Integration with LA/ Community MH Transformation (at LCP level x 5)/ SMI Health checks/ MH Workers in primary care/ Dementia	**X**			
Commissioning and Transformation support to deliver: • Children's Eating Disorders/ EIP/ ASD/ADHD (Adults and Children)/ Crisis (can link to Community Transformation) • Engagement with the Voluntary Sector		**X**	**X**	
• Perinatal/ Chronic Fatigue/ IPS/ ICS Crisis Care Concordat		**X**	**X**	
• Adult Eating Disorders/ CAHMS Tier 4				**X**

Mental Health – Transforming Care Programme				
• Annual health checks including flu & covid vaccination programmes	**X**			
Delivery of all Long-Term Plan commitments including: • Reducing reliance in inpatients (adults and children & young people) • CETR/CTRs including dynamic support systems (DSS/DSR) • Developing community services including market development & housing • LeDeR (current) – completion of reviews, learning into action and production/publication of annual report • Autism diagnostic / pre & post diagnostic support • Children & Young People Keyworker • Feeding into PC pathway to frame future strategic needs across NENC		**X**	**X**	
Oversight of delivery of quality • LeDeR – completion of reviews and learning into actions should also include 3-year strategy, workforce model and governance as part of new LeDeR policy • Assurance of transformational funding (per capita basis), adhoc and EOI funding bids • Oversight & escalation of host commissioner & commissioner oversight visits (quality of inpatient services) • Planning & Oversight of community infrastructure, inpatient and diagnostic provisions/support to achieve single, joined up pathways include Workforce strategy and plan linked to these requirements • Regional Interface • Developing community services including market development & housing • Co-production in the development and implementation of changes			**X**	
• Adult Secure • Strategic use of funding released from spec com bed reduction				**X**

Integrated Delivery and Development – Primary Care	Place	Area	NENC	Provider Collaborative
Primary Care Strategy				
• Co-produce through providing local knowledge and expertise to strategy development • Support delivery in line with agreed plans and priorities	X			
• To support development of a collective plan that recognises where places need to level up to impact on health outcomes		X	X	
• Developed through the ICS primary care collaborative			X	
• To act as reference/delivery group for strategy development	X	X		
Practice and PCN Development and Delivering Primary Care at Scale				
• Design and delivery of at scale projects • Effective use of population health information • Clinician to clinician interface across pathways • Develop clinical director leadership capability	X			
• Coordinated approach working with federations and PCNs to support consistent and joined up PCN development • Develop consistent approach to PCN engagement in place	X	X		
• Developed through the ICS primary care collaborative			X	
• Shared learning, support delivery co-production at scale and interface with place development	X	X	X	X

Primary Care Workforce	Place	Area	NENC	Provider Collaborative
• Development of additional roles and consistency in terms and conditions	X			
• Clear understanding of workforce pressures and impact on system and place delivery		X		
• Workforce strategy developed through primary care collaborative			X	
• Develop innovative employment models	X		X	

Primary Care Digital Transformation	Place	Area	NENC	Provider Collaborative
• Place based management and delivery of national digital initiatives • Place based development of digital schemes to support service transformation • Empower patients to take more control over their own health and care	X			
• Partnership digital delivery coordination group to ensure join up, shared learning and shared resources linked to HWB digital strategies		X		
• Development of digital strategy and deliverables through NENC Digital Workstream			X	
• Rapid development of digital service models			X	X

Primary Care and PCN interface with key priorities				
• Urgent care transformation • Community diagnostic service development and implantation • Enhanced health in care homes	**X**			
• Coordination to support collective development of integrated service models	**X**	**X**		
• Links to UECN, Diagnostic Board, Ageing Well Programme			**X**	
• Alignment with work of acute and community providers collaboratives	**X**	**X**		**X**
Population Health Management in Primary Care				
• Development of effective business intelligence and risk stratification to allocate and manage resources • Embed and accelerate learning from PHM development programme • Population Health Hubs to support delivery models	**X**			
• Sharing of best practice and tools on PHM • Development of joint population health hub including shared analytics and toolkits to support PCN's • Assurance of progress against the PHM maturity matrix in 'each place'		**X**		
• Build on system-wide tools (RAIDR) to support resilience in primary care • Links to PHM Strategy including levelling-up population outcomes and tackling inequalities			**X**	
• Support system transformation through agreed priorities			**X**	

Integration of Complex Care / CHC	Place	Area	NENC	Provider Collaborative
• Integration of CHC and ASC provision with core community offer supporting community services and voluntary sector. • Implementation of strategy and plans • Alignment of complex care and Adult Social Care budgets • Integration of teams and shared workforce which will work towards a shared purpose and shared efficiencies • Delivery of commissioned care provision at best value with associated outcomes focussing on strength-based approaches • More joined up assessment and care planning based on optimisation of needs and shared management of risk • Delivery of personalisation and joint PHB / integrated budget offers • Monitoring performance	X			
Having a Single Conversation Once: • Development of strategy and plans bringing together place based integrated services where makes sense to do once ◦ Strategic oversight with LAs to develop an integrated delivery model • Quality and safety • Local review meetings • Legal support – Court of Protection • DoLs / LPS • Contracts • Training and development strategies • Specialist equipment • Market Management and development • QIPP Efficiencies / VfM	X	X		

• Patient and Public involvement • Governance support ◦ Modelling and planning • S117?				
• Named Director Lead • Strategy and assurance plans • Compliance standards for returns • Coordination of performance and assurance of CHC and hospital discharges at ICS level • Personalisation agenda • Policies, including Lifestyle policy CHC Network			**X**	
Nursing and Quality – Children and Young People				
• Key deliverables from Long Term Plan • Restoration and recover in CYP services post Covid • Improvement in Quality of CYP services • Integration with Local Authority functions	**X**			
• Assurance and deliver through partnership governance • Potential for service delivery models across wider footprint		**X**		
• Distribute leadership model portfolio holder • Responsible for CYP programme of work and running of the ICS Delivery Group • System Leadership Oversight & Improvement • System wide support to restoration and recover of VYP services post Covid			**X**	

Nursing and Quality – Personalisation and Commitment to Carers				
• Provider oversight via quality monitoring and assurance of action and learning from complaints • Interface with regional team for complaints they are responsible for • System Leadership, oversight and assurance of personalisation, carers, patient experience feedback • Compliance with duty to consult and involve patients		**X**	**X**	
Nursing and Quality – Maternity				
• Maternity LTP transformation deliverables (transferred from Better Births) by providers • Ockenden Immediate & Essential Actions (Ockenden Report dec 2020)	**X**			
• Distributive leadership model portfolio holders • LMS oversight of maternity transformation, supporting and ensuring implantation by providers, supported by the ICS • Specialist midwifery leadership in LMS's, supported by perinatal leaders in Clinical networks and Neonatal networks • Perinatal Safety & Quality Oversight, reporting into local System Quality Group of ICS			**X**	
Nursing and Quality – Learning Disability and Autism				
• Delivery of all Long-Term Plan commitments including: • Reducing reliance in inpatients (adults and children & young people) • Annual health checks including flu & covid vaccination programmes • CETR/CTRs including dynamic support systems (DSS/DSR) • Developing community services including market development & housing • LeDeR (current) – completion of reviews, learning into action and production/publication of annual report ◦ Autism diagnostic / pre & post diagnostic support • Children & Young People Keyworker • Co-production in the development and implementation of changes	**X**	**X**		

• Oversight and assurance of all LTP commitments and see links to complex care functions above • Host Commissioner / Commissioner Oversight visits using shared resource	X	X	X	
• Oversight of delivery of quality • LeDeR – completion of reviews and learning into actions should also include 3-year strategy, workforce model and governance as part of new LeDeR policy • Assurance of transformational funding (per capita basis), adhoc and EOI funding bids • Oversight & escalation of host commissioner & commissioner oversight visits (quality of inpatient services) • Planning & Oversight of community infrastructure, inpatient and diagnostic provisions/support to achieve single, joined up pathways include Workforce strategy and plan linked to these requirements • Regional Interface	X	X		

Medicines Management	**Place**	**Area**	**NENC**	**Provider Collaborative**
• Leadership and implementation of MO priorities (quality improvement, innovation, productivity and prevention) and opportunities across PCNs. • Leadership and management of prescribing budget. • Local engagement of PCN Prescribing Leads with ICS agenda via prescribing forums. • PCN professional leadership, facilitating networking and workforce development. • Analysis and interpretation of prescribing data and intelligence. • PCN and prescriber engagement in prescribing quality e.g. antimicrobial resistance and opioids. • Expert input into pathway and guideline development. • Medication queries and advice relating to formulary.	**X**			

• Medicines related freedom of information requests (although responsibility for this may have to sit at ICS level). • Ongoing support for the Covid vaccination campaign. • Care home medicines related issues and education e.g. MOCH & proxy ordering. • Linking with public health e.g. reducing health inequalities. • Sustainable medicines/green agenda: Supporting delivery of local actions (although this is in PCN DES). • Patient, carer and public communications and engagement in relation to medicines. • Provider medicines management responsibilities including prescribing advice, monitoring of prescribing and implementation of guidelines /strategy • Place based senior pharmacist leadership for independent support and assurance • Development of local network of medicines management staff supporting primary care • Place based learning when things go wrong not just organisational • Placed based prescribing training not just organisational • Place based learning to develop / strengthen services / pathways • Supporting innovation in practice				

