Health and Wellbeing Board

Date	**Friday 21 June 2013**
Time	**9.00 am**
Venue	**Committee Room 1B, 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. Appointment of Chairman

2. Appointment of Vice-Chairman

3. Apologies for Absence

4. Substitute Members

5. Code of Conduct - Presentation by Governance Solicitor, Durham County Council

6. Declarations of Interest

7. Joint Health & Wellbeing Strategy Delivery Plan - Report of Head of Planning and Service Strategy, Children and Adults Services, Durham County Council (Pages 1 - 34)

8. Disabled Children's Charter for Health and Wellbeing Boards - Report of Head of Planning and Service Strategy, Adult and Children's Services, Durham County Council (Pages 35 - 74)

9. Durham Dales, Easington and Sedgefield Clinical Commissioning Group Local Priorities 2013/14 - Report of Chief Clinical Officer, DDES CCG (Pages 75 - 82)

10. Integration Pioneer Project - Joint Report of Corporate Director, Children & Adults Services, Durham County Council and Chief Operating Officer, North Durham CCG (Pages 83 - 86)

11. Policy Update - Report of Strategic Manager - Policy, Planning and Partnerships, Children and Adults Services, Durham County Council (Pages 87 - 98)

12. Review of Sustainable Community Strategy - Report of Head of Partnerships and Community Engagement, Durham County Council (Pages 99 - 102)

13. Alcohol Harm Reduction Strategy 2012-15 - Report of Consultant in Public Health, Children and Adults Services, Durham County Council (Pages 103 - 112)

14. Securing Quality in Health Services - Report of Project Director, Securing Quality in Health Services, Darlington CCG (Pages 113 - 120)

15. Monitoring Provider Quality in the NHS - Joint Report of Director of Clinical Quality and Primary Care Development, DDES CCG, Director of Quality and Safety, North Durham CCG and Medical Director, NHS England, Darlington and Tees Area Team (Pages 121 - 132)

16. Providing Safe and High Quality Care leading up to the Opening of a New Hospital - Joint Report of Chief Clinical Officer, DDES CCG and Chief Executive, North Tees and Hartlepool NHS Foundation Trust (Pages 133 - 152)

17. Update on Winterbourne Review Concordat Implementation - Report of Strategic Commissioning Manager, Children and Adults Services, Durham County Council (Pages 153 - 160)

18. Review of NHS Community Services - Joint Report Chief Finance and Operating Officer, DDES CCG and Chief Operating Officer, North Durham CCG (Pages 161 - 164)

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

20. Any resolution relating to the exclusion of the public during the discussion of items containing exempt information

21. Minutes of the Shadow Health and Wellbeing Board held on 6 March 2013 (Pages 165 - 172)

22. Pharmacy Relocation Application - Report of Director of Public Health, Children and Adults Services, Durham County Council (Pages 173 - 190)

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

Colette Longbottom
Head of Legal and Democratic Services

County Hall
Durham
13 June 2013

To: **The Members of the Health and Wellbeing Board**

: **Durham County Council**
Councillors L Hovvels, O Johnson and M Nicholls

R Shimmin	**Corporate Director of Children and Adult Services, Durham County Council**
A Lynch	**Director of Public Health, Durham County Council**
N Bailey	**North Durham CCG**
Dr K Bidwell	**North Durham CCG**
Dr S Findlay	**DDES CCG**
Dr D Roy	**DDES CCG**
J Bedlington	**Local Healthwatch**
S Jacques	**County Durham and Darlington NHS Foundation Trust**
A Foster	**North Tees and Hartlepool NHS Foundation Trust**
M Barkley	**Tees. Esk and Wear Valley NHS Foundation Trust**
C Harries	**City Hospitals Sunderland NHS Foundation Trust**

Contact: Ian Croft **Tel: 03000 269702**

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Health and Wellbeing Board

21st June 2013

Joint Health and Wellbeing Strategy Delivery Plan 2013/17

Report of Peter Appleton - Head of Planning & Service Strategy, Children and Adults Services, Durham County Council

Purpose of Report

1. The purpose of this report is to request the Health and Wellbeing Board agree the Joint Health and Wellbeing Strategy (JHWS) delivery plan 2013-2017 which is attached at Appendix 1.

Background

2. At the meeting on 8th November 2012, the Shadow Health and Wellbeing Board agreed the JHWS. Subsequently the JHWS has been approved at Cabinet, Clinical Commissioning Group (CCG) Boards and the County Durham Partnership.

3. The JHWS will influence a number of plans and Strategies, including the Council Plan, Sustainable Community Strategy, the Children, Young People and Families Plan and CCG Clear and Credible Plans.

4. The JHWS delivery plan will ensure that the JHWS is implemented and performance managed to ensure that the Health and Wellbeing Board is transparent in showing the progress that has been made in the JHWS and what is still left to do.

5. Following agreement at the Shadow Health and Wellbeing Board in January 2013, further discussion has taken place between local authority and CCG colleagues to reflect wider work programmes that are taking place within the NHS landscape.

6. Consequently, the Care Closer to Home Group and the Clinical Programme Board community services and intermediate care sub group will merge to become the Community Services and Care Closer to Home Group. The change in governance arrangements has been circulated to key stakeholders.

Development of the JHWS delivery plan

7. Work has taken place to align the JHWS delivery plan to relevant partnership strategic plans to ensure a coherent forward plan of action.

8. Further refinement has taken place to ensure that the JHWS delivery plan reflects the Clinical Commissioning Group's three local priorities. A separate report is presented at this meeting in relation to this issue.

9. The Health and Wellbeing Board governance arrangements have been utilised where appropriate in terms of lead responsibility for specific areas of work within the JHWS delivery plan to ensure accountability to the Health and Wellbeing Board. Other delivery

actions have lead officers who will carry out the specific areas of work, for example, Public Health consultants.

10. This work has also taken into account changes following the new NHS configurations from April 2013, in relation to who will be responsible for delivering actions.

11. Worksheets have been developed and will be provided for each identified delivery group/lead officer to take forward the actions in the JHWS delivery plan.

Performance Monitoring

12. The Joint Health and Wellbeing Strategy will be performance managed in order to provide an update on indicators, targets and direction of travel in relation to the delivery plan.

Recommendations

13. The Health and Wellbeing Board are requested to agree:
    - the JHWS delivery plan which is attached at Appendix 1
    - note that a performance report will be presented to the Health and Wellbeing Board in November 2013.

Contacts: Andrea Petty, Strategic Manager – Policy, Planning & Partnerships Tel: 03000 267312

Appendix 1: Implications

Finance - The demographic profile of the County in terms of both an ageing and projected increase in population will present future budget pressures to the County Council and NHS partners for the commissioning of health and social care services.

Staffing - No direct implications.

Risk - No direct implications.

Equality and Diversity / Public Sector Equality Duty – An Equality Impact Assessment has been completed for the Joint Health and Wellbeing Strategy (JHWS) and is available on Durham County Council's website.

Accommodation - No direct implications.

Crime and Disorder – No direct implications

Human Rights - No direct implications.

Consultation - Engagement events on the draft strategic objectives and actions in the Joint Health and Wellbeing Strategy took place in June/July 2012. Wider consultation was carried out on the full draft Strategy from 6th September – 19th October 2012.

Procurement - The Health and Social Care Act 2012 outlines that commissioners should take regard of the JSNA and JHWS when exercising their functions in relation to the commissioning of health and social care services.

Disability Issues – Issues in relation to disability have been considered throughout the development of the JHWS.

Legal Implications - The Health and Social Care Act 2012 places clear duties on local authorities and Clinical Commissioning Groups (CCGs) to prepare a JHWS. The local authority must publish the JHWS. The Health and Wellbeing Board lead the development of the JHWS.

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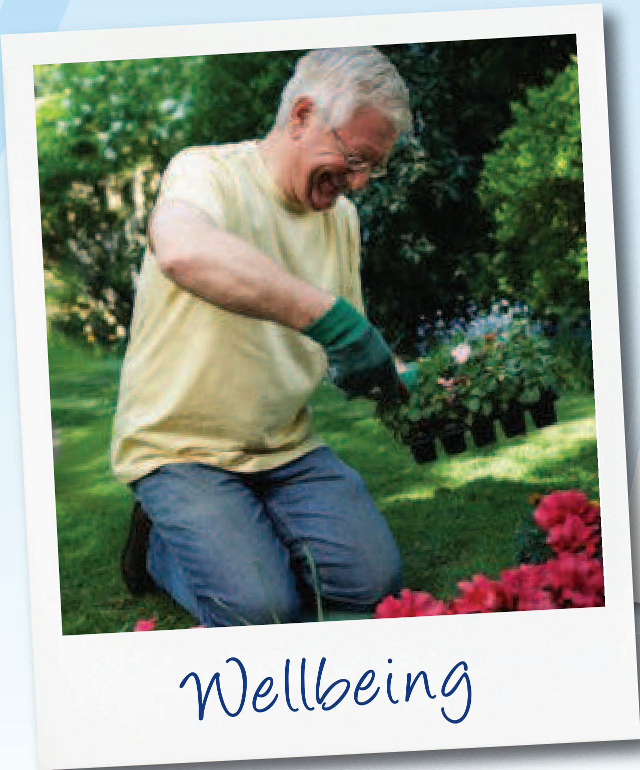
Support

Independence



Wellbeing

Health

County Durham Joint Health and Wellbeing Strategy 2013-2017

Delivery Plan

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

JOINT HEALTH & WELLBEING STRATEGY – DELIVERY PLAN 2013/2017

STRATEGIC OBJECTIVE 1: CHILDREN AND YOUNG PEOPLE MAKE HEALTHY CHOICES AND HAVE THE BEST START IN LIFE

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Improve support to women to start and continue to breastfeed their babies	**Public Health Portfolio Lead - Children and Young People**			Council Plan
• Undertake a social marketing campaign to support a change in breastfeeding attitudes and to promote the benefits of breastfeeding		April 2013	March 2014	
• Develop peer support programmes to provide information and listening support to women on low incomes in antenatal and postnatal periods to increase initiation and duration rates		April 2013	June 2014	
• Continue to commission the UNICEF Baby Friendly Scheme		May 2013	March 2015	
Improve support to families with children who are obese or overweight	**Public Health Portfolio Lead – Children and Young People**			Council Plan
• Develop a Healthy Weight Strategy that focuses on evidence based interventions around: ○ Parenting ○ Eating and feeding behaviour ○ Nutrition ○ Play and healthy activity, and ○ Enhance practitioners skills		April 2013	March 2014	
• Implement a Healthy Weight Strategy Delivery Plan		March 2014	December 2014	
Implement a single pathway for early intervention by midwives and health visitors in line with the Healthy Child Programme				
• Ensure a shared agreement with the NHS England Area Team is put in place for the health of 0-5 year olds in County Durham	**Public Health Portfolio Lead – Children and Young People**	April 2013	March 2014	Public Health core work
• Implement the Healthy Child Programme for 5-19 year olds		April 2013	March 2015	Public Health core work
• Ensure a mental health clinician is available to work with midwives in antenatal clinics for pregnant women who either have a mental illness or are at risk of developing a mental illness after giving birth	**Tees, Esk & Wear Valley (TEWV) Trust - Director of Operations for Durham and Darlington**	April 2013	April 2014	TEWV Locality Business Plan for County Durham and Darlington
• Implement the Poorly Child Pathway	**Clinical Commissioning Groups (CCGs)**	April 2013	March 2015	CCG Clear and Credible Plans
• Implement a Children's Respiratory Service pilot scheme to include offering an annual review to children under 8 with asthma and providing an Asthma Management Plan.	**Durham Dales Easington Sedgefield Clinical Commissioning Group (CCG)**	April 2013	March 2014	DDES CCG Clear and Credible Plan

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Continue to improve the emotional wellbeing of children and young people and provide effective, high quality mental health services to those who need it	**Clinical Commissioning Groups (CCGs)**			CCG Clear and Credible Plans
• Continue the development of emotional wellbeing provision with secondary schools (Year 10 – age 14/15)		April 2013	March 2014	
• Decommission children's Occupational Therapy and Speech and Language Therapy services and re-commission for 2014/15 following reviews		April 2013	March 2014	
• Increase targeted Child and Adolescent Mental Health (CAMHs) service provision for North Durham		April 2013	March 2014	
• Further develop and rollout Autistic Spectrum Disorder pathway and post diagnosis		April 2013	March 2014	
• Decommission and re-commission redesigned children's community nursing service		April 2013	March 2014	
Develop and provide a range of interventions to reduce the availability and access of age restricted products (e.g. tobacco and alcohol) to children and young people				
• Ensure intelligence and data is shared to enable an integrated model for a programme of enforcement	**Tobacco Control Alliance for County Durham**	April 2013	March 2014	Tobacco Control Alliance Plan
• Provide awareness courses for retailers		April 2013	March 2014	
• Undertake an intelligence-led approach to tackling cheap and illicit tobacco and alcohol		April 2013	March 2014	
• Work in partnership with Durham Constabulary to reduce proxy sales (alcohol)	**Alcohol Harm Reduction Group**	April 2013	March 2014	Alcohol Harm Reduction Strategy
Support children and young people to take part in positive activities which are appropriate for their age and reduce negative and sexual health risk taking behaviours e.g. smoking, drinking alcohol, teenage conceptions				
• Implement a programme of work in schools to tackle perceptions of risk taking behaviour e.g. smoking, alcohol use, sexual health	**Alcohol Harm Reduction Coordinator**	April 2013	August 2014	Children, Young People and Families Plan
• Implement the Risk and Resilience Strategy to enable children and young people to cope better with difficult situations and make healthier choices	**Locum Public Health Consultant**	April 2013	March 2017	Children, Young People and Families Plan
Improve the oral health of children living in County Durham	**Locum Public Health Consultant in partnership with Public Health England**	April 2013	March 2015	N/A
• To provide to primary school children the early uptake of dental services				

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Implement the 'baby clear' initiative (first phase of a North East project that aims to increase the uptake of stop smoking services for pregnant women) to reduce the number of women who continue to smoke during pregnancy	**Tobacco Control Alliance for County Durham in collaboration with CCGs**			
• Implement training to midwives/specialist stop smoking advisors to develop a new referral pathway		April 2013	March 2014	Tobacco Control Alliance Plan
• Support pregnant women to stop smoking by offering interventions in hospitals		April 2013	March 2014	CCG Clear and Credible Plans
Develop a process to implement and measure exposure of children to second hand smoke in line with the Smoke Free Families initiative	**Tobacco Control Alliance for County Durham in collaboration with CCGs**			
• Establish a baseline for County Durham of how many children are exposed to second hand smoke in the home and in the car		April 2013	March 2014	Tobacco Control Alliance Plan
• Public health through their smoking cessation and smoke free family initiatives to work with CCGs to reduce the number of children developing lower respiratory tract conditions		April 2013	March 2014	CCG Clear and Credible Plans

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Tracker	Breastfeeding initiation				
Tracker	**Prevalence of breastfeeding at 6-8 weeks from birth.**				
Tracker	**Percentage of children in reception with height and weight recorded who have excess weight**				
Tracker	**Percentage of children in year 6 with height and weight recorded who have excess weight.**				
Tracker	Children and young people's participation in out of school sport (year 6 and year 9).				
Tracker	Percentage of children and young people who report that they are happy (year 6 and year 9).				
Tracker	Percentage of children and young people who report that they feel lonely (year 6 and year 9).				
Target	Number of new referrals to Child and Adolescent Mental Health Services (CAMHS).	10% increase from previous year	10% increase from previous year	10% increase from previous year	10% increase from previous year
Tracker	Percentage of children and young people who report that they drink alcohol (year 9).				
Tracker	Percentage of children and young people who report that they take drugs (year 9)				
Target	Number of young people in Tier 3 treatment for drugs and alcohol with 4Real.	295			

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Tracker	Alcohol specific hospital admissions for under 18's.				
Target	Percentage of exits from young person's treatment that are planned discharges.	79%			
Tracker	**Under 16 conception rate**				
Tracker	**Under 18 conception rate**				
Target	Percentage of mothers smoking at time of delivery	20.6%			
Tracker	Infant mortality rate, per 1,000 live births and still births				
Tracker	Stillbirth and neonatal mortality rate per 1,000 live births and stillbirths.				
Tracker	Emotional and behavioural health of Looked After Children				
Tracker	Emergency admissions for children with lower respiratory tract infection (Directly age and sex standardised rate of children under 19 (0-18 years) admitted to hospital with lower respiratory tract infections as an emergency admission during the respective financial year)				