Medicines Management	Place	Area	NENC	Provider Collaborative
• Financial oversight, planning (quality improvement, innovation, productivity, and prevention), sharing of best practice, and identifying and remedying unwarranted variance, utilising tools such as the Model Health System. • Leadership of prescribing budget management and delivery of at-scale quality improvement, innovation, productivity, and prevention. • Prescribing quality and guidance: involvement in the design and scrutiny of pathways and formulary via Area Prescribing Committee and Formulary Subgroup. • Management of high-cost hospital drugs, linking with the level at which contract management is done, moving from a "who pays what" approach to variance analysis from a cost and quality perspective and putting plans in place to address variation, sharing learning across the ICS. • Management of e-prescribing decision support systems (e.g. OptimiseRx). • Advice on community pharmacy enhanced and locally commissioned services. • Sustainable medicines/green agenda: influence on formularies and pathways. • Identifying and addressing prescribing impact on health inequalities. • Population Health Management and prevention. • Shared resource for geographical specialist teams supporting the antimicrobial strategy • Using learning to develop /standardise and strengthen prescribing • Monitoring of place metrics for prescribing against national targets	X	X		

Medicines Management	Place	Area	NENC	Provider Collaborative
Statutory functions, including safeguarding and oversight of controlled drug issues, potential for delegation to place • Pharmacy workforce planning and strategy, along with education and training. • Provision of pharmacy expertise to other clinical networks and workstreams operating at ICS level, encouraging pharmaceutical input and scrutiny into other workstreams. • Quality & medicines safety, including Medicines Safety Officer role, thematic analysis of incidents, and responding to safety alerts e.g. sodium valproate, and responding to national priorities e.g. antimicrobial resistance, opioids. • Digital medicines strategy relating to medicines and pharmacy. • Production of a sustainable medicines/green agenda strategy. • Link with regional procurement groups. • Pharmaceutical membership of Regional Medicines Optimisation Committee (RMOC) • Development of Antimicrobial strategy linked to Clinical Strategy for ICS including mapping of current resources • Refocus Antimicrobial stewardship in line with 5 year Antimicrobial Resistance plan • Oversight and assurance • Delivery of medicines optimisation linked to antimicrobial strategy • System wide learning to improve services / pathways • Review of NICE guidelines and translation into practice			**X**	

ICB Function 6

Leading system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers

Corporate & Governance – HR and OD	Place	Area	NENC	Provider Collaborative
• Named Officer to support managers and staff • Implementation of strategy & policies	X	X	X	
• Named Director Lead • Strategy and assurance plans • Compliance standards for returns • Corporate standard and templates to distribute to SP/Place level • People's Plan • Recruitment and retention • Management support and development • Equality, diversity and inclusion			X	

People Plan Strategy	Place	Area	NENC	Provider Collaborative
			X	

Nursing and Quality - Nursing Workforce	Place	Area	NENC	Provider Collaborative
• Key deliverables from The People Plan • Delivery of the 50k Manifesto trajectories for individual organisations • Delivery of Inclusion commitments and improvements in WRES data • Support for workforce planning for future workforce in particular primary care (professional nursing responsibility for practice nurses)	X			
• Quality & Nursing Interface with: • ICS Workforce Boards responsible for system delivery, leadership and oversight of key nursing midwifery and AHP workforce developments • Support for delivery of inclusion commitments and improvements in WRES data • Support for system workforce planning for future workforce			X	

ICB Function 7

Leading system-wide action on data and digital:

working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the centre of their care

Digital Strategy and Delivery	Place	Area	NENC	Provider Collaborative
			X	

ICB Function 8

Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes

BI & Performance Information & Intelligence	Place	Area	NENC	Provider Collaborative
• Joint BI functions with LA? Enhanced support to Partnership on population health management, in particular into PCNs	X			
• BI function supporting Strategic Partnership and Places - Providing support to PCNs, PHM etc • Management of NECs contract for BI		X		
Performance				
• Performance management for Place	X			
• Strategic Performance management • Performance reporting for Place, Partnership & ICS			X	

ICB Function 9

Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.

Nursing and Quality – Safeguarding adults and children	Place	Area	NENC	Provider Collaborative
• Statutory responsibilities at provider and commissioner level for safeguarding children and adults with Police, Health and Local Authority • Place senior nurse leadership & membership of safeguarding boards providing independence and specialist expertise via Designated Professionals Specialist safeguarding support to places	X			
• There may be models of operational delivery over more than one place, coterminous with local authorities especially as workforce is sparse and fragile • Shared specialist support across geographical partnerships		X		
• Distributive leadership model portfolio holder • Oversight and escalation • Mutual aid and improvement support • Strategic development of blueprint • Interface with regional expertise			X	

Primary Care Estate	Place	Area	NENC	Provider Collaborative
• Place based planning and delivery with local partners to develop health and care estate to support service transformation	X			
• Develop and agree pipeline for strategic estates programme and priority for submission for capital investment		X		
• Budget holder for ICS estates/capital programmes • ICS-wide estates strategy and planning			X	
Corporate & Governance - Sustainability				
• Local knowledge and delivery • Sustainability champions locally • Planning and delivery of the Sustainability Development Management Plan (SDMP) • Management of returns	X			
• Named Director Lead • Strategy and assurance plans • Compliance standards for returns			X	
Corporate & Governance - Facilities Management and Corporate IT				
• Named Office Manager role to manage office and IT locally • Implementation of policies and procedures	X			
• Named Director Lead • Compliance standards • Development and maintenance of policies and procedures			X	

ICB Function 10

Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability.

Contracting	Place	Area	NENC	Provider Collaborative
• Contracting for CHC & out of hospital NHS and LA services (S75), third sector. • Contract management and reporting and associated staff resource (over time integration with LA function?). • Primary Care contracting – PCN, LIS (anything not nationally negotiated).	X		X	
• Contracting function supporting Places		X		
• Primary Care contracting GMS • Single contracts register • IS Contracting? • Procurement Advice and tendering function • Contracting advice			X	
• Single Contracting function with Independent Sector across NENC?			X	X

ICB Function 11

Planning for, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHS England and NHS Improvement.

Corporate & Governance – EPRR and Business Continuity	Place	Area	NENC	Provider Collaborative
• Business continuity planning for delivery of services at place • Working with public health for the services required to deliver pandemic plans • Working to support the LRF with delivery of emergency and multi-agency responses • Providing staff for joint on call rota • Named senior lead	X			
• On call rota			X	
• Named Director Lead • Strategy and assurance plans • Compliance standards for returns • National and regional EPRR returns • Information sharing for national and regional guidance			X	

Nursing and Quality – Out of hospital, Covid response support, Immunisation and Hospital Discharges	Place	Area	NENC	Provider Collaborative
• Providing quality and nursing leadership to primary care and community collaboratives X • Implementation of pulse oximetry at home and other models • SRO place leads for Covid vaccination program • Support to place and public health teams for all other immunisation and vaccination programs • Implementation of the discharge policy, reducing hospital length of stay and D2A • Collaboration with Quality Assurance of Discharges Group and implementation of agreed standards • SRO for covid vaccination program • Shared resource for all immunisation and vaccination programs	**X**			

ICB Function 12

Primary Care Network DES – Contractual and Delivery	Place	Area	NENC	Provider Collaborativ
• Delivery and monitoring of PCN DES and Network Services • Building capability and capacity through additional roles	X			
• Support alignment with place based integrated models and agreed priorities for recover and transformation		X		
• PCN contact development Specialist support and advice			X	
• Share learning support deliver through co-production of at scale services				X
Primary Care Delegated Commissioning Functions				
• Implementation of PCCC decisions, business as usual activity and local performance monitoring	X			
• Primary care Commissioning Committee as per the delegation of functions from HNSE/I (TBA)			X	
• ICS with delegated commissioning responsibility for primary care from NHSE/I			X	
• Support in planning and development			X	
Local Enhanced Services				
• Enhanced services aligned to local need and providing added value through PCN Scale delivery	X			
• Standardise where appropriate and demonstrate impact on health inequalities and deliver of plans		X	X	
• Engaged in discussion re LES development	X	X		

Enablers

Corporate & Governance – Communications and Engagement	Place	Area	NENC	Provider Collaborative
• Named Officer for Communications • Named Officer for engagement • Support to management • Implementation of strategy • Place based comms	X			
• Named Director Lead • Strategy and assurance plans • Compliance standards for returns • Corporate standard and templates to distribute to SP/Place level • NHS Engagement Mandate • AGM • Internal and external communications • Web development and maintenance • Media and PR (including press releases) • Engagement with key partner organisations			X	
Corporate & Governance – PALS, Complaints, MPs, FOIs				
• See mapping to Nursing & Quality function			X	

Nursing and Quality

Statutory Functions

Nursing and Quality – Patient Safety	Place	Area	NENC	Provider Collaborative
• Provider patient safety responsibilities including incident and serious incident management, duty of candour, implementation of SI framework • Place based senior quality leadership for independent support and assurance • Development of local network of patient safety specialists and establishment of same in primary care • Place based learning when things go wrong not just organisational • Placed based patient safety training not just organisational • Place based learning to develop / strengthen services / pathways • Utilising the proposed innovation, research and QI Hub	X			
• Shared resource for serious incident management for oversight and assurance • Using learning to develop / strengthen services / pathways		X		
• Potential for Distributive Leadership Model portfolio holder • Development of Patient Safety strategy linked to Clinical Strategy for ICS including mapping of current resources and support from Improvement Academy, Patient Safety Collaboratives and others, driven through quality governance arrangements • Oversight and assurance • System wide learning to improve services / pathways			X	