STRATEGIC OBJECTIVE 2: REDUCE HEALTH INEQUALITIES AND EARLY DEATHS

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Develop joint action plans with partners that will reduce the number of people who have cancer, heart disease and strokes through the implementation of systematic approaches to primary and secondary prevention				
• Use CCG health profiles to inform future commissioning • Review joint action plans based on CCG health profiles	**Public Health Consultant responsible for Cancer and CVD**	April 2013 November 2013	November 2013 March 2014	Council Plan
• Implementation of the Experience Led Commissioning Stroke Prevention and management strategy and action plan	**Durham Dales Easington Sedgefield Clinical Commissioning Group (CCG)**	April 2013	March 2014	DDES CCG Clear and Credible Plan
• Further develop the heart failure service in community/primary care, including a review of pulmonary rehab	**North Durham Clinical Commissioning Group (CCG)**	April 2013	March 2015	ND CCG Clear and Credible Plan
• Commission pathway improvements to the community stroke service	**North Durham & Durham Dales Easington Sedgefield Clinical Commissioning Group (CCG)**	April 2013	March 2015	ND CCG Clear and Credible Plan
Work with Clinical Commissioning Groups to ensure universal access to the Health Check Programme in County Durham • Increase uptake of Health Checks from community providers by: ○ Developing the capacity of existing Check4Life providers through an enhanced service level agreement ○ Commissioning new Check4Life providers including more community pharmacies and voluntary sector organisations ○ Conducting a social marketing campaign promoting heart health	**CCG's in collaboration with Public Health Consultant responsible for CVD**	April 2013	March 2014	Public Health Core Offer to CCGs/ Council Plan/CCG Clear and Credible Plans

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Raise the profile of cancer awareness and earlier diagnosis and encourage the uptake of cancer screening programmes from communities where take up is low	**Public Health Consultant responsible for Cancer**			
• Review implementation of National Cancer Strategy locally for County Durham		April 2013	March 2014	Council Plan
• Targeted work on earlier diagnosis of cancer to improve patient outcomes		April 2013	March 2014	CCG Clear and Credible Plans
• Implement cancer awareness measurement tool as a measure of cancer awareness		January 2014	March 2014	Council Plan
Use all available tools to identify areas and groups at risk of poor health outcomes and intervene appropriately to reduce the widening gaps in life expectancy	**Public Health Epidemiologist in collaboration with Clinical Commissioning Groups (CCGs)**			Public Health Core Offer to CCGs
• Develop a programme of health equity audits		April 2013	March 2014	
• Undertake a Cardiovascular Disease (CVD) health equity audit		April 2013	March 2014	
Work with the community and voluntary sector to offer interventions to people who do not engage well with mainstream health services	**Health Improvement Partnership**			Health Improvement Plan
• Use results from Health Equity Audits and associated Public Health Intelligence to target Health Trainer Services		April 2013	January 2014	
• Apply an asset based approach which involves communities in relation to the commissioning of the Health Trainer Programme including Health Trainer Champion provision		February 2014	March 2014	
Work together to reduce the number of people who misuse drugs and alcohol	**Public Health Consultant responsible for Alcohol and Drugs**			
• Develop a Drugs Strategy for County Durham		April 2013	March 2014	N/A
• Undertake further work to understand alcohol misuse in particular groups such as older people, pregnant women, those with dual diagnosis and veterans		April 2013	March 2014	
• Support Health Networks and the Voluntary and Community Sector to implement local alcohol related activities		April 2013	March 2014	Alcohol Harm Reduction Strategy
• Commission alcohol liaison nurses in Emergency Departments	**Alcohol Commissioning Manager**	April 2013	March 2014	CCG Clear and Credible Plans
Develop a comprehensive partnership approach to wider tobacco control actions to reduce exposure to second hand smoke, helping people to stop smoking, reduce availability (including illicit trade), reduce promotion of tobacco, engage in media and education and support tighter regulation on tobacco	**Tobacco Control Alliance for County Durham**			Tobacco Control Alliance Plan
• Undertake a tobacco control alliance plan self-assessment exercise		April 2013	July 2013	

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles	**Public Health Portfolio Lead - Physical Activity/ Obesity in partnership with DCC Culture and Sport**			Sport and Leisure Service Strategy 2011-14
• Review the Physical Activity Delivery Plan delivering a greater range of opportunities to increase participation and activity levels in County Durham		April 2013	March 2014	
• Develop and provide a community core offer for physical activity across the County with additional targeted opportunities based on geography/health need		April 2013	March 2014	
• Develop high quality, accessible and affordable facilities to encourage participation in physical activity e.g. cycle and walk routes/legacy gyms		April 2013	March 2014	
Develop a Healthy Weight Alliance for County Durham; bring all key elements of an obesity strategy together and strengthen work programmes	**Public Health Portfolio Lead – Childhood Obesity/ Adult Obesity**			Council Plan
• Develop a Healthy Weight Strategy and Delivery Plan		April 2013	March 2014	
• Implement a Healthy Weight Strategy Delivery Plan		March 2014	December 2014	
Produce a Food and Nutrition Plan for County Durham to include work around policy, food provision and access	**Public Health Portfolio Lead – Physical Activity/ Obesity & Food and Health**			
• Develop a food and health needs assessment to inform future procurement and commissioning of services		April 2013	June 2014	Public Health Delivery Plan
• Ensure national food and health campaigns are a visible part of health promotion strategies		April 2013	March 2014	Public Health Delivery Plan
• Develop food and nutrition plan		April 2014	October 2014	Council Plan
Develop and implement primary prevention programmes to improve health outcomes in general practice and save costs around quitting smoking, reducing problem drinking and improving exercise take up				
• Review Exercise Referral Pathway and implement recommendations	**Public Health Portfolio Lead – Physical Activity/ Obesity /Tobacco Control**	April 2013	March 2014	Council Plan
• Review the alcohol Local Enhanced Service (LES) in consultation with GP's, which will offer GP's the opportunity to screen and deliver alcohol brief interventions	**Clinical Commissioning Groups (CCGs)**	April 2013	August 2013	CCG Clear and Credible Plans
• Continue to develop weight management and stop smoking services	**Public Health Consultant responsible for Alcohol and Drugs**	April 2013	March 2015	Council Plan

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
To integrate and roll out interventions to address the impact of fuel poverty on excess mortality and morbidity • Identify strategic leadership and pool resources to 'streamline' services • Collect a baseline of current activity within County Durham	**Partnership Board for Older Adults in partnership with Public Health Consultant responsible for Winter Deaths**	 April 2013 April 2013	 March 2014 March 2014	Council Plan

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	**2014/15**	**2015/16**	**2016/17**
Target	**Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population**	**62.9 (2012)**	**58.8 (2013)**	**54.9 (2014)**	**51.3 (2015)**
Target	**Mortality from cancer for persons aged under 75 years per 100,000 population**	**116.1 (2012)**	**113.9 (2013)**	**111.8 (2014)**	**109.7 (2015)**
Tracker	Slope Index of Inequality.				
Target	**Take up of the NHS Health Check programme – by those eligible (percentage of eligible people who receive a NHS Health Check)**	**(20% of eligible population)**	**(20% of eligible population)**	**(20% of eligible population)**	**(20% of eligible population)**
Target	**Mortality from liver disease for persons aged under 75 years per 100,000 population**	**18.5 (2010-12)**	**18.8 (2011-13)**	**19.1 (2012-14)**	**19.4 (2013-15)**
Target	**Mortality from respiratory diseases for persons aged under 75 years per 100,000 population**	**28.5 (2010-12)**	**27.8 (2011-13)**	**27.1 (2012-14)**	**26.4 (2013-15)**
Target	**Mortality for persons aged under 75 years per 100,000 population**	**296.8 (2011)**	**288 (2012)**	**279.5 (2013)**	**271.2 (2014)**
Target	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date).	96%			
Target	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.	85%			
Tracker	**Male life expectancy at birth (years)**				

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Tracker	**Female life expectancy at birth (years).**				
Target	**Successful completions as a percentage of total number in drug treatment - Opiates**	**11%**			
Target	**Successful completions as a percentage of total number in drug treatment - Non Opiates**	**48%**			
Tracker	National alcohol-related admissions to hospital indicator (exact definition to be agreed by the Department of Health).				
Target	**Percentage of all exits from alcohol treatment that are planned discharges.**	**2 %points above England average**			
Target	**Four week smoking quitters per 100,000 population.**	**1193 per 100,000 (5,066)**			
Tracker	Estimated smoking prevalence of persons aged 18 and over				
Tracker	Proportion of physically active and inactive adults.				
Tracker	Excess weight in adults. (Proportion of adults classified as overweight or obese)				
Target	**The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period.**	**70%**			

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Target	The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period.	80%			
Target	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period.	60%			
Tracker	Reduce excess winter deaths.				

STRATEGIC OBJECTIVE 3: IMPROVE THE QUALITY OF LIFE, INDEPENDENCE AND CARE AND SUPPORT FOR PEOPLE WITH LONG TERM CONDITIONS

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Ensure the needs of carers are considered and increase the number of carers assessments offered	**Strategic Commissioning Manager OP/PDSI**	April 2014	March 2015	CAS Service Plan
Work together to support people who have dementia to live in their own home for as long as possible • Implement the National Dementia Strategy and other national, regional and local dementia initiatives giving particular attention to: ○ Increasing early diagnosis ○ Implement Year 2 of the care home liaison service model ○ Implement Year 2 of the acute care liaison model ○ End of life care ○ Support to remain independent	**Community Services and Care Closer to Home Group**	April 2013 April 2013 April 2013 April 2013 April 2013	March 2014 March 2014 March 2014 March 2015 March 2015	CCG Clear and Credible Plans
Work together to give people greater choice and control over the services they purchase and the care that they receive • Maintain numbers of people on direct payments for social care • Use marketing campaigns to extend the number of people on the Durham Information Guide (DIG) website	**Personalisation and Change Manager**	April 2013 April 2013	March 2014 March 2014	Council Plan
Extend Direct Payments for health services for people with long term conditions • Raise awareness of direct payments with CCGs • Increase numbers of people using personal health budgets	**Personalisation and Change Manager**	April 2013 April 2013	March 2014 March 2014	CAS Service Plan
Provide care as close to home as possible • Reform the urgent care system and improve joint working with social care to contribute to savings and cost avoidance of non-elective and unplanned care • Having regard to evaluation of the various locality schemes and national good practice to develop improved clinical and pharmacy support to vulnerable older people living in care/nursing homes • Subject to a positive evaluation to commission the care home mental health liaison service • In response to the Winterbourne Review Inquiry, Health and Care commissioners will: ○ Work together with service providers, service users and families to review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual, based on their and their families' needs and agreed outcomes; ○ Complete DoH 'Stocktake' to outline local progress against national Winterbourne commitments. ○ Put personal care plans into action so that all individuals receive personalised care and support in appropriate community settings	**Community Services and Care Closer to Home Group** **Local Winterbourne Implementation Group**	April 2013 April 2013 April 2013 April 2013 June 2013 April 2013	March 2014 March 2014 March 2014 June 2013 July 2013 June 2014	CCG Clear and Credible Plans

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Maintain people's independence at home and reduce unplanned admissions by expanding the use of self management programmes and technology	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans
• Evaluate the impact of Telehealth and Telecare pilots and consider mainstreaming if successful		April 2013	March 2014	
Improve the support to people on their return home from hospital, to enable them to recover more quickly, through better co-ordination of care	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans
• Evaluate the effectiveness of Home from Hospital service pilot to inform future commissioning		April 2013	March 2014	
• Roll out improvements to care planning and case management in nursing homes		April 2013	March 2014	
• Improve health related quality of life for people with long term conditions by reducing unplanned hospitalisation for chronic ambulatory sensitive conditions		April 2013	March 2014	
Improve people's ability to reach their best possible level of independence by providing more short term care (reablement/ intermediate care) in different settings	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans
• Increased access to independent and short term care over a 24 hours a day, 7 days a week timeframe		April 2013	January 2014	
• Help people to manage their own long term conditions through self-management		April 2013	March 2014	
• Commission robust community nursing services for better management of patients with long term conditions living in the community		April 2013	March 2014	
• Working jointly with County Durham and Darlington NHS Foundation Trust to progress co-ordinated services across the whole care pathway, including rapid response and the step up and step down model of care for intermediate care beds		April 2013	March 2015	
Provide more co-ordinated hospital discharge planning to avoid people returning back to hospital	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans
• Continue 30 day re-admission pilots, including evaluating their effectiveness		April 2013	March 2014	
• Scope and commission improved discharge planning arrangements		April 2013	March 2014	
• Support people who have frequent A&E attendances		April 2013	March 2014	
• Improve case management of patients with long term conditions		April 2013	March 2015	
Improve the way services work together to support people who have had a fall, and identify those who are at risk of falling	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans/CAS Service Plan
• Extend the falls pathway including improved opportunities for assessment on admission to hospital		April 2013	April 2014	

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Target	Percentage of carers assessments as a proportion of all social care assessments	37%			
Tracker	Carer reported quality of life				
Target	Overall satisfaction of carers with social services	82.6%			
Placeholder	Estimated diagnosis rate for people with dementia				
Target	Social care related quality of life - the percentage of service users reporting that the help and support they receive has made their quality of life better	92%	92%	92%	92%
Target	Proportion of people who use services who have control over their daily life	80.1%			
Target	**Proportion of people using social care who receive self-directed support, and those receiving direct payments**	**55%**	**60%**		
Target	Adults aged 18-64 per 100,000 population admitted on a permanent basis in the year to residential or nursing care	0.14 per 1000			
Target	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	8.5 per 1000			
Target	**Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services**	**85%**	**85%**	**85%**	**85%**

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Target	Percentage of people who have no ongoing care needs following completion of provision of a reablement package	55%			
Tracker	Emergency readmissions within 30 days of discharge from hospital (NB this is broader than long term conditions)				
Tracker	**Delayed transfers of care from hospital per 100,000 population**				
Tracker	**Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population**				
Tracker	Falls and injuries in the over 65s. (Age-sex standardised rate of emergency hospital admissions for falls or falls injuries in persons aged 65 and over)				
Tracker	Hip fractures in over 65s. (Age-sex standardised rate of emergency admissions for fractured neck of femur in persons aged 65 and over per 100,000 population)				

STRATEGIC OBJECTIVE 4: IMPROVE MENTAL HEALTH AND WELLBEING OF THE POPULATION

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles	**Clinical Commissioning Groups (CCGs)**			
• Progress the development of a more intensive integrated primary care mental health service		April 2013	March 2015	CCG Clear and Credible Plans
• Develop an evidence based pilot programme to increase resilience to improve wellbeing	**Health Improvement Partnership**	July 2013	March 2014	Health Improvement Plan
Work together to find ways that will support ex-military personnel who have poor mental or physical health	**CCGs with County Durham Partnership support**			CCG Clear and Credible Plans
• Consider re-commissioning and extending interventions that support ex-military personnel based on evaluation of pilot projects		October 2013	March 2014	
• Ensure that staff are aware of the specific needs of ex-military personnel through training		April 2013	March 2014	
• Actively engage with existing programmes that support ex-military personnel (Veterans Wellbeing Assessment and Liaison Service (VWALS)		April 2013	March 2014	
• Provide a forum where the voice of the service and ex-armed service personnel can be heard and can help influence service development		April 2013	March 2017	
• Enable partners working with service and ex-armed service personnel to come together to influence priorities through the County Durham Partnership		April 2013	March 2017	
Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment	**TEWV NHS Foundation Trust**			TEWV Quality Account
• Implement the recommendations of the review of the Care Programme Approach (CPA) to address employment needs		April 2013	March 2014	
• Embed the recovery approach within secondary mental health services		April 2013	September 2015	
Improve access to psychological therapies	**Clinical Commissioning Groups (CCGs)**	April 2013	March 2014	CCG Clear and Credible Plans

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Develop and implement a multi-agency Public Mental Health Strategy including Suicide Prevention for County Durham • Develop a Public Mental Health Strategy • Implement the Public Mental Health Strategy	**Public Health Portfolio Lead - Mental Health**	April 2013 September 2013	September 2013 March 2017	Council Plan
Develop a more integrated response for people with both mental and physical health problems, in particular supporting people with common mental health problems (such as depression or anxiety) • Review and re-commission out of area Mental Health placements • Subject to a positive evaluation to commission an acute hospital liaison service (Adult Mental Health and Older People Services) • Develop integrated care pathways to address physical and mental health needs where appropriate • Implement joint working arrangements with GPs & TEWV to ensure that primary care and secondary care pathways are inter-linked to address mental health and physical health needs	**TEWV NHS Foundation Trust/CCG's**	April 2013 April 2013 April 2013 April 2013	March 2014 March 2014 December 2015 December 2015	TEWV Trust Business Plan/ CCG Clear and Credible Plans

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Tracker	Self-reported wellbeing				
Tracker	Gap between the employment rate for those with a long term health conditions and the overall employment rate				
Target	Proportion of adults in contact with secondary mental health services in paid employment	9%			
Target	**Patient experience of community mental health services**	**87**			
Tracker	**Number of suicides**				
Tracker	Hospital admissions as a result of self-harm. (Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population)				
Target	**Percentage of adults receiving secondary mental health services known to be in settled accommodation at the time of their most recent assessment, formal review or multi disciplinary care planning meeting**	**85%**	**85%**	**85%**	**85%**
Tracker	Excess under 75 mortality in adults with serious mental illness				

STRATEGIC OBJECTIVE 5: PROTECT VULNERABLE PEOPLE FROM HARM

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Work together to provide support to victims of domestic abuse from partners or members of the family	**Safe Durham Partnership**			Safe Durham Partnership/ Domestic Abuse Strategy/Council Plan
• Commission a countywide specialist domestic abuse Outreach Service		April 2013	July 2013	
• Increase awareness of domestic abuse across services, organisations and the general public, through awareness raising campaigns		April 2013	March 2015	
• Provide training to all relevant staff across all appropriate agencies and organisations in order to recognise and identify signs and indicators of abuse, know how to deal with disclosure and understand what constitutes significant concern		April 2013	March 2015	
• Continue to develop service delivery across agencies in line with lessons learned from Domestic Homicide reviews		April 2013	March 2015	
Work in partnership to support vulnerable adults and children at risk of harm and work to stop abuse taking place • All partner agencies to have a strategic role in relation to safeguarding and promoting the welfare of children and adults within their organisation	**Local Safeguarding Children's Board/ Safeguarding Adults Board**	April 2013	March 2014	Local Safeguarding Children's Board Plan/ Safeguarding Adults Board
Ensure policies and procedures are in place to make it easier for individuals to highlight concerns of abuse, such as more efficient whistle blowing • Ensure all partners are aware of overarching safeguarding procedures by ensuring they are represented on the Safeguarding Adults Board	**Local Safeguarding Children's Board/ Safeguarding Adults Board**	April 2013	March 2014	CAS Service Plan
Work in partnership to identify signs of family vulnerability and to offer support earlier • Implement Think Family Programme to identify vulnerable families and provide intensive support	**Think Family Board**	April 2013	March 2014	Children, Young People and Families Plan

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Target	Repeat incidents of domestic violence	Less than 25%	Less than 25%	Less than 25%	Less than 25%
Target	The proportion of people who use services who say that those services have made them feel safe and secure	75%	75%	75%	75%
Tracker	Percentage of children and young people reporting that they are bullied when they are at school and when not at school (year 6 and year 9)				
Target	**Percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time**	**15%**	**14%**	**13%**	**12%**
Tracker	Number of Initial Child Protection Conferences relating to children becoming the subject of a Child Protection Plan where parental substance misuse/ parental alcohol misuse/ domestic abuse has been identified as a risk factor				
Tracker	Number of children with a Child Protection Plan per 10,000 population				
Tracker	Percentage of adult safeguarding referrals substantiated or partially substantiated				
Tracker	Number of Looked After Children per 10,000 population				
Target	**Percentage of children in need referrals occurring within 12 months of previous referral**	**21%**	**20%**	**18%**	**16%**

STRATEGIC OBJECTIVE 6: SUPPORT PEOPLE TO DIE IN THE PLACE OF THEIR CHOICE WITH THE CARE AND SUPPORT THAT THEY NEED

Strategic Actions/Sub-Actions	Lead	Timescale		Link to Relevant Plan
		Start	End	
Adopt and implement the North East charter relating to a 'good death' which aims to provide a guide to those people who are involved with people who are approaching the end of their life, to ensure the right services are available at the right time for individuals who are dying, their families and carers	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans/ NHS North East 'Good Death'
• Develop primary care mechanisms for identifying end of life patients		April 2013	March 2014	
• Progress advanced/anticipatory care planning for end of life patients		April 2013	March 2014	
• Incorporate requirements for quality monitoring of end of life care in residential and nursing home contracts		April 2013	April 2015	
Reduce the number of emergency admissions to hospital for people who have been identified as approaching their end of life by providing services in the community	**Community Services and Care Closer to Home Group**			CCG Clear and Credible Plans
• Roll out of 'Deciding Right'		April 2013	March 2014	
• Expand the End of life learning development pathway training		April 2013	March 2014	
• Roll out of guide to help GP's maximise the potential of the GP palliative care registers		April 2013	March 2014	

Performance Indicator Table

Indicators in bold are in the partnership basket of indicators

Indicator	Description	Targets			
		2013/14	2014/15	2015/16	2016/17
Tracker	Percentage of all deaths that occur in hospital, own home, hospice, care home.				
Tracker	Percentage of hospital admissions ending in death (terminal admissions) that are emergencies.				

GLOSSARY & ABBREVIATIONS

A&E	Accident and Emergency	**'Deciding Right'**	Deciding right is a north east wide initiative - the first in the UK - to integrate the principles of making advance care decisions for all ages. It brings together advance care planning, the Mental Capacity Act, cardiopulmonary resuscitation decisions and emergency healthcare plans.
Asset based approach	Using the skills and knowledge of individuals within a community, rather than focusing on the problems within a community. This approach aims to empower individuals.	**DDES**	Durham Dales, Easington and Sedgefield
CAMHS	Child and Adolescent Mental Health Services	**DIG**	Durham Information Guide
Carers Assessment	The draft Care Bill gives local authorities responsibility to assess carer's own needs for support, regardless of level of support provided.	**GP**	General Practitioner
CAS	Children and Adults Services	**Healthy Child Programme**	The healthy child programme sets out the good practice framework for prevention and early intervention services for children and young people and recommends how health, education and other partners working across a range of settings can significantly enhance a child's or young person's life chances.
CCG	Clinical Commissioning Groups are clinically-led groups that include all of the GP groups in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients.	**Health Trainer Champion / Service**	Health Trainer Champions work with Health Trainer services. They help Health Trainers engage with individuals and communities. Health Trainer Champions have a good understanding of their communities and help people to appropriately access services (NHS and non NHS).
CPA	A Care Programme Approach is provided to people with severe mental health problems or a range of different needs	**ND**	North Durham
CVD	Cardiovascular Disease	**North East Charter for a Good Death**	North East charter, which will guide health, social care, community, voluntary and other organisations, groups or individuals who plan, develop and provide end of life care or support. It will help to ensure the right services are available at the right time for individuals who are dying, their families and carers.
CYP	Children and Young People	**Poorly Child Pathway**	The Poorly Child Pathway is a plan to ensure that when children require medical intervention they receive it in the right place at the right time.
DCC	Durham County Council	**Telehealth**	Telehealth is the delivery of health-related services and information via telecommunications technologies.

GLOSSARY & ABBREVIATIONS

Telecare	Telecare is the term for offering remote care of elderly and physically less able people, providing the care and reassurance needed to allow them to remain living in their own homes eg fall detectors, smoke detectors, bed occupancy sensor.	**UNICEF Baby Friendly Scheme**	The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to encourage maternity hospitals to implement the 'Ten Steps to Successful Breastfeeding' and to practise in accordance with the 'International Code of Marketing of Breast Milk Substitutes' as well as work to implement the 'Seven Point Plan for Sustaining Breastfeeding in the Community' and ensure quality training and professional standards for midwifery and health visiting staff.
TEWV	Tees, Esk and Wear Valley NHS Foundation Trust	**VWALS**	Veterans Wellbeing Assessment and Liaison Service
UNICEF	United Nation's Children's Fund (formerly United Nation's International Children's Emergency Fund)		

Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

North Durham Clinical Commissioning Group

County Durham
and Darlington
NHS Foundation Trust

Tees, Esk and Wear Valleys
NHS Foundation Trust

North Tees and Hartlepool
NHS Foundation Trust

City Hospitals Sunderland
NHS Foundation Trust

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County Durham Joint Health and Wellbeing Strategy

2013-2017

Delivery Plan

Contact Details

If you have any questions or comments about this document please e-mail: JHWS.Evaluation@durham.gov.uk

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CAS9903 Children and Adults Services, CMI Team 2013

Health and Wellbeing Board

21st June 2013

Disabled Children's Charter for Health and Wellbeing Boards

Report of Peter Appleton, Head of Service - Planning & Service Strategy, Durham County Council

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Purpose of Report

1. The purpose of this report is to provide the Health & Wellbeing Board with details of:
   - The Disabled Children's Charter for Health and Wellbeing Boards (Appendix 2).
   - Evidence of how the County Durham Health and Wellbeing Board meet the needs of disabled children, young people and their families and any areas for further development (Appendix 3).

Background

2. Every Disabled Child Matters (ECDM) is the campaign for rights and justice for disabled children and their families. EDCM is a consortium campaign run by four of the leading organisations working with disabled children and their families: Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium.

3. The Children's Trust, Tadworth is the leading UK charity for children with acquired brain injury, multiple disabilities and complex health needs.

4. The Children's Trust, Tadworth and ECDM have developed a Disabled Children's Charter for Health and Wellbeing Boards and are requesting the County Durham Health and Wellbeing Board to sign up to the Charter. As a previous signatory to the EDCM's Local Authority Disabled Children's Charter the Health and Wellbeing Board are being asked to renew our commitment by signing up to this Charter.

5. The Charter is intended to support Health and Wellbeing Boards to meet their responsibilities towards disabled children, young people and their families, including those with special educational needs and with health conditions. Tadworth's Children's Trust and ECDM state that the benefits of the Health and Wellbeing Board signing the Charter include:
   - Publicly articulating a vision for improving the quality of life and outcomes for disabled children, young people and their families

- Having greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Building on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families

6. There are seven commitments in the charter and evidence as to how the charter commitments are met and areas for further development are detailed in Appendix 3. Under each commitment details are provided as to the expectations of the HWB in relation to those commitments.

7. The County Durham Health and Wellbeing Board already meet many of the commitments in the Charter, however there are some commitments that will need to be further developed/evidenced. These are provided below:

Areas for further development

Commitment 1

8. Work will be carried out as part of the review of the Joint Strategic Needs Assessment (JSNA) process to ensure that further information available in relation to disabled children and young people is considered for inclusion in the JSNA 2013.

9. The Joint Health and Wellbeing Strategy (JHWS) includes a strategic objective: "children and young people make healthy choices and have the best start in life" however further consideration will be given to supplementing information on strategic actions relating specially to disabled children and young people in subsequent reviews of the strategy.

Commitment 2 & 3

10. Further consideration will be given to the specific involvement and engagement of disabled children, young people and their families in relation to the review of the JSNA and JHWS.

Recommendations

11. The Health and Wellbeing Board are recommended to:
    - Note the contents of the Report.
    - Agree to sign up to the Disabled Children's Charter for Health and Wellbeing Boards, noting the further developments highlighted above.

- Note that a response to Tadworth Children's Trust and Every Disabled Child Matters will be agreed with the chair of the Health and Wellbeing Board.

Contacts: **Andrea Petty, Strategic Manager Policy, Planning & Partnerships Telephone No: 03000 267312**

Background papers – Disabled Children's Charter

Appendix 1: Implications

Finance - Not applicable

Staffing – Not applicable

Risk – Not applicable

Equality and Diversity / Public Sector Equality Duty – Under the Equality Act 2010 a person is classified as disabled if they have a physical or mental impairment which has a substantial and long-term effect on their ability to carry out normal day-to-day activities.

Accommodation – Not applicable

Crime and Disorder – Not applicable

Human Rights – Not applicable

Consultation – Consideration will be given to the wider engagement with disabled children, young people and their families as part of the review of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Procurement – Not applicable

Disability Issues – The Health and Wellbeing Board has been requested by Tadworth Children's Trust and Every Disabled Child Matters to sign up to the Disabled Children's Charter.

Legal Implications – Not applicable

Appendix 3: Charter for Disabled Children: County Durham Position

Commitment 1

'We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs'

How the charter commitments are met

The full range of sources of information collected on disabled children, young people and their families which will be used to inform the JSNA process.

1. The following information on disabled children and young people is collected to inform the JSNA process in order to identify need:
   - number of cases the Disability Social Work Team work with.
   - number of cases open to the Disabled Children's Service.
   - Comparison of achievements at Key Stage 2 and Key Stage 4 for pupils with Special Educational Needs (SEN) and all other pupils.
   - Number of SEN statements issued to support children who display behaviours, emotional and social difficulties (BESD).

2. As part of the School Census, information is collected on the numbers of pupils with a Special Educational Needs statement

3. As a Council, there is a statutory requirement to keep a register of information on children and young people with disabilities within County Durham. This is known as the Children's Network. At present there are 1,494 children currently registered with the Network.

4. This information ensures that parents and carers receive relevant details of news, support, as well as giving them the chance to comment on current services available for disabled children. Parents and carers are also encouraged to be involved in the consultations on the development of future services. Information regarding the Children's Network is readily available on the Durham County Council website including how to register with the Children's Network.

The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate

5. The information and data in relation to disabled children, young people and their families is provided from a number of organisations including Durham County Council, North Durham/Durham Dales and Easington

Clinical Commisisoning Groups Tees, Esk and Wear Valley NHS Trust (TEWV). The JSNA informs Joint Commissioning Strategies through the Joint Disability Commissioning process which is aligned to the Children and Families Trust.

The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families

7. County Durham's JSNA is used as an evidence base to provide overall strategic direction in terms of the key trends and issues in relation to the health and wellbeing needs of the community. Commissioners will use this information together with information in Commissioning Plans, survey information and performance information to assess the needs of local disabled children, young people and their families.

The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families

8. County Durham have a well established and robust parent participation forum to assist with identifying any missing hard to reach families.

9. North Durham and DDES CCG have developed Communications and Engagement Strategies that sits alongside their Clear and Credible Plans (CCP). The CCGs have a duty to involve people from diverse communities, for example travellers, disabled people, Black and Minority Ethnic (BME) people, people of different faiths, older and younger people, Lesbian, Gay, Bisexual and Transgender (LGBT) individuals. Hard to reach groups may include homeless people, Gypsies and Travellers, disabled people, people with mental ill health, minority ethnic groups, young people and those who live in relative rural isolation.

10. There is specific legal duty for CCGs to consult with people in the cases of gender and race, however in the area of disability the CCGs should not only consult, but also have a specific legal duty to involve disabled people. The NHS Health and Social Care Act 2012 reinforces these legislative requirements and requires all CCGs to seek outcomes which deliver a positive patient experience.

11. CCGs are committed to giving particular consideration to engaging with locally appropriate 'easy to overlook' groups eg:

    - perceptions, for example disadvantaged young people
    - social expectations, for example children and young people who are often not considered as appropriate to be engaged with and who themselves often do not expect to be taken seriously

12. The CCGS will aim to target these groups directly and to overcome barriers that prevent or discourage participation or involvement, for example by using interpreters, visual aids, adapting facilities for disabled people, providing care for dependents, being flexible over timing, location and transport and trying to use ‘neutral’ or safe buildings within the community. They will ensure they use the right channels and materials to engage with different groups such as public facing versions of documents, information formats such as easy read, other languages, Braille or audio, and face to face contact with groups where preferred. Digital communications will comply with the Equality Act 2010.

The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process

13. In the development of the Children, Young People and Families Plan and the Joint Disability Strategy, disabled children, young people and their families have been involved in the development of strategic actions and outcomes as part of the extensive consultation process with children and young people.

14. In the development of the JHWS the shadow Health and Wellbeing Board held a ‘Big Tent’ consultation and engagement event where a wide range of stakeholders including Children and Young People where involved in the development of strategic objectives and actions.

Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families

15. The JSNA is the evidence base used to inform the JHWS. Both the JSNA and the JHWS are public documents and are available on the Durham County Council website and accessible by the public.

Commitment 2

*‘**We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board’***

How the charter commitments are met

Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the JSNA process and next steps for JSNA engagement

16. The JSNA uses survey information as part of the evidence to identify need, this includes surveys from children and young people.

The JSNA is available on the Durham County Council website to all members of the public and services users including disabled children and young people to give their views.

Further consideration will be given to specifically identifying disabled children, young people and families to be involved in engagement activities relating to the JSNA/JHWS.

Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the JHWS and next steps for JHWS engagement

17. The following information outlines how the HWB directly engages with disabled children, young people and their families:

- In the development of the JHWS a 'big tent' engagement event was held to consult with stakeholders (including children and young people) on the strategic objectives and actions. Another event will be undertaken in October 2013 as part of the review of the JSNA/ JHWS.

- The JHWS has a specific strategic objective for Children and Young People - 'Children and young people make healthy choices and have the best start in life'. This is also identified in the Children, Young People and Families Plan where there has been specific consultation with the Investing in Children's 'eXtreme' reference group, specific to children with a disability and the Children and Families Trust. The HWB is informed by the work of the Children and Families Trust.

- The Joint Disability Commissioning Group work in partnership with disabled children and young people which report to the Children and Families Trust.

- A series of six public engagement events were held in July 2012 to raise awareness of North Durham CCG, to give an insight into what clinical commissioning is and to launch the Clear and Credible Plan to deliver future healthcare. This is being followed up with further engagement events in October where there will be an opportunity to discuss and influence future commissioning intentions. The Clear and Credible Plan and commissioning intentions were considered as part of the development of the JHWS.

- The CCGs also have Patient Reference Groups, working with Practice Managers and their individual practice patient forums. They will act as an advisory body for the locality, champion patient views and provide quality assurance that patient, carer and public concerns and needs are taken into account, so that quality services are provided in an appropriate, safe, effective and timely manner for the population.

- The Patient Reference Group act as a sounding board for engagement plans and ensures documentation used by the CCG is user friendly and is quality assured against agreed standards, offering advice and guidance to the CCG to ensure engagement activity is as inclusive and effective as possible.