Nursing and Quality – Quality Monitoring, Assurance and Oversight	Place	Area	NENC	Provider Collaborative
• Delivery of high-quality services • Quality Assurance and Improvement • Compliance with Regulatory standards • Place based senior nursing leadership for independent oversight and support	X			
• Gather intelligence for assurance to ICS • Collaboration with local authorities for QA of joint services • Support for achievement of regulatory compliance • Assessment of maturity in places for QA and improvement	X	X		
• Local System Quality Group (was QSG) responsibility • Identification of unwarranted variation impacting on quality in the ICS • Taking collaborative action to improve quality within the ICS • Taking collaborative action to reduce inequalities and take a population health approach • Regional interface and escalation			X	

Nursing and Quality – Infection Prevention & Control (IPC) – deep dive underway	Place	Area	NENC	Provider Collaborative
• Provider / Place responsibilities and accountabilities (Director of IPC) • Support and quality improvement to care settings with local authorities • Covid response and recovery • Health and public health collaboration • One IPC Place Workforce • Place based collaborative learning from infections, not just organisational	X			
• Assurance oversight of place via joint committees / groups • Potential for IPC models across a geography given IPC scarce resource		X		
• Distributive leadership model portfolio holder • ICS IPC SROs – AMR 5-year plan delivery • Ongoing Covid-19 response			X	
Nursing and Quality – Professional Clinical Nurse Leadership				
• Organisation clinical nurse leadership in organisations • Senior Place based nursing leadership to support workforce and upholding professional regulatory standards	X			
• Professional clinical leadership via established multidisciplinary networks • Responsible for establishing and managing ICS wide Directors of Nursing Network • Professional advisory function to ICS system leadership • Developing next stage for Practice Nurse 10 point plan – develop priorities with places and regional team			X	

Nursing and Quality – Patient Experience, Complaints				
• Place support for delivery of robust complaint management • Provider responsibilities and accountabilities • Delivery of organisation / place targets and improvements for patient experience including FFT / National Patient Experience Surveys • Personalisation • Achievement of Commitments to carers at local place	**X**			

Nursing and Quality – Care Homes / domiciliary care / supported living / independent living	Place	Area	NENC	Provider Collaborative
• Support and quality improvement to care settings with local authorities • Delivering programme of work to ensure resilient caring workforce and reducing hospital admissions: • React to Red • React to Falls • Care of the deteriorating resident • Safety strategies such as safe handover / safety huddles • IPC etc	**X**			
• Potential for geographical models dependant on workforce availability but must not dilute place effectiveness		**X**		

• Responsible for the setting up and management of the Quality Assurance of Discharges Group, setting system wide standards, improving processes and patient experience, sharing learning • Oversight of progress and quality & performance in relation to implementation of the discharge policy • Distributive Leadership Model portfolio holder • Oversight and assurance • Development of further programs with Improvement Academy and others			**X**	

Medical/Nursing and Quality – IFR	**Place**	**Area**	**NENC**	**Provider Collaborative**
• Pathway transformation to inform 'commissioning policies'	**X**			
• Pathway transformation to inform 'commissioning policies'		**X**		
• Function can only happen at ICS or may promote further inequalities • Model needs thinking though as 'commissioning policies' will need aligning and provider collaboratives will have a strong role in transformation of pathways • Need to establish independent IFR service provision (different models currently in place – gap for mental health IFRs)			**X**	
Medical/Nursing and Quality – Research				
• Provider involvement in research	X		X	
• TBA (awaiting deep dive)				

Nursing and Quality – Caldicott Guardianship				
• Place provider responsibilities	X			
• Assurance and oversight		X		
• ICS Caldicott Guardian with associated responsibilities			X	
Nursing and Quality – Freedom to Speak Up Guardianship				
• Place provider responsibilities • Additional independent resource through place based nursing leadership	X			
• Potential for supportive models over wider footprint		X		
• ICS Freedom to Speak Up Guardian • Quality oversight and assurance • Interface with region			X	

Nursing and Quality – Mental Health Homicides/ Independent Investigations	Place	Area	NENC	Provider Collaborative
• Reporting incidents and associated internal investigations • Implementation of recommendations from independent investigations (Health Service Guidance 94/27)	X			
• Mental Health Homicides are commissioned by NHSE/I • Oversight of incident reporting and investigations • Learning through System Quality Groups (was QSG)			X	

County Durham Care Partnership | NHS County Durham Clinical Commissioning Group | Tees, Esk and Wear Valleys NHS NHS Foundation Trust

County Durham and Darlington Adult Mental Health (AMH) Rehabilitation and Recovery services; Reprovision of Primrose Lodge, Chester le Street inpatient service, report following the outcome of targeted engagement

1.0 Introduction

The purpose of this paper is to provide details of the outcome of the further targeted engagement to support the proposal to relocate Primrose Lodge Inpatient Rehabilitation and Recovery unit from Chester le Street to Shildon. The initial paper was presented to the OSC in January which explained the rationale for the change, the engagement that had taken place up to that point and plan to undertake further targeted engagement in February and March before finalising the relocation.

2.0 Background

The paper submitted in January outlined the rationale for the change, the key factors are:

- Poor physical environment of Primrose Lodge which does not meet CQC requirements
- Service improvement work which has been undertaken over the last 18 months to review the rehabilitation role, function and pathway. The processes that have been implemented will further improve and support the recovery pathway for people using the service
- Significant investment in the community rehabilitation team and for the voluntary and community sector which has meant additional multi disciplinary staff to expand the service and offer more comprehensive support and to a wider number of service users. The investment has also enabled the service to enhance the community rehabilitation pathway to reduce the duration and reliance on bed-based interventions.
- The accommodation at Shildon meets the required privacy and dignity standards and significantly improves the physical environment whilst ensuring the principles of rehabilitation can be met. The ground floor accommodation would also improve access for patients with mobility issues. The building is configured to support and meet the Trust Privacy and Dignity Policy, including Eliminating Mixed Sex Accommodation Requirements. There are 8 bedrooms which are gender zoned, have en-suite facilities and a female only lounge has been identified.
- The pathway redesign events to improve the pathway and access to services, along with the significant investment in the community rehabilitation means that the service are confident, based on demand modelling that 8 beds would be

sufficient and allows the adoption of a more person centred and less institutional therapeutic milieu than a larger 15 bedded unit.

- We will retain and continue to develop the existing access to community venues and public transport from the Shildon base and ensure the social, leisure, education and health facilities which are key factors to support each individual's recovery continue to be accessed. The expanded community rehabilitation team will continue to support patients with accessing local amenities and activities within their local/home area.

3.0 Key Issues

The targeted engagement plan: how we engaged and with whom

How we engaged: We developed a briefing document which explains the proposal, background and rationale and offered the opportunity to contact the TEWV Locality Director to discuss further and /or to provide more detailed information. This is shown in Appendices 1.

We developed bespoke surveys, which were distributed on line and hard copy (postal) with tailored questions in each. The first survey was for service users, families, carers. The 2nd survey was for referring organisations/other organisations who support mental health rehabilitation. The questions sought to get feedback on respective stakeholder views of the current service, what works well and what can improve, from their perspective and role. The survey also asked them to rate their support for the proposal.
The surveys are shown in Appendices 2 , 3 and 4.
The briefing and/or surveys were issued w/c 31 January and 7 February.

The stakeholders: the matrix below details the stakeholders we targeted and identifies if they received the briefing and/or survey. Following the distribution of the briefing we were contacted by a number of organisations with questions and also opportunities to attend forums to explain the proposal further and seek direct feedback via this route. These were:

- Durham VCS resilience forum – 21 February - the proposal was well received and no concerns raised. Engagement with the forum has also helped develop as we were made aware of support organisations in Shildon that can further support the recovery pathway of service users
- County Durham CCG Patient and Public Engagement forum – 25 February
- We also held discussions with Shildon Local Area Action Partnership lead Officer

Stakeholder	Briefing	Patient/Carer/ Family Survey	Referring/Other Organisations Survey
Service users of Primrose Lodge and those supported by the community rehab team	X	X	
Families and carers of rehab service users	X	X	
Durham Community Mental Health Framework (CMHF) steering group members	X	x	x
Darlington CMHF steering group members	x	x	x
Tees Valley MH Alliance (Darlington members)	x		x
TEWV Governors in Durham and Darlington	X		
Shildon Town Council (at the request of Durham OSC)	X		
Healthwatch, Darlington and County Durham	X		
Durham and Darlington MPs	x		
Durham VCS organisations (via Chair of Durham county wide group) - attendance at 21 Feb mtg	X		X
LA housing and rehabilitation leads in County Durham and Darlington	X		
Durham MH Alliance - 8providers, 6 sub contractors, covers housing, welfare rights, bereavement, women support	X		x
County Durham CCG Patient/Public involvement group - attendance at mtg 24 February	X		X
Durham and Darlington PCN clinical directors/ business leads	X		
Durham Community Foundation	X		X
Police and crime commissioner	X		
Shildon and CLS Area Action Partnerships (AAP) , respectively	x		
Shildon councillors and CLS east councillor	x		
TEWV AMH Modern Matron, acute ward managers,	x		x
TEWV AMH Locality Manager, community team managers	x		x
Recovery College - Durham	x	x	x

4.0 Survey feedback and analysis:

We issued 53 surveys to patients and 43 surveys to family/carers. The survey was also made available to the referrers and other organisations mentioned above. We received 22 responses :

Individuals open to rehabilitation service - 9
Family/carers of those open to the rehabilitation service- 9
Other- 1
We received 2 completed surveys from referrer/ other stakeholders:

- Housing.com
- Durham County Council Commissioning Team and MH Strategic Operational Management

The office of the Police & Crime Commissioner responded to advise she had liaised with Durham Constabulary Force Leads on Vulnerability and the Neighbourhood Chief Inspector and there have been no issues raised with this proposal.

A full analysis of survey responses from service users, carer, family can be found in Appendices 5.
As there were only 2 responses from referrers and other organisations we have not completed a separate analysis, these responses have been included in the themes below.