Evidence of partnership working with any local groups of disabled children and young people

18. In County Durham, children and young people's views are used effectively and consistently to influence change, shape services, improve practice and service delivery. Children and young people contribute through the Investing in Children (IiC) service to high-profile issues such as obesity, emotional health and sexual health. Through the Development Agency, which was established in 2005 it was recognised that there was much to be gained by working in partnership with colleagues both locally in other parts of the country, facing different dilemmas.

19. As part of the CCGs communication and engagement strategy CCGs will engage and communicate with the wider population including service users, potential service users, relatives, carers, advocates, patient representative groups, health interest groups etc., ensuring they take into consideration the views of people including children and young people with learning disabilities and their families.

20. The Children's Act 1989 requires local authorities to provide a short break service designed to assist individuals who provide care for disabled children. This duty and the Breaks for Carers of Disabled Children Regulations 2011 came into force on the 1st April 2011. The regulations require each local authority to produce a short breaks service statement so that families know what is available and how to access these breaks/activities.

21. Durham County Council in partnership with the Making Changes Together Parents/Carers Group, the eXtreme Group from Investing in Children and key partners including health, have produced a Short Break Statement. The statement details what is available to children and their families.

22. Short break focus groups have commissioned services for children and young people with additional needs and have also overseen a grant programme for equipment. The short break focus group have also worked with the Local Authority to improve the range of activities and breaks that are available and they continue to be crucial to all developmental work.

23. The Learning Difficulties and Disabilities Inclusion Service work in partnership with schools, children and young people, parents and carers

and other professionals and agencies, in order to seek and promote educational inclusion and achievement of children and young people with learning difficulties or disabilities.

The Learning Difficulties and Disabilities Inclusion Service provide:

- Advice, consultancy and training to teachers, support staff and families
- Continuing Professional development training for Schools and Communities of Learning
- Assessment of children and young people's needs and advice relating to:
    - General Learning Difficulties
    - Early Years
    - Speech and Language
    - Specific Learning Difficulties (Dyslexia & DCD)
    - Access Technology
    - Physical Disabilities

24. The sensory support service is based on the Belmont Schools Campus and has a countywide remit to provide support services for Hearing Impaired (HI) and Visually Impaired (VI) children and young people including those with additional and complex needs.

25. Child and Adolescent Mental Health Service (CAMHS) which is a provider of specialist mental health services to children & young people up to 18 years of age and their families in County Durham offers a range of therapeutic services including direct & indirect clinical work, assessment, consultation and training. The direct therapeutic work offered includes family therapy, cognitive behavioural therapy, counselling, psychotherapy, group work, play therapy and parenting skills development. Neuropsychological assessment including assessment of attention difficulties, hyperactivity and complex social interaction and communication difficulties is available. Multi disciplinary teams, including child psychiatrists, psychologists, nurses, social workers, primary mental health workers and administrators work across the six locality teams within County Durham & Darlington.

Commitment 3

*'**We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board'***

How the charter commitments are met

Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement

26. The JSNA uses survey information as part of the evidence to identify need, this includes surveys from children and young people.

As part of the consultation process for the JSNA, the JSNA is available on the Durham County Council website to all members of the public and services users including disabled children and young people to give their views. This process will continue for the JSNA 2013.

Further consideration will be given to specifically identifying disabled children, young people and families to be involved in engagement activities relating to the JSNA/JHWS.

Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS and the next steps for the JHWS engagement

27. The Joint Disability Commissioning Group and the Inter Agency Transition Group (IATG) are responsible for the commissioning of services for disabled children and young people / young adults on behalf of the Joint Commissioning Board who are ultimately responsible to the Children's & Families Trust Executive Board. The JDCG is part of the governance structure for the Children & Families Trust with a working relationship to the Health and Wellbeing Board.

28. The Durham model is at the centre of all developments in County Durham for disabled children & young people. The model is nationally recognised as good practice brings key operational and strategic leads together with parents & young people to make positive changes together. It enables all stakeholders to participate in the development of services for children & young people with complex needs. This model has a number of focus groups that are linked and report to the County Durham Parents Steering Group and the Disability Trust Implementation Group. The process is governed by the Joint Disability Commissioning Group.

29. The Shadow Health and Wellbeing Board held a 'Big Tent' Engagement Event in June 2012 which enabled stakeholders to give their views on the development of the JHWS strategic objectives and actions. The JHWS has a specific strategic objective for Children and Young People - 'Children and young people make healthy choices and have the best start in life'. This is also identified in the Children, Young People and Families Plan where there has been specific consultation with the Investing in Children's 'eXtreme' reference group, specific to children with a disability. Another event will be undertaken in October 2013 as part of the review of the JHWS.

Evidence of partnership working with local parent groups, including the local Parent Carer Forum(s)

30. In addition to information provided above, Independent advocacy is available for disabled children, young people and their families. County Durham offers independent advice and support to parents of children with special educational needs through our Parent Partnership Service.

31. Natural Allies supports children and young people with disabilities, learning difficulties and additional support needs across the county to put across the views and feelings relating to the decisions that are made involving them, their education and their lives.

32. The CCGs have an annual commissioning engagement process which involves patients and the public in developing, considering and making decisions on any commissioning proposals that would have a significant impact on service delivery or the range of health services available:
    - involving patients and carers in redesigning services and/or pathways to deliver improved outcomes and better meet patients' needs
    - promoting the role of patients, carers and the wider community in improving their own health and well-being

33. Each GP practice has developed a patient reference group (PRG) and members from these attend locality-based PRGs to pool the views of local communities, identifying themes and trends.

Commitment 4

'We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account'

How the charter commitments are met

Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework etc

34. Indicators from the NHS Outcomes Framework, the Public Health Outcomes Framework, the Clinical Commissioning Assurance Framework, and the Adult Social Care Outcomes Framework are included in the JSNA and the JHWS. The JSNA, JHWS and Children and Families Plan are available to the public on the Durham County Council website.

Public information on the strategic direction the HWB has set to support key partners to improve outcomes for disabled children and young people. This may

be encompassed by the JHWS, but would need to be sufficiently delineated to demonstrate specific objectives and action for disabled children and young people

35. The JHWS sets out where we would like County Durham to be heading in terms of health and wellbeing. The JHWS includes strategic actions on how we plan to do this and these actions will be monitored ensuring all partnerships are held to account. Actions include:

    - We will continue to improve the emotional wellbeing of children and young people and provide effective, high quality mental services to those who need it.
    - Develop a coherent programme of parenting support, including intensive support where needed, through the One Point Service

36. Each CCG has identified their commissioning intentions for 2013/14 including:

    - Commission a high-quality early supported discharge service for people who have had an acute stroke. This reduces risk of death and disability, and decreases length of hospital stay, particularly in those with mild or moderate disability
    - Improve access to and uptake of general health services for those people with learning disability
    - Further develop and roll out the Autistic Spectrum Disorder (ASD) 14 week pathway currently in pilot in North Durham and commission ASD post diagnosis support
    - Review and re-commission out of area Mental Health placements

37. The Disability Commissioning Strategy/Plan covers the period 2012 - 15 and is supported by the overarching Joint Disability Strategy, the Transition Protocol, the Short Break Strategy and the SEND (Special Educational Needs and Disability) Strategy that are all endorsed by the Disability Joint Commissioning Group (DJCG) and the Joint Commissioning Board (JCB). The purpose of the Disability Commissioning Strategy/Plan is to understand and plan for the current and future needs of disabled children, young people and their Families to help them achieve good outcomes while ensuring Value for Money.

38. The Children, Young People and Families Plan 2012-2016 has the following key actions and indicators in relation to disabled children:
    - Deliver the Joint Disability Strategy
    - Improve education outcomes for children with SEN and other vulnerable groups by delivering high quality services.

39. Durham County Council's Children and Adults Services have identified priorities to:
- Ensure high quality provision is made and educational outcomes are improved for children with special educational needs (SEN) and other vulnerable group by:
    - Auditing and reviewing of the future demands for special educational needs provision.
    - Reviewing and consolidating the range and quality of alternative education provision across the authority, making changes to commissioning arrangements as required.
    - Ensuring the new alternative Key Stage 4 provision Green School is delivered and evaluate its first year of delivery.
    - Enabling parents / carers to have a central role in improving outcomes for their child by:
        - the delivery of 'Confident Schools, Confident Parents' programme across the county;
        - development of parent friendly information material; parent chartermark.
- Piloting the development of an inclusion charter mark for all Durham schools including Academies.
- Implementing the Accessibility Strategy.
- Implementing the changes to identification and assessment of children with special educational need in accordance with government directive.

Commitment 5

'***We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people'***

How the charter commitments are met

The way in which the activities of the HWB help local partners to understand the value of early intervention

40. This process is led through education or for those with the most complex of needs a social worker. To support the development of transition arrangements in County Durham a cross agency database has been developed and capacity building work has been undertaken with providers.

41. The transition protocol provides further information about all transition arrangements for young people with additional needs moving into adult services.

The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people

42. Transition support and arrangements are outlined in the cross agency Transition Protocol. Transition support and procedures cover a wide range of children and young people with additional needs as they move into adulthood.

43. Universal Plus Service (provide some level of additional support to enable children and young people with additional needs to access short breaks and activities).
    - Support and drive the transition protocol into practice
    - Commission a transition data base to further enhance commissioning
    - Develop capacity with local providers
    - Develop a robust work experience programme for disabled children and young people
    - Increase the paid employment opportunities for young people

44. The JSNA identifies the number of young people with a learning disability who made the transition from the children's disability team to the adults integrated learning disability team between 2010/11 to 2011/12.

Commitment 6

'We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners'

How the charter commitments are met

Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system

45. The HWB engages with wider partners through the County Durham Partnership (CDP) framework is made up of the CDP Forum, CDP Board, five thematic partnerships and 14 Area Action Partnerships. The focus of the AAP's is primarily on engagement.

46. The Public Health Team have responsibility for leading on the social determinants of health work programme. They will therefore:
    a. Help make clear the contribution of the SCS in addressing the social determinants of health and addressing health inequalities in County Durham
    b. Provide advice on what may be missing and what may need to be included for future reference
    c. Provide the best available evidence base to the SCS
    d. Develop a higher level project plan
    e. Ensure regular meetings with a representative from the Public Health team and the lead officers representing each of the five thematic partnerships take place to progress work.

Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care

47. The HWB is informed by the work of the Children and Families Trust and related sub-groups through its governance structure.

48. The HWB is informed by those with expertise in education, and children's health and social care. The Educational Psychology Service, in partnership with others, aims to improve the quality of life of children and young people through the promotion of emotional well-being, achievements, progress and inclusion. The Educational Psychology Service is responsible for, and/or contributes to, a number of innovative and proactive projects aimed at raising standards across the county. These include:

    - a range of high quality training for professionals
    - promoting emotional well-being and mental health
    - supporting school improvement through consultation and coaching
    - providing psychological therapies to individuals in schools and other settings

49. In County Durham there are a wide range of services for disabled children, young people, parents and carers from birth into adult services across Health, Social Care & Education.

50. It is acknowledged that the needs of children and young people will be individual to their disability and circumstances and therefore tailored commissioning will take place to ensure delivery of a holistic care package.

51. Access to services is based on a child/young persons assessed need and services can be accessed through either, self referral, medical assessment/diagnosis or an initial assessment.

52. Services will work holistically to enable disabled children & young people to reach their full potential and access wherever possible local provision.

53. The services that are delivered range through the spectrum of need and at any given stage in a Child or Young Persons pathway they may access services from all levels.

Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families

54. The Team for Disabled Children and their Families are to integrate with continuing healthcare assessors to create one specialist team for severely disabled children and young people. This will see an increase in the team's caseload, but will enable effective joint assessment and planning as well as interventions. Families have told us that they want to access one system instead of multiple pathways to services which is currently the case and the integration under a single management system will facilitate this development. This will support holistic assessments, care plans and transition into adult services.

55. Integrated Teams (One Point) have been developed which will enable services to be delivered in localities. The One Point Integrated Teams will provide universal and targeted services for all children and young people in County Durham and will contribute to early identification and intervention. One Point will provide services for the majority of children and young people with additional needs.

Commitment 7

'We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners'

How the charter commitments are met

Information on links to other local integration forums which set strategic direction for disabled children's services eg the local Children's Trust arrangements, the Local Safeguarding Board, the learning disability partnership board, the school forum etc

56. The Disability Joint Commissioning Group (DJCG) and the Inter Agency Transition Group (IATG) are responsible for the commissioning of services for disabled children and young people/young adults on behalf of the DJCG who are ultimately responsible to the Children and Families Trust Executive Board. These multi agency groups work in partnership with NHS County Durham, the Voluntary Sector and Families to deliver change.

57. The DJCG commissions services for disabled children, young people and their families on behalf of the JCB and reports progress on a regular basis for information.

58. Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group (CCG) have developed a Communications and Engagement Strategy. The strategy sets out how the CCGs will communicate, engage and manage relationships with stakeholders including the public, service users, local communities and a range of partners. Also, the commissioning intentions were informed by the JHWS and key issues and developments

identified by the contracts leads within North East Commissioning Support (NECS) including learning disabilities.

Evidence of how the JSNA and JHWS is aligned with other arrangements, such as reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements, child poverty strategies etc

59. Evidence from the JSNA is used to develop the JHWS. Information from the Children, Young People and Families Plan, CCG Commissioning Intentions, local accounts and various plans and strategies have been used in the development of the JHWS strategic objectives and actions.

The Children's Trust Tadworth
For children with multiple disabilities

every disabled child matters

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?

Benefits to Health and Wellbeing Boards of signing the Charter and meeting its commitments:

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Understand the true needs of disabled children, young people and their families in your local area and how to meet them
- Have greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Support a local focus on cost-effective and child-centred interventions to deliver long-term impacts
- Build on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develop a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families
- Demonstrate how your area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes For Children and Young People: Our Pledge' for a key group of children and young people[1]

Who are we talking about?

The Disabled Children's Charter for Health and Wellbeing Boards and this accompanying document have been developed to support Health and Wellbeing Boards (HWBs) meet the needs of all children and young people who have disabilities, special educational needs (SEN), health conditions, and their families. In this document, when we talk about disabled children and young people we are referring to all the children and young people in this group.

1 Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

Commitment 1: We have detailed and accurate information on the disabled children, young people and their families living in our area, and provide public information on how we plan to meet their needs

Statutory drivers

Health and Social Care Act 2012

Duty to prepare assessment of needs (JSNA) in relation to local authority area and have regard to guidance from Secretary of State

Information

The quality of data and information used to underpin the planning, commissioning and delivery of services for children and young people with very complex needs is often poor. The difficulty of developing accurate, robust data in a standard format about disabled children and young people is an enduring issue for local areas and for national agencies. Reliable performance information about the use and value of services is critical to commissioning decisions. The Children and Young People's Health Outcomes Forum identified the lack of accurate data as the single biggest challenge in relation to the development of outcomes for children with long-term health conditions, disabilities and life limiting conditions[2].

In March 2012, the CQC released a report entitled 'Healthcare for disabled children and young people'[3]. This report gave details of primary care trust (PCT) replies to a self assessment questionnaire on services for disabled children.

PCTs demonstrated an extremely worrying lack of awareness of the needs of local disabled children:

- **Five PCTs** claimed that **no disabled children and young people lived in their area**
- **Fifty five** PCTs **did not monitor whether services allocated as a result of Common Assessment Framework were delivered**
- **Sixty three** PCTs **didn't know how many children were referred for manual wheelchairs** and **nine said children were waiting over 51 weeks for wheelchairs**
- **Fifteen** PCTs said they **didn't provide short breaks services**

Due to the lack of reliable data on disabled children and young people, their strategic involvement and that of their parents is essential to gain a good understanding of the profile of this group

2 Children and Young People's Health Outcomes Forum (2012), Report of the long term conditions, disability and palliative care subgroup p.2

3 Care Quality Commission (2012), Healthcare for Disabled Children and Young People

and the particular challenges and experiences they face. Their views remain underrepresented in surveys and public and patient involvement in the health service.

Meeting Needs

One of the primary tools Health and Wellbeing Boards have to drive strategic commissioning in their areas is the Joint Strategic Needs Assessment (JSNA). The JSNA will assess the current and future health and care needs and assets of a local population and will underpin a Joint Health and Wellbeing Strategy (JHWS). It will interpret available data to develop an understanding of the causes of health inequalities and a narrative of the evidence.

The JSNA can only be an effective tool for evidence-based decision making if it is based on accurate and meaningful data. The bodies Health and Wellbeing Boards delegate collecting data to as part of the JSNA process, must focus on improving the quality and scope of information on disabled children and young people which they use, including: available national data sets; local information sources such as data from Common Assessment Frameworks; qualitative information from direct engagement with service users.

The JSNA process must develop an understanding of the local population which is sufficiently differentiated to understand the needs of all groups of children, particularly those who face the greatest inequalities or experience multiple disadvantages.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The full range of sources of information collected on disabled children, young people and their families which will be used to inform the JSNA process
- The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate
- The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families
- The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families
- The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process
- Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families

Key resources for meeting this Charter commitment

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Statutory guidance to support Health and Wellbeing Boards and their partners in understanding the duties and powers in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

NHS Confederation, Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Paper designed to support areas to develop successful Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Child and Maternity Health Observatory: support for commissioners

Help to find the right tools, data and evidence to review, plan and improve services in your local area.

Child and Maternity Health Observatory: tools and data

ChiMat provides easy access to a wealth of data, information and intelligence through a range of online tools designed to support decision-making.

Rightcare (2012), NHS Atlas of Variation in Healthcare for Children and Young Adults

Variations across the breadth of child health services provided by NHS England are presented together to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

LGA (2011), Joint Strategic Needs Assessment: Data Inventory

Offers practical help to councils, clinical commissioning groups and other members of health and wellbeing boards.

Children and Young People's Health Outcomes Forum (2012), Making data and information work for children and young people

Factsheet on making data and information work for children and young people, including resources.

Contact A Family (2012), Health and Wellbeing Boards: making the case to target disabled children services

Briefing for Parent Carer Forums on the reasons why the Health and Wellbeing board in their area should target disabled children in their Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing strategy (JHWS).

Commitment 2: We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC)

- The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

Article 7 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD)

- Children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

Health and Wellbeing Boards should ensure that the voice of disabled children and young people is always heard when decisions are being made that affect them. Health and Wellbeing Board members should use their influence to embed engagement with disabled children and young people throughout the health and care system and in the context of a continuous and current partnership.

The benefits of embedding participation of disabled children and young people are huge: better services will be developed driven by feedback from the people who know and use them; resources are not wasted on services that are not taken up or valued; services will be more child and young person friendly and accessible; disabled children and young people will have insight into the diverse needs and barriers faced by marginalised and vulnerable groups; improved accountability to children and young people as stakeholders; and direct benefits to disabled children and young people themselves such as increased knowledge of services,

confidence, and skills[4].

It should be recognised that many disabled children and young people may face significant barriers to their involvement, particularly in mainstream settings. Recent research from the VIPER project found that young disabled people's participation is still not embedded at a strategic, service level or individual decision-making. It found barriers to participation including a lack of understanding of what participation is and how you make it happen, lack of funding, inclusive practice, resources, time and training, and lack of consistent systems and structures[5].

All disabled children and young people communicate and have a right to have their views heard and this may require targeted approaches and the involvement of Voluntary Sector Organisations (VSOs).

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the Joint Health and Wellbeing Strategy (JHWS), and next steps for JHWS engagement
- Evidence of partnership working with any local groups of disabled children and young people

Key resources for meeting this Charter commitment

The NHS Confederation, Royal College of Paediatrics and Child Health and Office for Public Management (2011), Involving children and young people in health services

This report highlights the key findings and recommendations from an event held in September 2011 to discuss the key priorities for child health.

VIPER (Voice.Inclusion.Participation.Empowerment.Research)

VIPER is a three-year project funded by the Big Lottery Fund, to research young disabled people's participation in decisions about services. It began in Summer 2010.

VIPER (2012), The Viper project: what we found

Findings and key messages arising from the research activities of the VIPER project.

VIPER (2012), The Viper project: what we found from the survey

Summary of the findings and key messages from the research activities. The research summarised in this report was carried out between 2010 and 2012.

4 Participation Works (2008), How to involve children and young people in commissioning, p.6.

5 VIPER (Voice, Inclusion, Participation, Empowerment and Research) (2013), Hear Us Out, p.23.

Participation Works

Enables organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

Participation Works (2008), How to involve children and young people in commissioning

An introduction to commissioning from a variety of perspectives. It describes the different parts of the process and ways to support children and young people to participate in all aspects of commissioning.

Participation Works (2008), How to build a culture of participation

Information and practical ideas about how to embed participation throughout your organisation in a way that brings about change.

Participation Works (2010), Listen and Change - a guide to children and young people's participation rights

Aims to increase understanding of children and young people's participation rights and how they can be realised in local authority and third sector settings.

Making Ourselves Heard (MOH)

MOH is a national project to ensure disabled children's right to be heard becomes a reality.

Council for Disabled Children (2009), Making Ourselves Heard

Based on a series of eight seminars with local authorities this book sets out the current policy context for disabled children and young people's participation, outlines the barriers and challenges to effective participation and highlights what is working well.

Franklin, A. and Sloper, P. (2009) Supporting the participation of disabled children and young people in decision-making

Presents research exploring factors to support good practice in participation and discusses policy and practice implications.

DfEs (2003), Building a culture of participation: research report

Many of the case studies in this research are attempting to make participation more integral to their organisation.

Commitment 3: We engage directly with parent carers and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

The purpose of parent participation is to ensure that parents can influence service planning and decision making so that services meet the needs of families with disabled children. Effective parent participation happens when parents have conversations with and work alongside professionals, in order to design, develop and improve services[6].

The benefits of effective parent participation are well established: resources are not wasted on services that are not taken up or valued; parent carers' insight can help develop cost-effective solutions to local problems; a shared view can be developed between parents and professionals of how to support families within funding limitations; more costly interventions can be avoided in the future; and complaints can be reduced by Parent Carer Forums monitoring services and alerting commissioners and managers if problems occur. The Contact A Family resources below contain a wealth of evidence and case studies into how effective parent participation has benefited the local areas where it has been implemented.

Health and Wellbeing Boards should ensure that parent carers are involved in decisions that affect them at a strategic and service level. Health and Wellbeing Board members should use their influence to embed engagement with parent carers throughout the health and care system and in the context of a continuous and current partnership.

It should be recognised that parent carers may face significant barriers to their participation in mainstream settings but that this should not prevent their involvement in decision-making.

6 Definition from Together for Disabled Children (2010), How to guide to parent carer participation: Section 1 – parent participation as a process, p.2.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS, and next steps for JHWS engagement
- Evidence of partnership working with local parent groups, including the local Parent Carer Forum(s)

Key resources for meeting this Charter commitment

Together for Disabled Children (v2.0 2010), Parent carer participation: How to guide.

A guide to support parent carer forums, commissioners and managers to develop parent carer participation. It can be downloaded in the following separate sections:

Section 1 - The Process

Section 2 - producing information

Section 3 - consultation

Section 5a - successful meetings Together for Disabled Children

Section 5b - how to reach and engage parents

Section 5c - supporting parent representatives

Section 6b- for strategic leaders

How parent participation and parent carer forums leads to better outcomes for disabled children, young people and their families 2011

Contact A Family (2012), Parent Carer Participation: An overview

This short guide provides examples of successful parent carer participation

Contact A Family, Improving Health Services

Resources to support the commissioning and management of health services.

Contact A Family, Resources

Resources, case studies and information for professionals to help them improve how services are delivered, so they better meet families' needs.

Contact A Family (2013), Parent carer forum involvement in shaping health services - second report

Report into Parent Carer Forum involvement with the health service in the lead up to the new health system coming into effect.

Commitment 4: We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

Statutory drivers

Health and Social Care Act 2012

Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and to have regard to guidance from Secretary of State

Power of the HWB to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS

CCG is under a duty to involve HWB in preparing or significantly revising the commissioning plan – including consulting it on whether the plan has taken proper account of the relevant JHWS

Duty to provide opinion on whether the CCG commissioning plan has taken proper account of the JHWS. Power to also write to NHS England (formerly the NHS Commissioning Board) with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG). Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard and to consult HWB on this

Duty in conducting the performance assessment, to assess how well CCG has discharged duty to have regard to JSNA and JHWS and to consult HWB on its view on CCGs' contribution to delivery of any JHWS to which it was required to have regard (when conducting its annual performance assessment of the CCG)

In response to the report of the Children and Young People's Health Outcomes Forum, the Government set out its ambitions for improving health outcomes for children and young people by launching 'Better Health Outcomes For Children And Young People: Our Pledge'[7]. Health and Wellbeing Boards will play a key role in delivering on these ambitions.

Disabled children and young people will provide a crucial test of the effectiveness of the new health system and improving the outcomes they experience, including those in the NHS and Public Health Outcomes frameworks, will require concerted strategic leadership. However, if a Health and Wellbeing Board can improve integration for local disabled children and young people, who frequently test the interface between multiple services and agencies, it can deliver for all children and young people.

For the JSNA and JHWS process to make a positive impact on the outcomes faced by disabled children, young people and their families, it is essential that the evidence collected through the JSNA process reflects the outcomes that are most meaningful to them. Health and Wellbeing Boards should use the JSNA process to develop a shared understanding of the needs of disabled children, young people and their families, and the causes of the poor outcomes and inequalities

7 Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

they experience. They should set clear strategic outcomes for partners to meet and ensure that mechanisms are in place to measure and monitor progress towards achieving them.

The JHWS should address how the needs of disabled children, young people and their families should be met and make recommendations on cost-effective approaches to reducing the health inequalities they experience. However, if this group is not identified as a priority in the JHWS, the Health and Wellbeing Board should demonstrate how it is providing strategic direction for partners to meet the needs of disabled children and young people.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework, etc.
- Public information on the strategic direction the HWB has set to support key partners to improve outcomes for disabled children and young people. This may be encompassed by the JHWS, but would need to be sufficiently delineated to demonstrate specific objectives and action for disabled children and young people.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people's health and wellbeing in changing times

The purpose of this report is to support implementation of the health reforms to improve children and young people's health and wellbeing.

Report of the Children and Young People's Health Outcomes Forum (2012)

The Children and Young People's Health Outcomes Forum was established by the Secretary of State for Health and tasked with responding to the challenges set out in Sir Ian Kennedy's report published in 2010 'Getting it right for children and young people'.

Report of the Children and Young People's Health Outcomes Forum - report of the long-term conditions, disability and palliative care sub-group (2012)

Report discussing the challenges around improving outcomes for this group of children.

Report of the Children and Young People's Health Outcomes Forum - inequalities in health outcomes and how they might be addressed (2012)

Report commissioned by the co-chairs of the Children and Young People's Health Outcomes Forum from Maggie Atkinson, Children's Commissioner for England.

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Children and Young People's Health Outcomes Forum (2012), Commissioning in the new NHS for children, young people and their families

Poster setting out the Children and Young People's Health Outcomes Forum's vision for successful commissioning for children, young people and their families in the new NHS.

Department of Health (2013), Improving Children and Young People's Health Outcomes: a system wide response

The Children and Young People's Health Outcomes Forum report made recommendations, aimed at DH, DfE and a wide range of health system organisations, to improve health outcomes for children and young people. This document contains the system-wide response setting out the action already undertaken, in progress and planned in response to the recommendations.

Department of Health (2013), Better health outcomes for children and young people: Our Pledge

Government response to the report of the Children and Young People's Health Outcomes Forum, setting out shared ambitions across the NHS to improve outcomes and services for children and young people.

Contact A family and Strategic Network for Child Health and Wellbeing in the East of England (2012), Principles for commissioning and delivering better health outcomes and experiences for children and young people so that they are comparable with the best in the world

Poster showing 6 principles for commissioning and delivering better health outcomes and experiences for children and young people, developed by the Strategic Network for Child Health and Wellbeing in the East of England.

Department of Health (2010), The NHS Outcomes Framework 2011/12

The outcomes and indicators which make up the first NHS Outcomes Framework, following the consultation Transparency in outcomes – a framework for the NHS.

Commitment 5: We promote early intervention and support smooth transitions between children and adult services for disabled children and young people

The report of the Children and Young People's Health Outcomes Forum emphasised the importance of early intervention and transitions within a life-course approach to reducing health inequalities[8]. This is particularly significant for disabled children and young people and their families, who often struggle to obtain a diagnosis and access appropriate support at an early age and when transitioning to adult services, which affects their outcomes throughout their lives.

It should be emphasised that disabled children and young people may transition to adult services up to the age of 25. Health and Wellbeing Boards should consider the needs of disabled children and young people from 0-25 as well as ensuring smooth transitions to adult services.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The way in which the activities of the HWB help local partners to understand the value of early intervention
- The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people

Key resources for meeting this Charter commitment

Graham Allen MP (2011), Early Intervention: The Next Steps

An independent report to Government, which argues that many of the costly and damaging social problems for individuals can be eliminated or reduced by giving children and parents the right type of evidence based programmes between 0-18 and especially in their earliest years.

Graham Allen MP (2011), Early Intervention: Smart Investment, Massive Savings

Graham Allen MP's second independent report to the Government sets out how early intervention programmes can be paid for within existing resources and by attracting new non-government money.

Child and Maternity Health Observatory, Knowledge Hub: Transitions

The transitions to adulthood hub brings together a range of resources and evidence relating to young people's transition process into the adult world. It is constantly updated with new resources.

8 Report of the Children and Young People's Health Outcomes Forum (2012), p.38

Early Support

A way of working, underpinned by 10 principles that aim to improve the delivery ofservices for disabled children, young people and their families. It enables services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

Early Support (2012), Key working: improving outcomes for all - Evidence, provision, systems and structures

A summary of the key evidence and consistent elements of a key working approach. It presents an analysis of the implications of key working that cuts across health, social care and education.

Ofsted (2013), Good practice resource - Early intervention through a multi-agency approach: Sheffield City Council

Sheffield City Council has developed a creative and innovative approach across the children's workforce by introducing a multi-agency perspective in providing preventative services to children and families.

C4E0, Improving the wellbeing of disabled children through early years interventions (age 0–8)

This section contains the following resources in support of improving the wellbeing of disabled children through early years interventions (age 0–8) priority: links to online tools; key online publications from C4EO partners and other organisations.

Institute of Public Care (2012), Early Intervention and Prevention with Children and Families: Getting the Most from Team around the Family Systems

Briefing paper arguing that effective local systems to identify families who would benefit from additional support and to coordinate support from a range of agencies is as important as delivering effective services.

Transition Information Network (TIN)

An alliance of organisations and individuals who come together to improve the experience of disabled young people's transition to adulthood. TIN is a source of information and good practice standards for disabled young people, families and professionals.

TIN Resource Library

You can use the search form to find a range of resources that can help you to improve your provision for disabled young people in transition to adulthood.

Preparing for Adulthood (PfA)

A 2 year programme funded by the Department for Education as part of the delivery support for 'Support and aspiration: A new approach to special educational needs and disability' green paper. It provides knowledge and support to all local authorities and their partners, including families and young people, so they can ensure young people with SEN and disabilities achieve paid work, independent living, good health and community inclusion as they move into adulthood.

Preparing for Adulthood (2012), PfA resource list

Created for the PfA 'How are you doing?' events which took place in June and July, 2012. Resources are listed under: Paid employment; Independent living; Good health; Community inclusion.

Sloper, P., Beecham, J., Clarke, S., Franklin, A., Moran, N. and Cusworth, L. (2011) Transition to adult services for disabled young people and those with complex health needs, Research Works, 2011-02, Social Policy Research Unit, University of York, York

This research aimed to provide evidence of what works well in developing and implementing multi-agency coordinated transition services for disabled children and those with complex health needs and their families. It also assessed the costs of the services.

Commitment 6: We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

Statutory drivers

Health and Social Care Act 2012

Duty to encourage integrated working:

- between commissioners of health services and commissioners of social care services
- in particular to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006

Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer integration of commissioning

Disabled children and young people access services across multiple agencies, and therefore are disproportionately affected by poor integration between health and social care services and a lack of coordinated commissioning. Health and Wellbeing Boards must work with key partners to meet the needs of disabled children and young people, including: education providers and schools; safeguarding boards, local children's trust arrangements; learning disability partnership boards; and others. Health and Wellbeing Boards should make recommendations to ensure that disabled children and young people experience seamless integration between the services they access.

In particular, Health and Wellbeing Boards should consider how they engage with education services, including schools and colleges, because of the significance of joined up-working between health, education and social care to disabled children and young people's outcomes.

To promote integrated commissioning Health and Wellbeing Boards will also need to consider how specialised health services commissioned by NHS England are joined up with locally commissioned services and ensure they are taken into account by their JSNA and JHWS.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care
- Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system
- Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families

Key resources for meeting this Charter commitment

Together for disabled children (2009), Facilitating integrated practice between children's services and health

> This report contains examples of innovative working practice where services are integrated with health.

Council for Disabled Children (2006), Pathways to success: Good practice guide for children's services in the development of services for disabled children - evidence from the pathfinder children's trusts

> This project ran from April 2004 to March 2006 and set out to work alongside the pathfinder children's trusts in developing new ways of working and to capture the learning from their work. The work covered: stratgeic planning; commissioning services, pooling budgets; joint working and co-location; assessment process and information sharing.

East Midlands, Everybody's learning (2012), Assured safeguarding: GP and Health Leader edition

> Resource to help commissioners and health providers reassure themselves they are doing everything possible to ensure that children within the services for which they are responsible are as safe as possible.

Ofsted (2012), Improving outcomes for disabled children by integrating early support and prevention services: Luton Borough Council

> Luton's services for disabled children and their families bring together practice across health, social care and education services, alongside innovative short break and early support provision. The development of an extensive range of integrated early support and prevention services is improving outcomes for disabled children and preventing situations deteriorating so that child protection or looked after services become necessary.