Theme	Who responded with this theme	Comments	Our response
Recognition of the benefits of better facilities in the Shildon facility e.g. ensuites, ground floor access.	-Current/ previous service users -Families/carers -Referrers and other organisations	There was consensus and recognition of the importance of the environment at the Shildon unit.. 'Comfortable environment', 'access to an en-suite' and 'ground floor access' listed as the most important for recovery in the survey answers, with 56% of service users responding that a 'comfortable environment' was most important to them.	Positive to see that the importance of a good environment is noted and recognised
Concerns around reduced bed numbers	- Families/carers -Referrers and other organisations	There were several respondents who expressed concerns around the reduction of beds and the ability of the community teams to manage service users in the community with the bed reduction. One of the referrer organisations questioned whether a more single	The service has established a mobilisation group – overseeing each patient's discharge plan which is reviewed weekly.

		occupancy supported type unit should have been explored to promote greater independence.	There will be a phased bed reduction based on each service users agreed discharge plan – over a number of months. We will agree how we can share with stakeholders on a regular basis the impact of the enhanced community team and their ability to facilitate earlier discharge and support more service users in the community
Request for more activities in the new facility (with a focus on Activity of Daily Living)	-Current/previous service users - Families/carers	The responses from the servicer user questionnaires showed Activities of Daily Living were the most useful to support recovery. There was a request for more activities in the new facility with 'lifestyle skills' to promote independence and recovery. A response from a service users families advised "Need constant help, activities and support."	This is helpful feedback for the service to continue to develop their rehabilitation and recovery offer and increase provision when necessary to meet individual needs
Praise for clinical staff and the value of the support they provide	- Current/previous service users - Families/carers	There was widespread praise for the clinical staff and the support they provide. "there is always someone to answer my calls …. I am grateful for the staff." There was recognition from responses that the multi disciplinary staff who support service users are all valued with each discipline receiving a high level of support as aiding their recovery . "Nursing and clinical team very important but the availability of psychology/other support is useful too. "	Positive to receive this feedback and see the impact the staff roles have to service users and their family. We continue to develop new roles with our voluntary sector partners including activity coordinators.
The new location has been recognised as a	-Families/carers -Referrers and other organisations	The survey responses recognised the importance of access to local community resources and therefore the support or concern reflects the home address of each respondent to the current or new	We recognise as a county wide facility that any location will not be ideal for all Durham residents.

positive and a negative change depending on the respondents address in County Durham		unit. Some responses highlighted the good community facilities in Chester le Street and questioned whether there was the same level in Shildon. The Service Manager attended the VCS forum in February to present the proposal and received feedback on the range of community activities that can support the rehabilitation service. This included feedback from Shildon community organisations who gave details of walking and other groups in the area. When asked if service users had been offered support in their area 67% of service users surveyed had been offered support in their local home area.	However, we have very good links with community organisations across county Durham and Darlington, and these have been developed further through this engagement process, in particular for community facilities available in Shildon. We recognise we will need to continue to work hard to ensure we have knowledge of and links with relevant community support, and keep this regularly updated.
Rating the proposal	-Current/ previous service users -Families/carers -Referrers and other organisations	The rating scale for this question was between 1-5; 1 is 'do not support' and 5 is 'fully support'. The average rating for the proposal was 3.9, with 9 respondents rating the proposal as '5- fully support'. 3 respondents rated the proposal as 1 or 2 with limited support.	The responses recognise the importance of environment to aid recovery, with concerns about reduced beds and accessing community facilities. An overall positive rating for the proposal

5.0 Conclusion:

The targeted engagement has been with a range of stakeholders with each provided with a summary of the proposal and the opportunity to provide further feedback, based on their experience of the service, either as a service user, a family member or carer or as a referring organisation via a be-spoke survey. We also invited any stakeholder to get in touch, with the offer of a meeting and provision of further information if required. We attended a CCG involvement meeting and a VCS County wide forum as well as individual discussions with Area Action Partnership leads. The office of the Police and Crime Commissioner has confirmed that the Durham Constabulary Force Leads on Vulnerability and the Neighbourhood Chief Inspector have no issues raised with this proposal.

Analysis of survey responses shows the average rating for the proposal is 3.9 (5 is fully support) with recognition and support of the importance of an improved environment of the Shildon unit and the ability of the staff to continue to support service users recovery. Concerns regarding the bed reduction and the range of community facilities in Shildon were expressed. We have outlined our responses to the feedback and we recognise we need to increase our communication with service users and their families about how the move will be managed, via a phased bed reduction. We recognise we need to provide more information to them and other stakeholders about the range of support the expanded community rehabilitation team provides and the impact they have had on reducing the reliance on beds. We will improve the range of information we have available regarding community facilities and how we share and discuss this with service users and their families and referrer organisations so they have more re-assurance about the level of support available.

On balance, this engagement along with feedback from the previous improvement events, highlights the strength of support and recognition of a good environment to support recovery. The engagement highlighted concerns regarding bed numbers, however we remain confident we can manage the reduction safely and effectively. For those who responded to the engagement there was a good level of rated support for the proposal.

6.0 Recommendations:

- The Local Authority Overview and Scrutiny Committee is requested to receive the report detailing the outcome of the targeted engagement to support the proposal to re-provide the Primrose Lodge unit from Chester le Street to Shildon with a reduction from 15 to 8 beds
- The Overview and Scrutiny Committee is requested to support the proposal and relocation of the inpatient rehabilitation service to Shildon.

Jennifer Illingworth
Director of Operations
County Durham and Darlington, TEWV

Mike Brierley
Director of Mental Health & Learning Disability
Durham Tees Valley Partnership

Appendix

Appendices 1 – stakeholder briefing

This briefing explains the Trust and County Durham CCG proposal to relocate the TEWV Primrose Lodge Rehabilitation and Recovery Unit from Chester le Street to Shildon as part of our rehabilitation environment and pathway improvements.

The current facility has 15 beds and is commissioned for County Durham and Darlington residents. It provides supportive interventions for service users with mental health needs who need a period of rehabilitation to support them to live safely and well in the community. The Unit offers opportunities for education and skills building, for a period of up to 9 months, allowing for future independent/ supportive living. The current building is located in Chester le Street, however it is no longer fit for purpose and does not meet CQC regulatory standards for privacy and dignity and accessibility (bedrooms are located upstairs). The preferred option is to re-locate the service into a vacant Trust building in Shildon. The facility has 8 en-suite bedrooms, ground floor accommodation with access to good outside space and offers a significantly improved environment for staff and patients. This property has previously been utilised as a rehabilitation facility and most recently a crisis and recovery house. We have experience of being a good neighbour and partner in Shildon and it is important to us that this continues.

TEWV also has a 15 bed rehabilitation unit at West Park Hospital Darlington (Willow Ward) which will remain and is unaffected by this proposal.

There have been significant improvements and investment to the rehabilitation service pathway to strengthen the needs led approach and to enhance rehabilitation community based support in line with national policy. This additional investment will ensure that service users have access to an enhanced multi disciplinary team and can be supported in their local home area. This strengthens the ability of service users to utilise the support mechanisms in their own community which play a vital role in keeping them safe and well in the community. Rehabilitation pathways have been improved to ensure voluntary sector and third sector organisations are embedded within the pathway. Shildon is well located as a county wide inpatient rehabilitation service as well as offering outreach to a range of activities and support organisations across County Durham and Darlington.

These factors mean we will reduce the duration and reliance on inpatient stays and are confident we can manage within the reduced number of beds. For those individuals who need an inpatient stay to support their recovery, the unit at Shildon offers a much improved environment and a modern health facility. We will continue to work collaboratively with service users and our partner organisations to help establish meaningful activities and support mechanisms for each service user as they move from inpatients and to maintain their recovery in their local community.

I hope this briefing has been helpful in explaining the proposal and the reason for the change of location. We want to be a good neighbour and partner and are happy to discuss the proposal further with you if this would be helpful. We are happy to receive any comments and have also developed a short on line survey for patients, families and referrers to complete.

Please provide any comments or to request further information, the survey or a meeting to Jennifer Illingworth, Locality Director, TEWV at jenniferillingworth@nhs.net, or write to me at West Park Hospital, Edward Pease Way, Darlington, County Durham. Please get in touch or provide your comments before the end of February so that they can be included in the report we will submit to the Overview and Scrutiny Committees.

Appendices 2- Families and carer survey :

Q1 please can you indicate your role:

- Carer

- Family member/friend

- Other

Q2. Have you been supported by the rehab service as a family member/carer?

- Yes
- No
- Don't know

Please explain answer

Q3. In your experience what has made the biggest difference to your family member/friend etc

- Activities/community work
- Nursing/Clinical Team
- Other

If other please let us know what this is/was:

Q4: Please can you score your support for the proposal to relocate Primrose Lodge from Chester le Street to Shildon.

Do Not support 1 2 3 4 5 Fully support

Q5. Please provide any other comments you would like us to consider:

Appendices 3- Service user survey :

Q1. Are you a:

- Current service user at Primrose Lodge

- Previous service user in Plodge

Q2. From you experience what would you say is the most important to you to help your recovery, (please choose as many as applicable) :

-Comfortable environment

-Access to an En-suite

-Ground Floor/disabled access

-Access to activities

-Accessing community resources

-Other

Comments:

Q3. From your experience who are you receiving support from:

-Nurses

-HCAs

-OTs

-Psychologists

-Activity coordinators

-Physiotherapist

-Pharmacy

-Physical health nurse

Q4. Following on from the above question, who do you feel is beneficial to your recovery?