Commitment 7: We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

Statutory drivers

Health and Social Care Act 2012

Power to encourage close working (in relation to wider determinants of health):

- between itself and commissioners of health-related services
- between commissioners of health services or social care services and commissioners of health-related services

Power to appoint additional members to the board as deemed appropriate

Power for HWB to request information for the purposes of enabling or assisting its performance of functions from:

- the local authority
- certain members or those they represent with a duty to provide

Children Act 2004

Requirement for each local authority to have a children's trust board which must include representatives of the local authority and each of the children's trust 'relevant partners'

Local safeguarding children's boards put on statutory footing

Children and Families Bill 2012-13 (currently in Parliament)

(Clause 25) Local authorities must promote the integration of special education, health and care provision.

(Clause 26) Local authorities and their partner CCGs must make arrangements for the joint commissioning of education, health and care provision for children and young people with SEN.

(Clause 27) Local authorities must keep under review special education provision and social care provision for children and young people with SEN and consider the extent that it is sufficient to meet their needs.

(Clause 30) Local authorities must publish a Local Offer containing information about services available for children and young people with SEN, including education, health and care provision.

The role of the Health and Wellbeing Board must be understood in relation to new and existing partnerships, including: local children's trust arrangements; local safeguarding children's boards; learning disability partnership boards; and others. A clear local framework on how these partnerships interact needs to be established to avoid the duplication of effort or even

competing for resources.

The JSNAs and JHWS need to be aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block[9]; safeguarding arrangements; child poverty strategies; and children and young people's plans if they are still used.

Additionally, the Children and Families Bill currently in Parliament contains clauses for promoting integration between special educational provision, health and social care provision (25), making joint-commissioning arrangements (26), keeping education and care provision under review (27), and producing a local offer (30), for children and young people with SEN. These new duties on local authorities all have a clear relevance to the functions of the Health and Wellbeing Board to encourage integrated working, promote close working and undertake a JSNA and JHWS. This is particularly important as CCGs will be under a new duty to secure specific services in education, health and care plans for children and young people with SEN[10]. Indicative regulations also make clear that local authorities must consult Health and Wellbeing Boards when preparing and reviewing its Local Offer[11].

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Information on links to other local integration forums which set strategic direction for disabled children's services, e.g. the local children's trust arrangements, the local safeguarding board, the learning disability partnership board, the school forum, etc.
- Evidence of how the JSNA and JHWS is aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements; child poverty strategies, etc.

Key resources for meeting this Charter commitment

NHS Confederation (2012), Children and young people and health and wellbeing boards: putting policies into practice

> Developed by the health and wellbeing board learning set for children and young people, part of the National Learning Network for health and wellbeing boards, to give HWB members some ideas of how other boards are organising themselves to deliver coordinated services for children and young people.

9 See Department for Education (2012), School funding reform 2013-14, pp. 16-20

10 See Department for Education website (2013), Children and young people with special educational needs to benefit from new legal health duty

11 The Special Educational Needs (Local Offer) (England) Regulations 2014: http://media.education.gov.uk/assets/files/pdf/c/clause%2030%20draft%20regulations%20sen%20local%20offer.pdf

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). Local Authorities' Approaches to Children's Trust Arrangements (LGA Research Report)

The Local Government Association commissioned the National Foundation for Educational Research (NFER) to investigate local authorities' approaches to their children's trust arrangements and how they are fulfilling their duty to promote cooperation with partners to improve children and young people's health and wellbeing.

General resources

The Marmot Review (February 2010), Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010

Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England.

Kennedy, Prof Sir Ian (September 2010) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs

An independent review of services provided by the NHS to children and young people, concentrating on understanding the role of culture in the NHS. It focuses on areas where there are cultural barriers to change and improvement and makes recommendations.

NHS Confederation - Resources for Health and Wellbeing Boards

The NHS Confederation has been working with each health and wellbeing board learning set in collaboration with the NHS Institute for Innovation and Improvement, Department of Health and Local Government Association to produce publications which summarise their key points of learning and which will be shared with other shadow health and wellbeing boards.

NHS Confederation (2012), Children and young people's health and wellbeing review of documents

Briefing summarising the key policy documents on children and young people's health and wellbeing that have been published over the last two years."

NHS Confederation (2012), Support and resources for health and wellbeing boards

Summary of the support available to spread networking and learning opportunities for Health and Wellbeing Boards

NHS Confederation (2012), National learning network for health and wellbeing board publications 2012

A list of publications produced by The National Learning Network for health and wellbeing boards to share learning and support the establishment of well functioning boards.

Local Government Associaton - Resources for Health and Wellbeing Boards focusing on children, young people and family issues

The Health and Wellbeing Board learning set for children and young people looked at the issues important to the development of Health and Wellbeing Boards. The learning sets are a part of the Department of Health's development and support programme for Health and Wellbeing Boards which is supported by the LGA, NHS Confederation and NHS Institute. Nine learning sets focused on a number of themes including governance, resources and public engagement.

Getting the Best Out of Your Health and Wellbeing Board Leadership Development Offer - Health and Wellbeing Board Information Resource

This document brings together information about publications and websites which should be of value to Health and Wellbeing Boards.

Child and Maternity Health Observatory

ChiMat was established in 2008 as a national public health observatory to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health.

National Voices

The national coalition of health and social care charities in England. They work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

Regional Voices

Supports the voluntary sector to successfully influence local strategic decision making in health and social care. This group of pages links to a variety of resources to support you develop strategies to influence in your local area.

About Us

Every Disabled Child Matters is the national campaign to get rights and justice for every disabled child. It is run by four leading organisations working with disabled children and their families: Contact a Family, Council for Disabled Children, Mencap and the Special Educational Consortium.

The Children's Trust, Tadworth is the leading UK charity for children with acquired brain injury, multiple disabilities and complex health needs. The Trust's services include the UK's largest rehabilitation centre for children and young people with acquired brain injury, nursing care for technology-dependent children, and education for children and young people with profound and multiple learning difficulties and complex health needs.

Health and Wellbeing Board

21st June 2013

Durham Dales, Easington and Sedgefield Clinical Commissioning Group Quality Premium Priorities for 2013/14

Report of Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Purpose of Report

1. The purpose of this report is to confirm DDES CCG's portfolio of quality premium indicators for 2013/14. The NHS planning framework "Everyone Counts – Planning for Patients 2013/14" provided a timetable for CCGs to submit plans to meet the requirement outlined within the body of the document.

2. This report summarises DDES CCG's final plan submitted to the Area Team of the National Commissioning Board on the 28th March 2013. This report is a follow up on the report discussed at the Health and Wellbeing board on 6th March 2013 entitled "DDES CCG, Planning Framework and Final Commissioning Intentions for 2013/14" providing further detail on the national quality premium areas and the three local quality premium areas with rationale for selection and change.

Quality Premiums – National Measures

3. In December 2012 the NHS Commissioning Board published guidance "Quality Premium: 2013/14 guidance for CCGs" which outlined how the 'quality premium' is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for the associated improvements in health outcomes and reducing inequalities.

4. The national quality premiums are categorised and aligned to the NHS outcome domains, the percentage that the national quality premiums contribute towards the CCG quality premium reward are as follows:
   - Reducing potential years of life lost form amenable mortality (12.5%)
   - Reducing avoidable emergency admissions (25%)
   - Improve patient experience of hospital services (12.5%)
   - Prevent healthcare associated infections (12.5%)

   The remaining 37.5% allocation of the quality premium will be equally apportioned to the delivery of three local priorities.

Quality Premiums – Local Priorities

5. At the end of 2012 the National Commissioning Board published a supporting document for CCGs: "Outcomes benchmarking support packs: CCG level" which provided CCG level information on population profiles, deprivation and disease prevalence, hospital activity profiles as well as a cross section of health outcomes indicators related to the NHS outcome domains.

6. The DDES CCG Outcome support pack identified 12 areas where DDES CCG had outcomes in the worst quintile in the country, which included:
    - Potential years of life lost (PYLL) from causes considered amenable to healthcare
    - Under 75 mortality rate from cardiovascular disease
    - Under 75 mortality rate from respiratory disease
    - Under 75 mortality rate from cancer
    - Health related quality of life for people with long term conditions
    - Unplanned hospitalisation for chronic ambulatory sensitive conditions (adults)
    - Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
    - Emergency admissions for acute conditions that should not usually require hospital admission
    - Patient reported outcome measures for elective procedures – hip replacement
    - Emergency admissions for children with lower respiratory tract infections
    - Incidence of Healthcare associated infection (HCAI): MRSA
    - Incidence of Healthcare associated infection (HCAI): C Difficile

    For the full spine chart showing DDES CCG outcomes please see Appendix 2.

7. As articulated in the 6th March 2013 Shadow Health and Wellbeing Board paper entitled "DDES CCG, Planning Framework and Final Commissioning Intentions for 2013/4" DDES CCG initially selected the following indicators which are all outcomes where DDES CCG are in worst quintile:
    - Under 75 mortality rate from cancer
    - Health related quality of life for people with long term conditions
    - Emergency admissions for children with a lower respiratory tract infection

    These local quality premium indicators were agreed at the Health and Wellbeing Board during the March meeting and were the same as those initially submitted by neighbouring CCGs providing opportunities for working at scale.

8. The NHS planning framework "Everyone Counts – Planning for Patients 2013/14" provided a timetable for CCGs to enable a dialogue between the CCG and the NHS England Area Team between submissions. The NHS England Area Team (Durham, Darlington and Tees) provided significant feedback on a numbers of areas including the selection of local quality premium indicators. There was concern around the stability of the 'Health related quality of life for people with long term conditions' indicator due to the high level of variance over time. It was

noted by the Area Team that only a handful of CCGs across the Country had chosen this indicator because of this and that the CCG might want to consider changing. After consideration of this fact all CCGs in the Durham, Darlington and Tees (DDT) area who first selected this indicator changed it. One neighbouring CCGs changed to a compound indicator where the risk of variation was reduced; another CCG in the DDT area changed it to the indicator 'Estimated diagnosis rate for people with dementia'. DDES CCG changed the indicator to: 'Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s' which is an area where DDES CCG has amongst the worst performance in the Country.

9. DDES CCG regret that the Health and Wellbeing board were not consulted of this change before the submission date, but unfortunately due to the tight timescales involved this was not possible. The NHS England Area Team have confirmed that they will be discussing priorities for the next financial year earlier in the year so that these can be debated by the Health and Wellbeing Board and subsequently agreed by them in good time. As the NHS England Area Team will also be part of that process they will be able to advise of any changes to the process in a more timely fashion as they will have more experience of what is required of the process.

10. The final submission made to area team on the 28th of March included the following local quality premium priorities:
    - Reducing under 75 mortality rate from cancer
    - Reducing unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
    - Reducing emergency admissions for children with a lower respiratory tract infection

Implications

11. The new local quality premium indicator supports the Health and Wellbeing Board Strategic Aim "Children and young people make healthy choices and have the best start in life" by ensuring that children in Durham Dales, Easington and Sedgefield receive improved services so that they and their families are able to manage the child's asthma, diabetes and epilepsy more effectively preventing hospital admissions, reducing family stress and improving life opportunities for the child. Within our clear and credible plan DDES CCG have a commitment in improving the health and wellbeing of our children by having a specific strategic aim focussed on child health "Make sure our children and young people have a better start in life". The selection of this new quality premium indicator further demonstrates our ambition to make real changes in the health system for our children and young people.

12. DDES CCG would welcome work to further understand the issues surrounding why our children have many more admissions than average for asthma, diabetes and epilepsy along with lower respiratory tract infections and are keen to work with Public Health colleagues to better understand any underlying issues.

13. Even though the "Health related quality of life for people with long term conditions" indicator is no longer a local quality indicator for the purposes of

attracting quality premium resources in to the county it will continue to be a high priority for DDES as agreed with the Health and Wellbeing Board. We will continue to do all that we can to improve this indicator and it will be monitored closely by the CCG as part of our internal performance data set.

14. DDES CCG would like to reassure the Health and Wellbeing board that our work programme remains comprehensive and this can be seen from our most recent Plan on a Page in Appendix 3.

Recommendations

15. It is recommended that the Health and Wellbeing Board:

- note the contents of this report
- support DDES CCG in the selection of their local quality premium priorities.

Contacts:

Jonathan Wrann, Commissioning Manager – Service Planning and Reform, North of England Commissioning Support (NECS). Tel (0191 3744198. E-mail jonathan.wrann@nhs.net

Stewart Findlay, Chief Clinical Officer, DDES CCG. Tel (0191 3713220). E-mail stewartfindlay.ddes@nhs.net

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Appendix 1: Implications

Finance: Priority indicators are linked to 37.5% of the Quality Premium Reward

Staffing: DDES CCG with support from North of England Commissioning support have secured the staff capacity to take forward these priority areas. Colleagues from Public Health will also be involved in better understanding any underlying issues.

Risk: Failure to achieve targets will have a detrimental effect on the health of patients in the area and also not achieve Quality Premium Rewards.

Equality and Diversity / Public Sector Equality Duty: There are no implications to Equality and Diversity

Accommodation: There are no implications to accommodation

Crime and Disorder: There are no Crime and Disorder implications

Human Rights: There are no implications to Human Rights

Consultation: Report is for information only

Procurement: Not applicable

Disability Issues: Not applicable

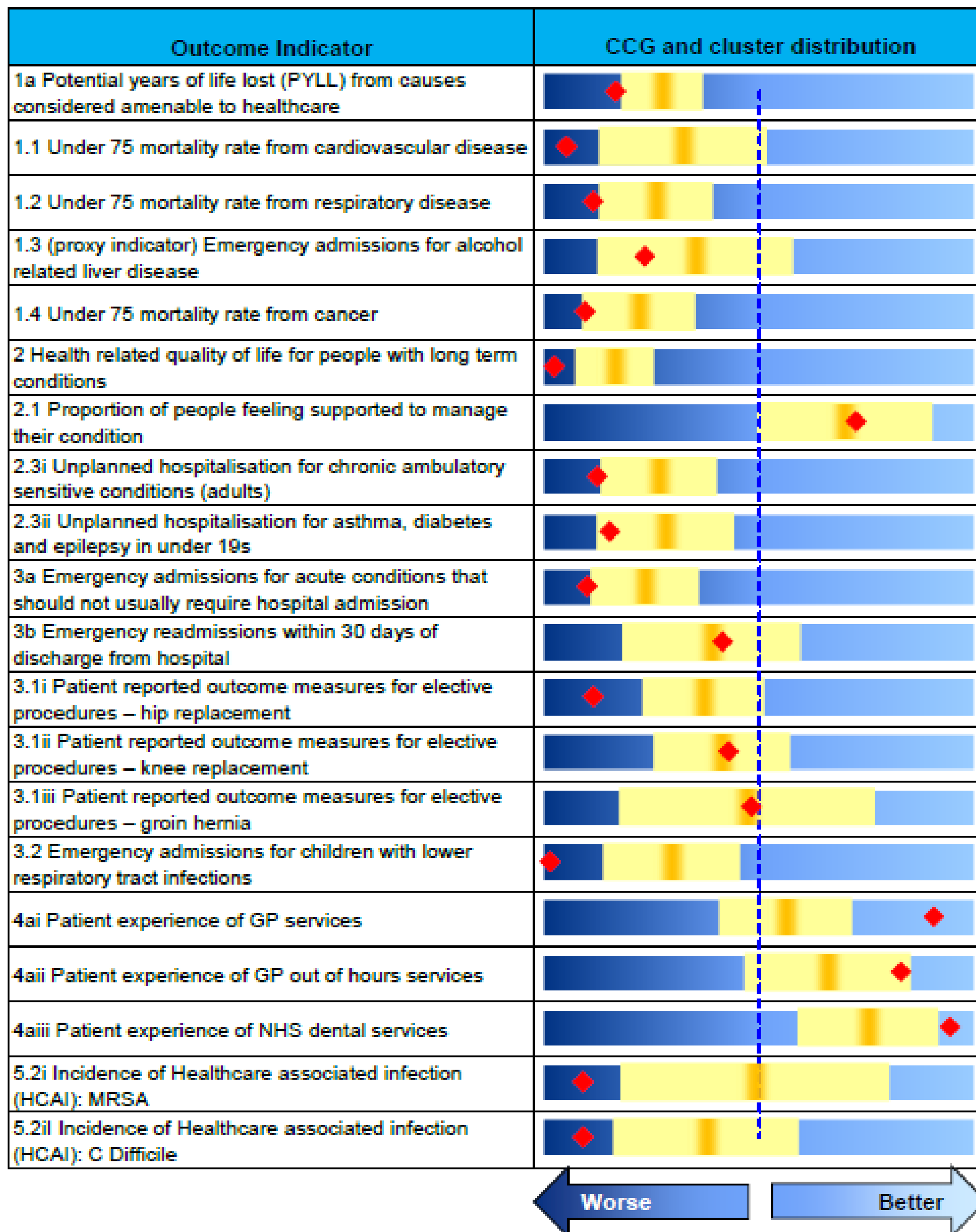
Legal Implications: Not applicable

Appendix 2

NHS Durham Dales, Easington and Sedgefield CCG
Summary spine chart

The chart below shows the distribution of the CCGs on each indicator in terms of ranks. This CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same ONS cluster as this CCG. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

This CCG is in the Mining & Manufacturing cluster



Appendix 3

DDES CCG – Plan on a Page 2013/14

Vision: Excellent Health for the local communities of DDES

We will deliver our strategic aims through clinical leadership and working in partnership with Durham County Council, North Durham CCG, Darlington CCG and the National Commissioning Board and with support from North of England Commissioning Support.