-Nurses

-HCAs

-OTs

-Psychologists

-Activity coordinators

-Physiotherapist

-Pharmacy

-Physical health nurse

Comments:

Q5. What do you think is helpful to support your recovery (please tick all that apply to you) :

-Leisure/outdoor/physical activities

-Creative/technology activities

-ADL activities e.g. cooking, personal care etc

-Social/community activities

-Vocational/educational activities

-Faith activities

-Other

Comments:

Q6. Have you been supported in your local home area (area in which you will be discharged to) by rehabilitation staff:

-Yes

-No

-Don’t know

Comments:

Q7: Please can you score your support for the proposal to relocate Primrose Lodge from Chester le Street to Shildon.

Do Not support 1 2 3 4 5 Fully support

Q8: Please provide any other comments you would like us to consider.

Appendices 4- Referrers and other organisations survey :

Q1. Please specify what organisation you currently work in:

Q2. How can we ensure that the current pathways into the rehabilitation service from your organisation can be maintained or improved:

Q3. From your professional viewpoint and/or any feedback you have received about the Rehabilitation services, what do you think the main strengths of the service currently based at Primrose Lodge:

- The facilities

- Access to meaningful interventions

- Support from the Multi disciplinary team

- Support from Voluntary/third sector organisations

- Other

Please provide any comments:

Q4. How can we work with your organisation to enhance/improve rehabilitation services for our service users:

Q5. Do you have any other comments you would like us to consider for this proposal:

6.Please can you score your support for the proposal to relocate Primrose Lodge from Chester le Street to Shildon.

Appendices 5- Analysis of responses from the service user, family and carer surveys

These responses are both service users, carers and families combined, as the survey was created under the same entity.

1. Are you a...?

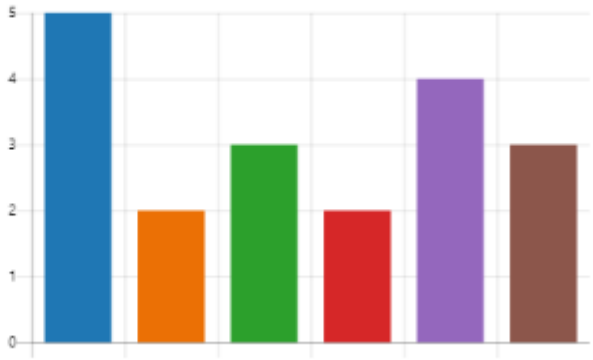
More Details

Current service user of Primro...	6
Previous service user of Primr...	2
Carer/advocate	1
Family Member/friend	8
Other	1

2. From your experience, what would you say was most important to you to help your recovery? (Please choose as many as applicable)

More Details

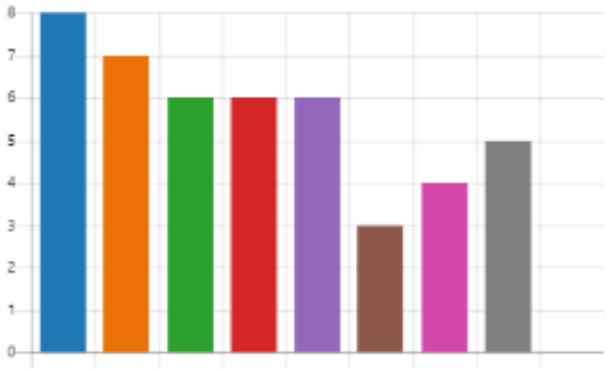
Comfortable environment	5
Access to an en-suite	2
Ground floor/disabled access	3
Access to activities	2
Accessing community resources	4
Other	3



3. From your experience at Primrose Lodge, who did you receive support from?

More Details

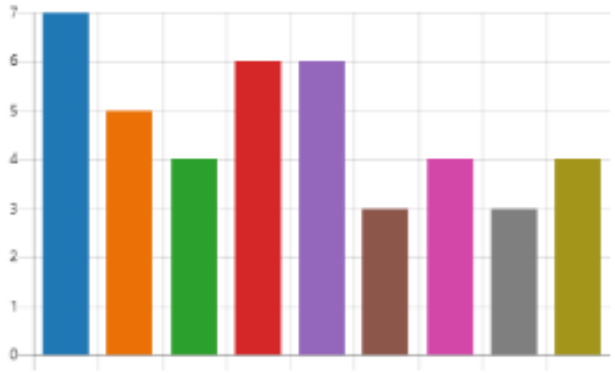
Nurses	8
HCAs	7
OTs	6
Psychologists	6
Activity Coordinators	6
Physiotherapist	3
Pharmacy	4
Physical health nurse	5
Other	0



4. Following on from the above question, who did you feel was beneficial to your recovery at Primrose Lodge?

More Details

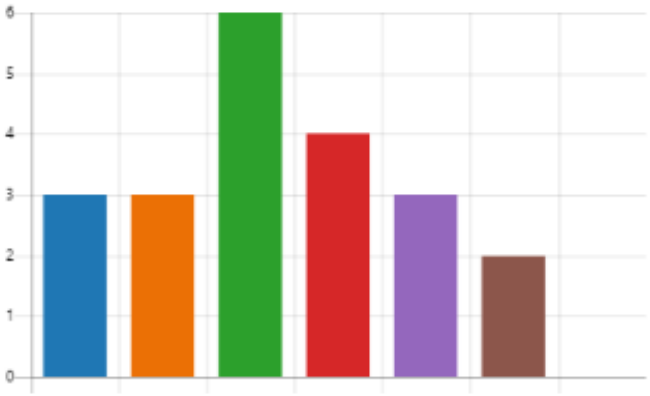
Nurses	7
HCAs	5
OTs	4
Psychologists	6
Activity coordinators	6
Physiotherapists	3
Pharmacy	4
Physical health nurse	3
Other	4



5. What do you think is helpful to support your recovery? (Please tick all that apply to you)

More Details

Leisure/outdoor/physical activ...	3
Creative/technology activities	3
ADL activities e.g. cooking, pe...	6
Social/community activities	4
Vocational/educational activiti...	3
Faith activities	2
Other	0



6. Have you been supported in your local home area (the area in which you will be/were discharged to) by rehabilitation staff?

More Details

Yes	6
No	2
Not sure	1
Other	0

7. Have you been supported by the rehab service as a family member/carer?

More Details

Yes	8
No	1
Not Sure	0
Other	7

Please note the ‘other’ responses are where respondents provided comments to go alongside their answers, this should not be counted as a separate response.

8. In your experience, what has made the biggest difference to the service user?

More Details

Activities/community work	0
Nursing/Clinical Team	5
Other	4

9. Please can you score your support for the proposal to relocate Primrose Lodge from Chester le Street to Shildon.

More Details Insights

16
Responses

3.81
Average Number

This was rated 1-5, 1 being ‘do not support’ and 5 being ‘fully support’. The number shown above differs from the average rating as shown in the main body of the text as this includes the 2 surveys completed by referrers and other organisations.

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Adults, Well-being and Health Overview and Scrutiny Committee

21 March 2022

Quarter Three, 2021/22 Performance Management Report

Ordinary Decision

Report of Paul Darby, Corporate Director of Resources

Electoral division(s) affected:

Countywide.

Purpose of the Report

1 To present an overview of progress towards achieving the key outcomes of the council's corporate performance framework and highlight key messages to inform strategic priorities and work programmes.

2 The report covers performance in and to the end of quarter three, October to December 2021.

Performance Reporting

3 The performance report is structured around the three components.

(a) High level state of the County indicators to highlight areas of strategic significance. These are structured around the County Durham Vision 2035.

(b) Council initiatives of note against the ambitions contained within the vision alongside a fourth 'excellent council' theme contained within our Council Plan[1].

(c) A long list of key performance indicators against the themes of the Council Plan.

4 It also includes an overview of the continuing impact of COVID-19 on council services, our staff, and residents.

[1] approved by full council October 2020

Long and Independent Lives

5 Gym membership at our leisure centres currently stands at around 16,000, a reduction of around 4,500 since the start of the pandemic. In addition, attendances have dipped to just over 850,000, a reduction of a third on pre-pandemic numbers. We expect both gym memberships and attendances to recover by March 2023.

6 We are continuing to invest in walking and cycling infrastructure, work to tackle food poverty, provide focused activity across mental and physical well-being, and support smoking quitters. Our new MOVE programme is encouraging both adults and children to get moving and keep moving as part of their everyday life - and in addition to advice, guidance and one-to-one tailored support has provided almost 800 free gym or swim memberships,

7 Across adult social care, there is a decreasing trend in permanent admissions to residential and nursing care. Multiple factors associated with activity, practice and the continuing impact of the pandemic are responsible for this reduction. The proportion of older people remaining at home 91 days after discharge from hospital into reablement services is at its highest point for more than three years, and almost 93% of individuals achieved their desired outcomes from the adult safeguarding process.

8 However, only 70.1% of service users were assessed or reviewed within the last 12 months. This is reflective of operational pressures while coming out of the pandemic resulting in the need to prioritise more pressing work, the bedding in of a new case management system which was introduced in June 2021, alongside the need to increase confidence in reporting mechanisms. We are considering additional resource to improve performance and are revising our approach to social care annual reviews. We expect that performance will return to pre-pandemic levels in 2023.

9 Financial support to the adult social care market is continuing, with over £68 million provided during the pandemic. Domiciliary care providers have also received a 10% uplift to support with recruitment and staff retention pressures.

The impact of COVID-19

10 The COVID-19 pandemic has caused an unprecedented health emergency across the globe. Restrictions to contain the virus, minimise deaths and prevent health and social care systems being overwhelmed remain in place, and are continuing to impact our everyday lives, our health, and the economy.