Strategic Aims [Local priorities in red]	Prioritised Initiatives [link to outcome framework domains]
Improving the health of the population [U75 Cancer mortality]	Implementation of the Experience led commissioning Stroke prevention and management strategy and action plan Q Targeted work on cancer screening, including breast screening, genetic testing and haematuria screening (delivering NICE guidance) Q Targeted work on early diagnosis of cancer to improve patient outcomes To support Public Health with the commissioning of alcohol liaison nurses in emergency departments. Q Commission a high-quality early supported discharge service for people who have had an acute stroke Q Commission community-based pulmonary rehabilitation programmes and encourage appropriate referral according to NICE guidelines Q To support Public Health with the smoking cessation and smoke free family initiatives to reduce the number of children developing lower respiratory tract conditions Work with providers in the community to develop services to support people's health and wellbeing
Making sure our children and young people have a better start in life. [Emergency admissions for children with lower respiratory tract infections] [Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19]	Develop and commission a regional maternity service specification Q Decommissioning and recommissioning of children's therapy services following reviews Q Develop and roll out, following review and validation, the Poorly Child Pathway Q Further develop and roll out the Autistic Spectrum Disorder 14 week pathway and post diagnosis support Q Decommission/recommission redesigned children's community nursing service to ensure continuity Q
Tackling the challenges of an ageing and growing population	Review and re-commission out of area Mental Health placements Q Roll out of the 'year of care' pathways as defined by the Payment by Results guidance Q Redesign intermediate care services in line with CDD intermediate care blue print Taking account of reviews, commission robust community nursing services for better management of patients with LTCs Q Implementation of the retinal screening common pathway Q Review pathways in Mental Health focussing on care closer to home, matching supply to service user demand whilst ensuring value for money. To include pilot of psychosexual therapy and the development of counselling services Q Improve access to and uptake of general health services for people with learning disability (LD) Q Work with the End Of Life clinical network to End of Life Care Q Subject to a positive evaluation to commission an acute Hospital Liaison Service (Adult Mental Health and Older People Services) Q Subject to a positive evaluation to commission the Care Home Mental Health Liaison Service Q Having regard to evaluation of the various locality schemes and national good practice to develop improved clinical and pharmacy support to vulnerable older people living in care/nursing homes Subject to evaluation, implement Telehealth/Telecare Subject to evaluation of the various locality initiatives, put in place community based diabetes services Q Implementation of recommendations from the Winterbourne enquiry Q Improve access to psychological therapies Increase early diagnosis of dementia
Making services more accessible and responsive to the needs of our communities	Review urgent care provision focusing on in/out-of-hours with possible integration, improved access to primary care and hard to reach communities Q To ensure equality of access to leg ulcer management in the community Q Following successful evaluation, roll out of the rheumatoid arthritis review scheme in Primary care Q Further development of Emergency Department 'front of house' services for key patient groups Development of Physiotherapy AQP Service Q Expand primary care opticians services e.g. intra ocular hypertension referral refinement Q
Managing our resources effectively and responsibly	Review of (non-specialist) nurse led secondary care activity Q Review of day case procedures carried out in outpatient setting Q Local relocation of Urology service provision to drive up efficiency Q Development of Ambulatory care services in City Hospital Sunderland and North Tees FT Q Roll out of post discharge tariffs as defined by the Payment by Results guidance Q Primary care workforce development to include Career Start Practice Nurse Scheme (to be decommissioned and re-commissioned) Q Implementation of gain-sharing mechanism for high cost drugs across secondary/primary care Q Review of increased GP demand for secondary care cardiology services Q Review of services for the provision of non-medical equipment Q Review ambulance services Q Review of prescribing, noting cost savings from category M drug pricing and drugs coming off patent Q Evaluate 30 day readmission pilots Q Implementation of outcomes of the Francis 2 report Q

Outcome framework

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have positive experience of care
- Treating and caring for people in a safe Environment and protecting them from harm

Cross Cutting Programmes

- Acute Quality Legacy Project
- Quality, Innovation, Productivity and Prevention Programme - contributing projects labelled Q
- Locality Innovation throughout the three DDES localities (Durham Dales, Sedgefield and Easington)

Risks

- Managing increased provider activity above affordable levels due to local population demographic trends.
- Ensuring commissioning business continuity by managing capacity and capability pressures resulting from the current significant structural change within the NHS.
- Ability of providers to respond appropriately to Francis 2 and to meet Performance requirements of the NHS constitution, the NHS mandate and Outcomes Framework "Everyone Counts" both in terms of quality and activity.
- Uncertainty around CCG allocations particularly in respect of new specialised commissioning arrangements.

Health and Wellbeing Board

21st June 2013

Integration Pioneer Project

Report of Rachael Shimmin, Corporate Director, Children & Adults Services, Durham County Council / Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group

Purpose of the Report

1. The purpose of this report is to provide the Health and Wellbeing Board with:

   - information relating to the recent government request for expressions of interest from local areas wishing to become pioneers of health and social care integration
   - an overview of the development of an improved Intermediate Care 'Short Term Intervention' Model which could be used to inform this expression of interest

Background

2. In May 2013 the government released a request for local areas to submit an expression of interest to become 'pioneers' of health and social care integration with the aim of ensuring person-centred coordinated care becomes the norm across the sector.

3. This request also aimed to build upon the vision detailed within the 'Integrated Care and Support: Our Shared Commitment' Report which indicated the key objectives underpinning this initiative, which includes:
   - enable and encourage local innovation
   - address current barriers to integration
   - disseminate and promote learning to support better integration with the aim of improving patient outcomes and experience

4. In accepting that each local area is unique and will need to develop an integrative approach to suit the needs of the local people, the selection criteria is quite broad. The government are looking for initiatives able to adopt a whole system approach to providing coordinated and outcome focused care incorporating local health, public health, social care systems and the voluntary sector where appropriate. This approach must be able to demonstrate the ability to implement change at both scale and pace and develop a robust evidence base on which to build improvement moving forward.

5. Localities selected to become integration 'pioneers' will be provided with tailored support in implementation to facilitate the use of best practice and shared learning on a national basis.

Current Review of Intermediate Care Provision

6. It is proposed that the current review and planned transformation of Intermediate Care Provision form the basis of the integration 'pioneer' expression of interest.

7. The importance of driving patient centred care and support has been recognised within County Durham, particularly within the former Care Closer to Home Group featuring representation from Clinical Commissioning Groups, County Durham and Darlington NHS Foundation Trust and Durham County Council. More specifically it has been accepted that this will require a move away from the provision of care in the acute setting towards more flexible, locality based provision where appropriate.

8. In view of this, in January 2013 the former Care Closer to Home Group committed to oversee a high level evaluation of current Intermediate Care Services with a view to developing an Outline Business Case for a proposed operating model moving forward within County Durham.

9. The proposed model was developed with input from a comprehensive list of primary stakeholders and aimed to be both flexible and accessible in providing credible alternatives to hospital admission through incorporating the following objectives:
    - Admission avoidance to an acute bed
    - Re-admission avoidance to an acute bed
    - Admission avoidance to 24 hour care

10. While some progress had been made in working towards an integrated approach within current Intermediate Care services, further opportunities for improvement remained. These included:
    - Addressing the current restrictive definition of Intermediate Care excluding some referrals who could potentially benefit from short term support
    - Resolving a number of inconsistencies in the service delivered across the County
    - Improving current accessibility of the service
    - Reducing pressure placed on the acute setting through increasing demands due to demographic trends.
    - Resolving instances of silo working exacerbated by multiple, incompatible data systems across key organisations.

11. This resulted in the development of a 'Short Term Intervention' Model which aimed to optimise opportunities for improvement highlighted above through incorporating the following:
    - A non-restrictive definition which ignores medical diagnosis allowing access to all those who will benefit for up to 6 weeks.
    - A 24/7 single point of access (SPA) responsible for the collection of relevant information at the point of referrals and commissioning intermediate care beds and sitting services out of hours.
    - The SPA will be supported by an 8am-8pm multidisciplinary assessment team responsible for identifying the most appropriate short term intervention service once an individual is considered to be medically stable.

- GP Beds will also form part of the model with GPs maintaining admission rights through the SPA
- Short Term Intervention Services may include Intermediate Care Beds, Step Up/Step Down and Time to Think Beds, provision of Telecare and Telehealth, administering of IV Fluids and Antibiotics in the Community, Community Equipment, Rehab Therapy, Reablement and Sitting Services amongst others. Bringing together all existing services into one holistic model, which will be evaluated over an 18 month period to inform the future commissioning strategy for the service moving forward, based on value for money and patient and service user outcomes.

Possible Outcomes

12. Successful submission to become an integration 'pioneer' could bring a number of general and specific benefits for County Durham including:

    - Recognition as a practitioner of best practice in pursuing coordinated, patient-centred care through the use of an integrated, whole system approach.
    - Tailored support from the Department for Communities and Local Government and their partners, to help achieve effective outcomes from programme

13. It should be noted that there is no financial implications to becoming an integration 'pioneer'

Recommendations

14. The Health and Wellbeing Board is recommended to:
    - Support the application process
    - Be involved in the ongoing development of becoming a pioneer of health and social care integration
    - Accept further reports on progress.

Contact: Rachael Shimmin, Corporate Director, Children and Adults Services, email: Rachael.Shimmin@durham.gov.uk, Tel: 03000 267355

Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group, email: Nicola.Bailey5@nhs.net, Tel: 0191 6053169

Background papers: None

Appendix 1: Implications

Finance – The submission of the expression of interest to become an integration pioneer will be conducted as part of the existing Intermediate Care project and will, therefore, require no additional financial investment

Staffing - None

Risk – No additional risks will arise as a result of this submission

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation - None

Procurement - None

Disability Issues - None

Legal Implications- None

Health and Wellbeing Board

21st June 2013

Policy Update

Report of Andrea Petty, Strategic Manager - Policy, Planning and Partnerships, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to provide the Health and Wellbeing Board with an overview of key policy developments since March 2013.

Policy Developments

Care and Support

2. Queens Speech - Draft Care Bill

In July 2012, the Department of Health published a draft Care and Support Bill which underwent pre-legislative scrutiny. The Queen's Speech in May 2013 stated that the 'Care Bill' would be progressing through Parliament in the 2013/14 session.

The Care Bill seeks to consolidate provisions from over a dozen different Acts into a single, modern framework for care and support and to enact a fundamental reform of the way the law works. It aims to focus care and support legislation on the wellbeing of individuals.

Following the Government's announcement in February 2013 on the Dilnot proposals, the Bill will now also introduce a capped model for funding social care. It will also include a national minimum eligibility, and carers will have a legal right to an assessment for care for the first time. Following the failings at Stafford Hospital, the Bill will introduce Ofsted-style ratings for hospitals and care homes.

No action – for information only.

3. Safeguarding vulnerable people in the reformed NHS – Accountability and Assurance Framework

This document, issued by NHS England on 21st March 2013, updates and replaces 'Arrangements to secure children's and adult safeguarding in the future NHS – the new accountability and assurance framework – interim advice' issued by the NHS Commissioning Board Authority in September 2012. It describes how the NHS system will work from April 2013.
The framework aims to:

- Promote partnership working to safeguard children, young people and adults at risk of abuse, at both strategic and operational levels
- Clarify NHS roles and responsibilities for safeguarding, including in relation to education and training
- Provide a shared understanding of how the new system will operate and, in particular, how it will be held to account both locally and nationally
- Ensure that professional leadership and expertise are retained in the NHS, including the continuing key role of designated and named professionals for safeguarding children
- Outline a series of principles and ways of working that are equally applicable to the safeguarding of children and young people and of adults in vulnerable situations, recognising that safeguarding is everybody's business.

No action – for information.

4. NHS Constitution for England

The updated constitution, published on 26th March 2013, sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this constitution in their decisions and actions.

No action – for information.

5. Transforming Care: A national response to Winterbourne View Hospital and Joint Partner Statement

This report, published on 28th March 2013, sets out the government's final response to the events at Winterbourne View hospital. It sets out a programme of action to transform services for people with learning disabilities or autism and mental health conditions or behaviours described as challenging. It lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism, who also have mental health conditions or behaviours viewed as challenging.

The Department of Health will publish a progress report later in the summer, setting out how well the sector is meeting the milestones and providing further checks to make sure that the number of people in assessment and treatment centres continues to reduce.

A report is presented to the Health and Wellbeing Board on 21st June 2013 to provide an update on a national and local basis.

6. Care Quality Commission – Our strategy for 2013 to 2016

The CQC published its strategy on 18th April 2013 and is making radical changes to the way in which it inspects and regulates services to make sure they provide people with safe, effective, compassionate and high-quality care, and to encourage them to make improvements.

The changes CQC is making include:

- Appointing a Chief Inspector of Hospitals, a Chief Inspector of Social Care and Support, and considering the appointment of a Chief Inspector of Primary and Integrated Care.
- Developing new fundamental standards of care.
- Making sure inspectors specialise in particular areas of care and lead teams that include clinical and other experts
- Introducing national teams in NHS hospitals that have specialist expertise to carry out in-depth reviews of hospitals with significant or long-standing problems.
- Improving our understanding of how well different care services work together by listening to people's experiences of moving between different care services.
- Publishing better information for the public, including ratings of services.
- Strengthening the protection of people whose rights are restricted under the Mental Health Act.

The changes will come into effect in NHS hospitals and mental health trusts first. The CQC states that this is because it recognises there is an urgent need for more effective inspection and regulation of these services. The CQC will then extend and adapt its approach to other sectors between 2014 and 2016.

No action – for information.

7. Adult Social Care Outcomes Framework 2013 to 2014

Published on 29th April 2013, the framework:

- describes the principles for the way in which the framework should be used, and its role in supporting local improvement;
- provides a national commentary on adult social care outcomes in 2011 to 2012, the first year of the operation of the framework;
- sets out the Adult Social Care Outcomes Framework (ASCOF) for 2013 to 2014;
- provides a forward look for the development of the framework in future years.

The ASCOF Handbook of Definitions sets out the technical detail of each measure, with worked examples to minimise confusion and inconsistency in reporting and interpretation.

This information will be incorporated into the council's strategic planning and performance processes with regard to adult social care.

The Adult Social Care Outcomes Framework is being taken into account during the process of reviewing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

8. Guide to the Healthcare System in England

This guide, published on 3rd May 2013, explains organisations in the healthcare system and how they work together and includes the Statement of NHS Accountability. The guide covers:

- providing care
- commissioning care
- safeguarding patients
- empowering patients and local communities
- education and training
- supporting providers of care
- the role of the Secretary of State for Health.

The accountability statement explains how decision-making works in the NHS and fulfils the commitment set out in principle 7 of the NHS Constitution.

The guide will be updated annually.

No action – for information.

9. Integrated Care: Our Shared Commitment

This framework document on integration was published by the Department of Health on 13th May 2013. It is signed by 12 national partners and sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

The document includes ten commitments, which every organisation has signed up to deliver, including: outlining how national resources will support local work, promises to ensure tools are available to help, details of how information will be used to enable integration, and plans to accelerate learning across the system.

The publication of the document is accompanied by an invitation for expressions of interest from local areas to become integration 'pioneers'. A letter has been sent to local authority chief executives, chairs of Health and Wellbeing Boards, CCG clinical leads and provider chief executive officers across the social care and health system.

The Health and Wellbeing Board is requested to note that a report is presented to the Health and Wellbeing Board on 21st June 2013 to request support for an expression of interest being submitted on behalf of County Durham.

Public Health

10. A Framework for Sexual Health Improvement in England

This document, issued on 12th April 2013, sets out the government's ambitions for improving sexual health and aims to provide the information, evidence base and support tools to enable those involved in sexual health improvement to work together effectively. It also aims to ensure that accessible high quality services and support are available to everyone.

From April 2013, local authorities commission most sexual health services but clinical commissioning groups and NHS England also have a role. Support is provided to these bodies by Public Health England.

No action – for information.

11. Tackling Teenage Pregnancy: Local Government's New Public Health Role

Public health became the responsibility of local government when it transferred from the NHS to local authorities in April 2013. This briefing for councillors and officers, published on 23rd April 2013 by the Local Government Association, explains the challenges facing councils and the opportunities they have to tackle teenage pregnancy and reduce health inequalities in local communities.

Link to briefing on Tackling teenage pregnancy

Teenage pregnancy is a key action within the Joint Health and Wellbeing Strategy with key measures to monitor progress.