11 However, roll-out of the UK's vaccination programme, which has reduced both hospital admissions and deaths, allowed the government to implement plans for a gradual and phased route out of lockdown.

12 Working with government organisations and within the context of national developments, we continue to protect our communities, support those affected by the pandemic, and develop plans for future recovery.

13 The COVID-19 surveillance dashboard can be accessed here.

Risk Management

14 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. The latest report can be found here.

Recommendation

15 That Adults, Well-being and Health Overview and Scrutiny Committee notes the overall position and direction of travel in relation to quarter three performance, the impact of COVID-19 on performance, and the actions being taken to address areas of underperformance including the significant economic and well-being challenges because of the pandemic.

Author

Andy Palmer Tel: 03000 268551

Appendix 1: Implications

Legal Implications

Not applicable.

Finance

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

Consultation

Not applicable.

Equality and Diversity / Public Sector Equality Duty

Equality measures are monitored as part of the performance monitoring process.

Climate Change

We have declared a climate change emergency and consider the implications of climate change in our reports and decision-making.

Human Rights

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.

Staffing

Performance against a number of relevant corporate health indicators has been included to monitor staffing issues.

Accommodation

Not applicable.

Risk

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

Procurement

Not applicable.

Appendix 2

Durham County Council Performance Management Report

Quarter Three, 2021/22

Long and Independent Lives

1 The ambition of Long and Independent Lives is linked to the following key objectives:

(a) County Durham will have a physical environment that will contribute to good health;
(b) We will promote positive behaviours;
(c) Health and social care services will be better integrated;
(d) People will be supported to live independently for as long as possible by delivering more homes to meet the needs of older and disabled people;
(e) We will tackle the stigma and discrimination of poor mental health and build resilient communities.

Council Services

A physical environment contributing to good health

2 A Health Impact Assessment on the leisure centre transformation programme and proposed refurbishments is ongoing with an expected completion date of spring 2022. Relevant information and data have been collected during quarter three on the proposed refurbishments at Abbey, Peterlee, Spennymoor and Teesdale leisure centres.

3 COVID-19 has impacted gym memberships at our leisure centres. There are approximately 4,500 fewer than at the start of the pandemic in April 2020. Although growth in gym membership was on target for the first two months of quarter three, the Omicron wave affected both sales and cancellations in December resulting in total memberships falling from 16,309 to 16,080. Attendances followed a similar pattern, with growth over the first part of the quarter but an exceptionally quiet December. As at the 31 December 2021, quarterly attendances totalled 850,494 which is 31% fewer (-261,158) than the same period pre-COVID (ending December 2019). Although disappointing, this was due to the Omicron wave, and targets for both gym memberships and attendance are set for a full recovery for March 2023.

4 To attract new customers and re-engage those who left during the pandemic, we have launched our £1.2 million MOVE programme which encourages people to get moving and keep moving as part of their everyday life. The programme provides tips, signposting and dedicated one to one support to help people overcome barriers to exercising more. As of mid-January, we had allocated 752 free gym or swim memberships, 99 of which were to young people aged 11 to 15 years, and are on track to meet our target of 1,750. We aim to convert a high number of these to paid for memberships when their free membership ends.

5 During quarter three, our Playing Pitch Strategy was approved and we are now focussing on developing an implementation plan and funding strategy to deliver the first tranche of recommendations. We aim to improve 49 pitches across the county both in terms of quality and the number of teams these pitches can accommodate.

Promoting positive behaviours

6 It is recognised that targeting women who smoke, from the very start of their pregnancy and thereafter, is essential in increasing the quit rate. Further work to address this has been undertaken in quarter three; this includes the development of an online booking system for GP receptionists, which enables them to provide details of the Stop Smoking Service to pregnant women at the earliest opportunity.

7 The Smoking Quitters Case Management System contract with AN Computing Limited commenced in December 2021.

8 Horden Together is a place-based partnership project aiming to improve public safety by offering support with a broad range of issues, including emotional health, crime, anti-social behaviour, housing, drugs, alcohol and environmental issues. This includes the development of the Horden Resource Centre; this will provide an active community resource, providing office space for multiple partners committed to implementing the Making Every Adult Matter approach, including substance misuse recovery. Work on the centre was completed in December 2021.

9 A new service run by Wellbeing for Life commenced during quarter three to provide a cardio-vascular disease (CVD) prevention programme. This has been incorporated into the NHS Health Check programme, to provide support for patients identified as requiring support to address health behaviour which places them at risk of CVD. This service will increase the provision of advice and guidance for lifestyle behaviour changes.

10 Work continues on the development of a physical activity strategy for County Durham. During quarter three, a series of stakeholder workshops were held and, once all information has been collated, it is expected that the final strategy will be presented to the County Durham Health and Wellbeing Board in March 2022.

11 A number of workshops have taken place during quarter three to set the new priorities for the Healthy Weight Alliance (HWA) for 2022. These will be presented to the HWA in the new year, with group members to set priorities for the HWA to focus on for 2022. Work has also commenced to develop a resource detailing all Healthy Weight support services available across County Durham.

Better integration of health and social care services

12 Wellbeing for Life services continued to be reinstated during this quarter, to engage local residents in positive health behaviours and addressing wider determinants. Support is being implemented via hybrid ways of working to maximise opportunities to engage local residents, depending on their needs.

13 Contain Outbreak Management Funding has been awarded to Wellbeing for Life, to help support County Durham and Darlington NHS Foundation Trust manage patients on hospital waiting lists. The 'Wellbeing for the Time Being' programme aims to proactively engage with pre-op patients to offer them both physical and psychological support whilst waiting for their operation. The programme is also linking directly with the new weight-loss management service being developed.

People will be supported to live independently for as long as possible

14 Multiple factors associated with activity, practice and the continued impact of the pandemic alongside the changing of case management systems in June 2021 are reflected in the continued decrease in permanent admissions to residential and nursing care.

permanent admissions to residential and nursing care per 100,000 population October to December…		
2019 (pre-COVID)	2020	2021
566.8	432.6	395.4
	189 fewer people from 2019	41 fewer people from 2020

15 During quarter three, 88.3% of older people remained at home 91 days after discharge from hospital into reablement services. Significantly higher than the same period last year (83.5%), this performance is at its highest point for more than three years having steadily increased during the pandemic. For this indicator we continue to perform well against regional and national figures.

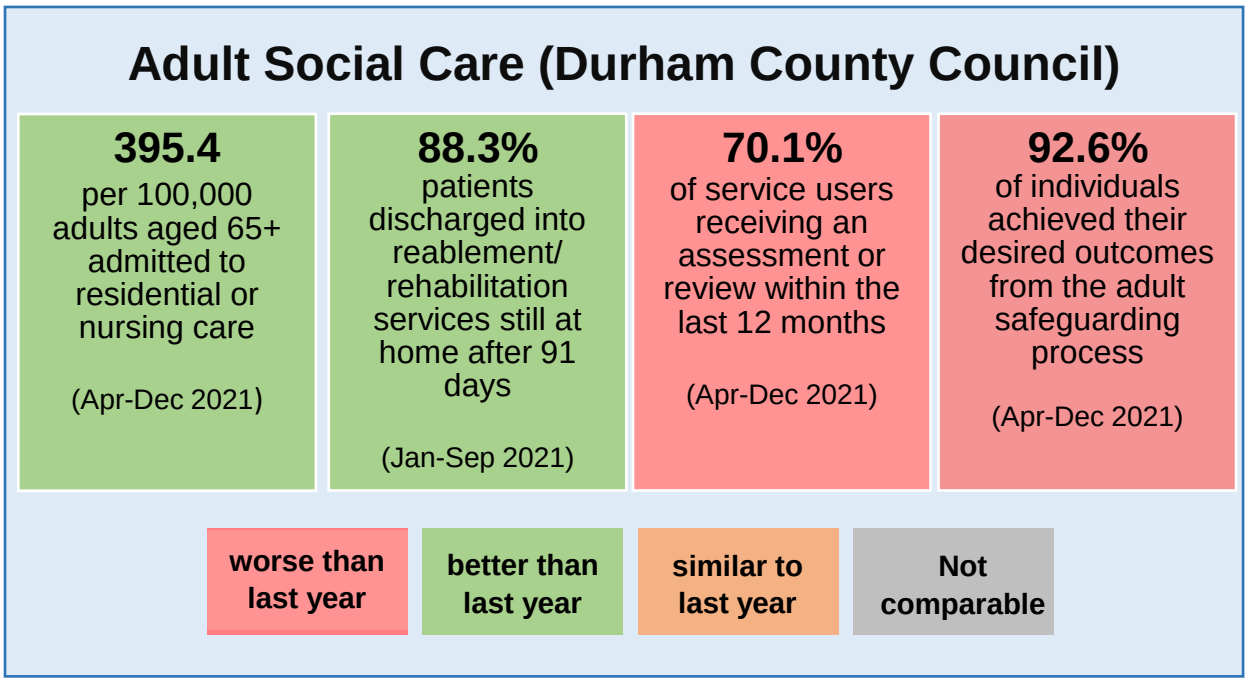
16 In relation to the adult safeguarding process, 92.6% of individuals achieved their desired outcomes during quarter three: a slight reduction over the last two quarters, the same period last year (94.5%) and for quarter three prior to the start of the pandemic (94.9%).

17 The percentage of service users assessed or reviewed within the last 12 months has continued to reduce over the last year. Factors for this performance include; the change to a new case management system, which increased the administrative burden in recording reviews until the first 12 month cycle is complete, operational pressures while coming out of the pandemic have meant

other work has had to be prioritised, ongoing work required to increase confidence in practice and new reporting mechanisms; all these present challenges to performance integrity. It should be noted that the high performance in 2020 was partly due to reduced demand across certain areas of adult social care during the pandemic, which allowed social workers to focus on the timeliness of reviews.

Service users assessed or reviewed within the last 12 months October to December…		
2019 (pre-COVID)	2020	2021
86.8%	92.7%	70.1%

18 Whilst the pandemic has, to some extent, affected both assessment rates and admissions to permanent care, ongoing issues with our new case management system continue to impact the indicators. To mitigate this impact, additional resource is being considered to improve performance and Adult Care is revising its approach to social care annual reviews. The view of the service is that a period of bedding in is required to regain previous levels of confidence. We anticipate that performance will return to pre-pandemic levels for indictors in 2023.



19 During quarter three, Care Connect answered 97.5% of calls within a minute, showing an improvement on the previous quarter (96.7%) and in line with the service target (97.5%). The Care Connect emergency response rate (arriving at the property within 45 minutes of a call) is consistently above the 90% target and this quarter was 96.9% with 4,395 calls responded to within 20 minutes.

20 Although we have seen a slight increase this quarter in the number of Care Connect customers, over the longer term we are still seeing a downward trend in both the number of customers and connections. Compared to last year the number of connections decreased 2.2% and the number of customers by 2.6%. However, this is a slower rate of decrease than last quarter when connections and customers fell 3.3% and 3.8%, respectively.

Tackling the stigma of poor mental health and building resilient communities

21 The Time to Change Hub aims to reduce stigma and discrimination towards people who experience mental health problems and to raise awareness of the signs and symptoms of poor mental health. The small grants funding panel received 33 applications in quarter three, with 11 projects being shortlisted.

22 County Durham is part of the North East Public Mental Health Network, considering the regional key priority areas for investment during the COVID-19 recovery period. To support this, a regional Mental Health and Financial Wellbeing campaign was held during quarter three.

23 The Mental Health and Wellbeing Alliance aims to co-produce, co-ordinate and provide a range of support services for people with mental health needs. Final contracts have been awarded during quarter three and the Alliance will be operational from April 2022. Public Health is part of the Alliance development Board, to provide reference for the governance of this new arrangement.

Key Performance Indicators – Data Tables

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 2020/21 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.

More detail is available from the Strategy Team at performance@durham.gov.uk

LONG AND INDEPENDENT LIVES

Are our services improving the health of our residents?

Ref	Description	Latest data	Period covered	Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	updated this quarter
34	% of mothers smoking at time of delivery	13.9	Jul-Sep 2021	14.7 (amber)	14.3 (green)	9.0 (red)	11.7 (red)	12.9 (red)		Yes
35	Four week smoking quitters per 100,000 smoking population	2,452 [1,830]	Apr 2020 - Mar 2021	Tracker	2,945 [2,198] (red)	1,670 (green)	2,213 (green)	2,736 (red)		No
36	Male life expectancy at birth (years)	77.8	2018-20	Tracker	78.3 (amber)	79.4 (red)	77.6 (green)	77.9 (amber)		No
37	Female life expectancy at birth (years)	81.2	2018-20	Tracker	81.8 (amber)	83.1 (red)	81.5 (amber)	81.6 (amber)		No
38	Female healthy life expectancy at birth (years)	58.3	2017-19	Tracker	58.4 (amber)	63.5 (red)	59.0 (amber)	61.0 (red)		No
39	Male healthy life expectancy at birth (years)	59.6	2017-19	Tracker	59.3 (green)	63.2 (red)	59.4 (green)	60.5 (amber)		No
40	Excess weight in adults (Proportion of adults classified as overweight or obese)	64.8	2019/20	Tracker	63.3 (red)	62.8 (red)	67.6 (green)	69.6 (green)		No
41	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population	14.3	2018-20	Tracker	13.4 (red)	10.4 (red)	12.4 (red)	12.6 (red)		No
42	Prevalence of breastfeeding at 6-8 weeks from birth (%)	29.1	Apr-Jun 2021	Tracker	31.4 (red)	47.6 (red)	35.4 (red)	35.1 (red)	2020/21	No
43	Estimated smoking prevalence of persons aged 18 and over*	14.3	2020	Tracker	17.0	12.1 (red)	13.6 (red)	13.5 (red)		Yes
44	Self-reported well-being - people with a low happiness score	10.9	2019/20	Tracker	9.5 (red)	8.7 (red)	10.6 (amber)	9.6 (red)		No
45	Participation in Sport and Physical Activity: active	58.7%	May 2020-May 2021	Tracker	58.1% (amber)	60.9% (amber)	59.7% (amber)			No
46	Participation in Sport and Physical Activity: inactive	31.3%	May 2020-May 2021	Tracker	30.6% (red)	27.5% (red)	28.9% (amber)			No

*Smoking prevalence data is taken from the Annual Population Survey which, prior to the COVID-19 pandemic, was collected via face-to-face interviews. In 2020, due to the impact of the pandemic, this moved to telephone only collection. Data between 2019 and 2020 cannot, therefore, be compared.

Are people needing adult social care supported to live safe, healthy and independent lives?

Ref	Description	Latest data	Period covered	Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	updated this quarter
47	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	395.4	Apr-Dec 2021	N/a	432.6 (green)					Yes
48	% of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	88.3	Jan-Sept 2021	N/a	83.5 (green)	79.1 (green)	72.1 (green)	80.0 (green)	2020/21	Yes
49	% of individuals who achieved their desired outcomes from the adult safeguarding process	92.6%	Apr-Dec 2021	Tracker	94.5 (red)	94.8 (red)	94.9 (red)	96.0 (red)	2020/21	Yes
50	% of service users receiving an assessment or review within the last 12 months	70.1	Apr-Dec 2021	Tracker	92.7 (red)					Yes
51	Overall satisfaction of people who use services with their care and support	69.6	2019/20	Tracker	67.8 (green)	64.2 (green)	67.5 (green)	66.2* (green)		No
52	Overall satisfaction of carers with the support and services they receive (Biennial survey)	51.2	2018/19	Tracker	43.3** (green)	38.6 (green)	47.2 (green)	41.8* (green)		No
53	Daily delayed transfers of care beds, all, per 100,000 population age 18+	2.9	Feb 2020	Tracker	1.5 (red)	11.0 (green)	7.0 (green)	11.0* (green)		No
54	% of adult social care service users who report they have enough choice over the care and support services they receive	77.6	2019/20	Tracker	75.1 (green)	66.6 (green)	73.0 (green)	69.2* (green)		No

*unitary authorities

** results from 2016/17 survey

Other additional relevant indicators

LONG AND INDEPENDENT LIVES

Are children, young people and families in receipt of universal services appropriately supported?

Ref	Description	Latest data	Period covered	Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	updated this quarter
24	% of free school meals (FSM) eligible pupils taking FSM	76.0	Jan 2021	Tracker	75.8 (green)	82.6 (red)	82.6 (red)			No
25	Under-18 conception rate per 1,000 girls aged 15 to 17	19.0	2019	Tracker	26.4 (green)	15.7 (red)	21.8 (green)	21.5 (green)		No
26	% of five year old children free from dental decay	73.2	2019	Tracker	74.2 (amber)	76.6 (red)	76.7 (red)	71.7 (green)		No
27	Alcohol specific hospital admissions for under 18s (rate per 100,000)	52.8	2017/18-2019/20	Tracker	54.7 (green)	30.7 (red)	55.4 (green)	55.3 (green)		No
28	Young people aged 10-24 admitted to hospital as a result of self-harm (rate per 100,000)	361.2	2019/20	Tracker	354.3 (red)	439.2 (green)	536.6 (green)	656.3 (green)		No
29	% of children aged 4 to 5 years classified as overweight or obese**	24.9	2019/20	Tracker	24.0 (red)	23.0 (red)	24.8 (amber)	25.0 (green)		No
30	% of children aged 10 to 11 years classified as overweight or obese**	37.6	2019/20	Tracker	37.7 (green)	35.2 (red)	37.5 (amber)	37.2 (amber)		No

**The National Child Measurement Programme ended in March 2020 when schools closed due to the COVID-19 pandemic. Comparisons to North East and Nearest Statistical Neighbours should be treated with caution as not all submitted of their measurements. NCMP data for the academic year 2020/21 has been published, however, local authority data is not available due to a 10% sample in each area being recorded.

CONNECTED COMMUNITIES

How well do we reduce misuse of drugs and alcohol?

Ref	Description	Latest data	Period covered	Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	updated this quarter
85	% of successful completions of those in alcohol treatment	35.0	Oct 2020-Sep 2021	Tracker	33.2 (green)	35.9 (amber)	30.7 (green)			Yes

Ref	Description	Latest data	Period covered	Period target	12 months earlier	National figure	North East figure	Nearest statistical neighbour	Period covered if different	updated this quarter
86	% of successful completions of those in drug treatment - opiates	5.7	Oct 2020-Sep 2021	Tracker	5.6 (green)	4.7 (green)	3.3 (green)			Yes
87	% of successful completions of those in drug treatment - non-opiates	38.4	Oct 2020-Sep 2021	Tracker	30.4 (green)	33.6 (green)	30.0 (green)			Yes

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Adults Wellbeing and Health Overview and Scrutiny Committee

21 March 2022

Quarter 3: Forecast of Revenue and Capital Outturn 2021/22

Report of Corporate Directors

Paul Darby, Corporate Director of Resources

Jane Robinson, Corporate Director Adult and Health Services

Electoral division(s) affected:
Countywide

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 December 2021.

Executive Summary

2 This report provides an overview of the forecast of outturn, based on the position to 31 December 2021. It provides an analysis of the budget outturn for the services falling under the remit of the Overview and Scrutiny Committee and complements the reports considered by Cabinet on a quarterly basis.

3 The forecasts indicate that AHS will have a cash limit underspend of £0.189 million at the year-end against a revised revenue budget of £126.214 million, which represents a 0.15% underspend.

4 In arriving at the cash limit position, Covid-19 related expenditure of £2.659 million offset by Covid-19 related savings of £3.101 million have been excluded. Covid-19 costs are being treated corporately and offset by Government funding as far as possible.

5 Based on the forecasts, the Cash Limit balance for AHS as at 31 March 2022 will be £6.145 million.

6 Details of the reasons for under and overspending against relevant budget heads are disclosed in the report.

7 The AHS capital budget for 2021/22 is £0.377 million, as at 31 December 2021, and there has been capital expenditure incurred of £0.320 million.

Recommendation

8 It is recommended that the Adults Wellbeing and Health Committee note the financial forecasts included in this report.

Background

9 County Council approved the Revenue and Capital budgets for 2021/22 at its meeting on 24 February 2021. 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 - £126.214 million (original £133.618 million)*
- *AHS Capital Programme – £0.377 million (original £1.210 million)*

10 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	133,618
Transfer from Contingencies – Transforming Care	371
Budget Transfer – Safeguarding Adults Board	149
Budget Transfer – Transitions	(150)
Budget Transfer – First Aid Training	(5)
Budget Transfer - CYPS	(4,500)
Budget Transfer – Partnerships to CYPS	(30)
Budget Transfer – Resources	(5)
Use of (+)/contribution to cash limit reserve (-)	(1,507)
Use of (+)/contribution to AHS reserves (-)	(1,727)
Revised Budget	**126,214**

11 The use of / (contribution) to AHS reserves consists of:

Reserve	**£'000**
Contribution to AHS - Social Care Reserve	(1,694)
Contribution to Public Health Reserve	(33)
Total	**(1,727)**

12 The summary financial statements contained in the report cover the financial year 2021/22 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

13 The updated forecasts show that the AHS service is reporting a cash limit underspend of £0.189 million against a revised budget of *£126.214 million* which represents a 0.15% underspend. This compares with the forecast cash limit underspend at September of £2.350 million.

14 The tables below show the revised annual budget, actual expenditure to 31 December 2021 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 £000	YTD Actual £000	Forecast Outturn £000	COVID 19 Costs £000	COVID Under spends £000	Cash Limit Variance QTR3 £000	Memo-Forecast Position at QTR2 £000
Employees	38,883	27,385	37,078	(43)	0	(1,848)	(895)
Premises	2,116	574	2,222	0	0	106	118
Transport	2,256	956	1,352	0	634	(270)	(76)
Supplies & Services	5,064	5,095	7,071	(50)	0	1,957	1,120
Third Party Payments	291,593	167,658	295,822	(2,566)	0	1,663	(1,808)
Transfer Payments	11,278	7,540	10,548	0	0	(730)	(928)
Central Support & Capital	31,660	20,930	33,273	0	0	1,613	345
Income	(256,636)	(149,663)	(261,783)	0	2,467	(2,680)	(226)
Total	**126,214**	**80,475**	**125,583**	**(2,659)**	**3,101**	**(189)**	**(2,350)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	COVID 19 Costs £000	COVID Under spends £000	Cash Limit Variance QTR3 £000	Memo-Forecast Position at QTR2 £000
Central/Other	11,024	(45,654)	11,229	0	0	205	(315)
Commissioning	4,769	8,648	4,451	0	0	(318)	(172)
Head of Adults	109,160	123,670	108,616	(2,633)	3,101	(76)	(1,863)
Public Health	1,261	(6,189)	1,287	(26)	0	0	0
Total	**126,214**	**80,475**	**125,583**	**(2,659)**	**3,101**	**(189)**	**(2,350)**

15 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. central admin recharges and capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£559,000 under budget on employees due to effective management of vacancies. £33,000 over budget in respect of supplies and services and premises. £833,000 net under budget on direct care related activity.	(1,359)
Safeguarding Adults and Practice Development	£89,000 under budget on employees due to effective management of vacancies. £26,000 net over recovery of income.	(115)
Ops Manager OP/PDSI Services	£360,000 under budget on employees due to effective management of vacancies. £327,000 under budget linked to transport and supplies and services. £2.488 million net over budget on direct care-related activity partly due to a part year 10% increase in the domiciliary fee rate.	1,801
Ops Manager Provider Services	£208,000 net under budget on employees due to effective management of staff vacancies. £21,000 net under budget in respect of transport, supplies and services, and premises. £173,000 over recovery of income.	(402)
Operational Support	£30,000 under budget on employees due to effective management of vacancies. £24,000 over budget on supplies and services. £5,000 under achievement of income.	(1)
		(76)
Central/Other		
Central/ Other	£295,000 under budget mainly in respect of uncommitted budgets to support future operational activity. £500,000 over budget in respect of increased bad debt provision.	205
		205
Commissioning		
Commissioning	£150,000 under budget on employees due to effective management of staff vacancies. £168,000 under budget in respect of effective contract management.	(318)
		(318)

Service Area	Description	Cash limit Variance £000
Public Health		
General Prevention Activities	Under budget against flu vaccination budget (-£20,000).	(20)
Healthy Communities Strategy and Assurance	Under budget on employees due to vacant Mental Health at work practitioner post (-£24,000). Net contract saving; Wellbeing for Life, Data Collection Service NHS Midland and Newcastle Council Netter Health at Work (-£5,000).	(29)
Living and Ageing Well	Fresh and Balance contract CDDFT over budget (+£26,000), historic inflationary Agenda for Change (+£11,000). Smoke free manager post corrected income from Regional LA7 (-£53,000). Over budget on Nicotine Replacement Therapy (+£30,000) Uncommitted base budgets relating to the Drug & Alcohol Recovery Service Ridgemount House, tenancy ended Mar 21. Temple Cross W-RAD (-£103,000). Dilapidation costs at Ridgemount House (+£4,000). Saddler House electricity costs (+£14,000). Thames House historic rates charges (+£12,000). East Durham additional capital cost (+£25,000). Whinney Hill additional cleaning costs (+£2,000). Health Checks estimate under budget (-£151,000), FP10 Prescription costs estimate under budget (-£20,000), Supervised Consumption estimate under budget (-£39,000), Additional income from Northern cancer Alliance (-£65,000).	(307)
Public Health Grant and Reserves	Amount to balance the cash limit variance (+£570,000) made up principally of savings from vacant posts and contracts in each service area as described.	570
Public Health Team	Under budget on staffing – vacant posts within the Public Health Team and staff travel and supplies and services.	(238)
Starting Well and Social Determinants	Former Enuresis Contract saving (-£40,000), Young Parent Pathway (-£20,000), less Holiday Activity with Food February contribution (+£30,000), Durham University evaluation project contract (+£9,000), Inflationary Pressure invoice Integrated Sexual Health Contract (+£45,000)	24
		-
AHS Total		**(189)**

16 The service grouping is on track to maintain spending within its cash limit. The forecast outturn position incorporates the MTFP savings built into the 2021/22 budgets, which for AHS in total amounted to £0.974 million.

17 The council continues to face significant additional costs in relation to the Covid-19 outbreak and significant loss of income. All additional costs and loss of income, net of Covid-19 related underspending, are being treated corporately and therefore excluded from the cash limit.

18 The major area of additional cost in respect of AHS is £2.659 million for the additional financial support paid to providers. This support includes a temporary 2% uplift in specified fees to 30 September 2021, and targeted

support given to residential care homes where occupancy levels dropped significantly (in excess of 10%).

19 The major areas of forecast Covid-19 related savings in respect of AHS are as follows (£3.101 million):

(a) £0.634 million in respect of short-term spot hire of vehicles and car allowances etc;

(b) A CDCCG contribution towards additional COVID-related arrangements is £2.467 million.

20 The cash limit reserve for Adult and Health Services is forecast to be £6.145 million after incorporating the 2021/22 forecast and transfers to other earmarked reserves.

Capital Programme

21 The AHS capital programme comprises two schemes, the Public Health drug and alcohol recovery services premises upgrade and the upgrade of Hawthorn House respite centre in Provider Services.

22 Reports are taken to MOWG during the year where revisions to the AHS capital programme are required. The capital budget currently totals £0.377 million.

23 Summary financial performance to 31 December 2021 is shown below.

AHS	Actual Expenditure 31/12/2021 £000	Current 2021-22 Budget £000	(Under) / Over Spending £000
Provider Services – Hawthorn House	273	336	(63)
Public Health – Drug and Alcohol Premises Upgrade	47	41	6
	320	**377**	**(57)**

24 Officers continue to carefully monitor capital expenditure on a monthly basis. There has been £0.320 million of 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.

Background Papers

25 Cabinet Report 16 March 2022 Forecast Revenue and Capital Outturn 2021/22 – Period 31 December 2021.

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

Appendix 1: Implications

Legal Implications

The consideration of regular budgetary control reports is a key component of the Council's Corporate and Financial Governance arrangements. This report shows the forecast spend against budgets agreed by the Council in February 2021 in relation to the 2021/22 financial year.

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital outturn position alongside details of balance sheet items such as earmarked reserves held by the service grouping to support its priorities.

Consultation

Not applicable.

Equality and Diversity / Public Sector Equality Duty

Not applicable.

Human Rights

Not applicable.

Crime and Disorder

Not applicable.

Staffing

Not applicable.

Accommodation

Not applicable.

Risk

The consideration of regular budgetary control reports is a key component of the Councils Corporate and Financial Governance arrangements.

Procurement

The outcome of procurement activity is factored into the financial projections included in the report.