12. Public Health England's priorities for 2013 to 2014

Published on 26th April 2013, the 5 priorities of Public Health England are:
1. Helping people to live longer and more healthy lives by reducing preventable deaths and the burden of ill health associated with smoking, high blood pressure, obesity, poor diet, poor mental health, insufficient exercise, and alcohol
2. Reducing the burden of disease and disability in life by focusing on preventing and recovering from the conditions with the greatest impact, including dementia, anxiety, depression and drug dependency
3. Protecting the country from infectious diseases and environmental hazards, including the growing problem of infections that resist treatment with antibiotics
4. Supporting families to give children and young people the best start in life, through working with health visiting and school nursing, family nurse partnerships and the Troubled Families programme
5. Improving health in the workplace by encouraging employers to support their staff, and those moving into and out of the workforce, to lead healthier lives.

No action – for information.

13. Public Health Outcomes Framework 2013 to 2016 and Technical Updates

The Public Health Outcomes Framework concentrates on:

- increased healthy life expectancy
- reduced differences in life expectancy
- healthy life expectancy between communities

These documents are published under section 73B (1) of the NHS Act 2006 (inserted by section 31 of the Health and Social Care Act 2012) as ones that local authorities must have regard to in the exercise of their public health functions.

This information will be incorporated into the council's strategic planning and performance processes with regard to public health.

The Public Health Outcomes Framework is being taken into account during the process of reviewing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

14. Helping to Prevent Osteoporosis: Good Nutrition and Safe Sunlight Exposure

The All-Party Parliamentary Osteoporosis Group (APPOG) has undertaken an inquiry into the role of nutrition in promoting good bone health and preventing osteoporosis. This has incorporated the role of both diet and safe-sunlight exposure. The latter is required by our bodies to produce sufficient levels of vitamin D, needed for the absorption of calcium.

The inquiry examined the types of lifestyle choice that we need to make to provide ourselves with the nutrients necessary for healthy bones. It has aimed to establish the impact of current dietary and sunlight exposure patterns upon bone health in England. The group scrutinised barriers that exist to a nutritious lifestyle. It is also studied the place of supplements and food fortification in supporting good nutrition for our bones.

The inquiry has found that the UK population is not getting enough of the right nutrients needed to maintain good bone health. APPOG has made seven recommendations in total.

As a follow up to this inquiry, in 2012, the APPOG co-chairs wrote to the leader of every upper-tier local authority in England to ask what steps they are taking to improve bone health through nutrition and safe sunlight exposure. This is in light of the new public health responsibilities that local councils in England are assuming from the NHS as part of the reforms set out in the Health and Social Care Act 2012. APPOG has received replies from 102 councils to date.

APPOG have reiterated the need for local authorities to conduct or commission outcomes-focused public health campaigns which mitigate the increasing number of hospital admissions for fractures in older people, by promoting these bone-protective lifestyle measures. APPOG has requested that Health and Wellbeing Board's push for a public health initiative locally that

promotes safe sunlight exposure, Vitamin D supplementation in vulnerable groups and a healthy, calcium-rich diet.

The Health and Wellbeing Board is asked to note that the letter received from the All-Party Parliamentary Osteoporosis Group (APPOG) has been considered by Public Health colleagues in Durham County Council in their work. For example, as part of the Physical Activity delivery plan and and the Healthy Weight Strategy and delivery plan.

15. Consultation on the Sustainable Development Strategy for the Health and Care System 2014 - 2020

In January 2013, the NHS Sustainable Development Unit launched a consultation on the development of a Sustainable Development Strategy for the Health and Care System for 2014 - 2020.

The strategy is the sustainable development plan for the health, public health and social care system. It builds on the NHS Carbon Reduction Strategy, reinforcing and supplementing the key actions from the strategy and outlining practical steps that need to be taken to move the health system further on the journey towards sustainable healthcare delivery.

The purpose of this consultation and engagement process is to get help from local authorities and health and wellbeing boards in understanding how and where to focus health and care sector efforts to deliver more financially, socially and environmentally sustainable care.

The previous five year strategy (Carbon Reduction Strategy) focused on NHS organisations. The proposal is to expand the scope of the next strategy to include all organisations with a responsibility for health and care, in line with the current health and care system reforms.

The consultation ran until 29th May 2013.

The Health and Wellbeing Board is asked to note that the Sustainable Development Strategy for the health, public health and social care system will be launched in January 2014.

Clinical Commissioning Groups

16. NHS (Clinical Commissioning Groups – Payments in respect of quality) Regulations 2013

In December 2012, the NHS Commissioning Board published draft guidance covering the 2013/14 Quality Premium. The draft guidance set out what a clinical commissioning group (CCG) would need to achieve during 2013/14 to attract a quality premium. The draft guidance was subject to the content of regulations and the guidance being published as final. Quality premium payments will be made in 2014/15.

The Department of Health published regulations in March 2013. The quality premium is intended to reward CCGs for:

- improving the quality of services commissioned for local populations
- improving outcomes for patients
- reducing inequalities in access to health care and outcomes from health care.

CCGs will be given the payments - likely to be around £5 per patient – for meeting certain targets. The payments will be broken down into: 25% for reducing or maintaining a 0% change in unnecessary emergency admissions; 12.5% for meeting targets around reducing healthcare associated infections; 12.5% for rolling out the friends and family test; 12.5% for reducing amenable mortality rates by at least 3.2%.

CCGs will not receive the payments if they do not achieve financial balance and payments will be reduced if they fail to meet targets set out in the NHS Constitution, including those related to waiting times.

The Health and Wellbeing Board is asked to note that a report is on the meeting agenda for 21st June 2013.

17. DDES CCG Prospectus and North Durham CCG Prospectus

Prospectus documents for NHS Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group (CCG) and North Durham CCG have been circulated. The prospectus documents outline:

- CCG background
- How local health needs will be met
- Vision and aims
- Key initiatives
- Budget
- How to get involved.

The draft CCG Prospectus documents for DDES and North Durham CCGs have previously been circulated to Health and Wellbeing Board members and no comments have been received. Therefore, the Health and Wellbeing Board is asked to endorse the draft prospectus documents so they can be finalised.

18. Social Value in Health Care Programme

This programme is designed to support local areas to implement the Public Services (Social Value) Act 2012 though collaboration between the public sector and local voluntary and community and social enterprise (VCSE) organisations in the arena of health and care commissioning and delivery. The programme is being managed by Social Enterprise UK (SEUK) in partnership with the Institute for Voluntary Action Research (IVAR) and is supported by the Department of Health.

The programme is built around area based partnership working and seeks to ensure that the essential contribution of VCSE organisations is recognised and valued within the new health landscape. It builds on a body of evidence that emphasises the need to bring together VCSE organisations, public sector practitioners and commissioners to build mutual trust and understanding while practically addressing local problems and jointly developing solutions through a focus on Social Value.

No action – for information only

Health and Wellbeing Boards

19. Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

To support health and wellbeing boards, the Department of Health has worked with stakeholders on producing this statutory guidance, published on 25th March 2013, which explains the duties and powers of Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs).

The purpose of the guidance is to support health and wellbeing boards and their partners by:

- laying out duties, which underpin JSNAs and JHWSs to be undertaken by CCGs and local authorities through health and wellbeing boards from April 2013;
- explaining how JSNAs and JHWSs will fit together with commissioning plans in the modernised health and care system; and
- setting out how the JSNA and JHWS process will enable the NHS and local government to make real improvements to the health and wellbeing of local people.

This guidance is being taken into account in the development of the JSNA 2013 and the review of the Joint Health and Wellbeing Strategy for County Durham.

The Health and Wellbeing Board is asked to note that the Statutory Guidance is being taken into account during the review of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

20. Pharmaceutical Needs Assessments: Information Pack

Each health and wellbeing board (HWB) must assess needs for pharmaceutical services in its area, and publish a statement of its first pharmaceutical needs assessment (PNA) and of any revised versions.

The information pack, published by the Department of Health on 9th May 2013:

- gives the legislative background
- outlines what the term ‘pharmaceutical services’ includes in relation to PNAs
- outlines the minimum information that must be in PNAs
- expands on what the legislation says about the publication and updating of PNAs
- explains the consultation requirements
- outlines matters to consider when making assessments.

It also includes examples of the ways in which primary care trusts developed their first PNAs, providing HWBs with an indication of how they may wish to approach their work.

The Health and Wellbeing Board is asked to note that a Pharmaceutical Needs Assessment will be undertaken in County Durham by April 2015, in line with national timescales, and will be presented to the Health and Wellbeing Board in early 2015.

21. Health and Wellbeing Improvement Support

The Local Government Association (LGA) has been working with the Department of Health to develop an offer of help, support and challenge for the members and organisations involved in local health and wellbeing boards, local healthwatch and public health in local government, to address local issues and improve the wellbeing of their local people.

Developed in partnership with NHS England, Public Health England, Healthwatch England, the NHS Confederation and the Department of Health, the offer is aimed at supporting boards in 2013/14 by:

- Establishing a single information hub, supported by several organisations, which local health agencies and their partners can tap into for support and learning
- Using the existing sector-led improvement tools, such as peer challenge, to help health and wellbeing boards reflect on their approaches and improve them for the benefit of local people
- Delivering tailored support for clinical commissioning groups
- Producing a revised version of the self-assessment framework for boards to access
- Providing a regionally based support offer, including local chairs’ networks and bespoke support
- Delivering a national event to bring together board members to share learning and experiences.

The Health and Wellbeing Board is asked to note that Durham County Council has signed up for regular bulletins about the LGA’s support offer. These bulletins will be circulated to the Health and Wellbeing Board as appropriate.

Recommendations

22. The Health and Wellbeing Board is requested to:
    - Note this report for information.
    - Endorse the CCG prospectus documents for North Durham and DDES CCG.

Contact: Andrea Petty, Strategic Manager - Policy, Planning & Partnerships
Children and Adults Services, Durham County Council
Tel. 03000 267 312

Appendix 1 - Implications

Finance – No implications

Staffing – No implications

Risk – No implications

Equality and Diversity / Public Sector Equality Duty – No implications

Accommodation – No implications

Crime and Disorder – No implications

Human Rights – No implications

Consultation – No implications

Procurement – No implications

Disability Discrimination Act – No implications

Legal Implications – No implications

Health and Wellbeing Board

21st June 2013

Review of the Sustainable Community Strategy

Report of Gordon Elliott, Head of Partnerships and Community Engagement, Assistant Chief Executive, Durham County Council

Purpose of the Report

1. To provide the Health and Wellbeing Board (H&WB) with an update on how work is progressing on the renewal of the Sustainable Community Strategy (SCS) and identifying cross thematic priorities across the County Durham Partnership (CDP).

Background

2. The SCS, as agreed by all partners through the CDP and by the Council at the Full Council meeting on 24th March 2010, is the overarching strategic plan for the county and is a 20 year document that should be reviewed every three years. The extent of recent changes has increased the significance of this.

Approach

3. All partners recognise that it is important to have an SCS as it is the single strategic plan for the county that shows how all partners across the County are working towards shared priorities and how this will make a difference.

4. The CDP Board held their annual away day in September 2012 and re-affirmed the Altogether Better Durham vision and the five priority themes as the right framework on which to build going forward. The Board also agreed the key areas to be covered by the new document. Following the away day, an initial timeline was developed, agreed and aligned to thematic partnership reviews. A presentation was given to all five thematic partnerships where each agreed an appropriate way forward and nominated an officer to liaise with the CDP team to progress this.

5. It was acknowledged that the proposed approach should take into account the timings of the proposed thematic reviews. Other important issues to consider were the election of the Police and Crime Commissioner and the health reforms, particularly the establishment of the Joint Health and Wellbeing Strategy. Also, new and emerging data available following the Census 2011 will be released at various intervals throughout the year. The Local Elections that took place in May 2013 were also an important factor as engagement of Elected Members is important to this process.

6. Since the SCS 2010-2030 was agreed in 2010 the landscape has changed significantly. The General Election in May 2010 saw immediate implications for the County Durham Partnership and all partner organisations but this was only the start of the changes. Significant reduction in resources has meant changes to services which have then had, and continue to have, a collective impact on local communities. These have been further compounded by the wider economic situation.

Thematic Partnerships

7. At a thematic level, since 2010 there have been changes to some thematic priorities (SCS high level objectives). Changes to the overarching objectives for Altogether Healthier are shown below:

Altogether Healthier

Health and Wellbeing Partnership Plan/SCS 2010	**Joint Health and Wellbeing Strategy 2013/17**
Improve life expectancy	Children and young people make healthy choices and have the best start in life
Reduce health inequalities	Reduce health inequalities and early deaths
Improve mental health and wellbeing of the population	Improve the quality of life, independence and care and support for people with long term conditions
	Improve mental health and wellbeing of the population
	Protect vulnerable people from harm
	Support people to die in the place of their choice with the care and support they need

8. Where priorities have changed for other thematic partnerships, such as the Safe Durham Partnership, these will be reflected in the Sustainable Communities Strategy.

9. It is important that the SCS has a consistent whole strategy approach and is not simply a repeat of the five separate thematic strategies. In doing this there are some issues that will need to be addressed by thematic partnerships, for example, it is important for thematic partnerships to see where their objectives fit with the work of others, not only for cross thematic working but also in light of the collective impact of reductions or changes to services.

10. Other issues will also need to be addressed, for example, there appears to be a disproportionality of objectives across the five thematic areas and an inconsistent presentation of the importance given to addressing inequalities. These types of issues need to be considered so that a consistent way forward can be agreed for the SCS.

11. These are the types of issues that will be discussed with thematic partnerships over the next few months to enable the first draft of the SCS to be completed and discussed with partnerships.

New features of the SCS

12. In addition to the changing landscape and the five priority themes there are a number of new sections of the SCS that will show how the partnership is maturing and bringing greater benefits. The added value of the wider networks with the Voluntary and Community Sector, Local Councils, Faith communities and the Armed Forces will be a key part of the renewed document. Also, building on the strengths within local communities (an asset based approach) is something that, moving forward, will become more important as all partners look to realise efficiencies.

13. It was recognised, following discussions during the development of the Joint Health and Wellbeing Strategy (JHWS), that the social determinants of health need to be the responsibility of all parts of the CDP in order to address them properly.

14. Public Health colleagues are currently identifying any cross thematic priorities where there is an impact on the social determinants of health. As part of this a gap analysis is being undertaken in the form of a thematic mapping exercise with the purpose of beginning dialogue and debate around potential crossovers and areas for joint work based on good practice.

15. Following discussions at the County Durham Partnership Board on locality arrangements and how we look at key issues within the County at a sub county level through census data and other statistical analysis, five sub county geographies have been determined and agreed for use in the SCS. This has led to a new piece of work being developed that will offer a sub county view on what life is like within the county, at the five agreed geographies, and will give all partners the option to shape and target their work differently. This new Strategic Partnership Analysis will be a new feature in the SCS.

Next steps

16. A detailed project plan is being developed and will be shared with all thematic partnerships within the next two weeks.

17. In order to be able to develop CDP priorities that will make up the SCS Action Plan moving forward, work will be carried out with the thematic partnerships in order to be able to focus on the priorities and outcomes that will have the biggest impact.

18. The H&WB, along with all thematic partnerships, is key to developing these priorities and outcomes and optimising the opportunity offered through the renewal of the SCS.

Recommendations and reasons

19. The H&WB is asked to

- Agree the approach for the review of the SCS
- Agree to receive further updates as appropriate.

Contact: Clare Marshall, Principal Partnerships and Local Councils Officer Tel: 03000 263591
Graeme Grieg, Senior Public Health Specialist Tel: 03000 267382

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - The actions set out in this report aim to ensure equality and diversity issues are embedded within the working practices of the CDP.

Accommodation - None

Crime and Disorder - Altogether safer is the responsibility of the Safe Durham Partnership.

Human Rights - None

Consultation - The County Durham Partnership framework is a key community engagement and consultation function of the Council and its partners. The recommendations in the report are based on extensive consultation with AAP partners and the establishment of a Sound Board to progress the recommendations and will continue this consultative approach.

Procurement - None

Disability Issues - None

Legal Implications - None

County Durham Health and Wellbeing Board

21st June 2013

Alcohol Harm Reduction Strategy 2012 - 15

Report of Claire Sullivan, Consultant in Public Health, Children and Adults Services, Durham County Council

1. Purpose of the report

The purpose of this report is to provide the Health and Wellbeing Board with an update on the Alcohol Harm Reduction Strategy 2012-15. This report details the strategic aim and objectives within the strategy and the plans for 2013/14.

2. Background

The Safe Durham Partnership launched its first three year Alcohol Harm Reduction Action Plan in July 2009. Since this date, the Alcohol Harm Reduction group and its three thematic sub groups (Prevention, Treatment and Control) have developed, implemented and monitored the action plans.

The overarching vision for the County Durham Alcohol Harm Reduction Strategy is:

"T*o reduce the harm caused by alcohol to individuals, families and communities in County Durham while ensuring that people are able to enjoy alcohol responsibly."*

Following a stakeholder event in May 2012 and subsequent consultation the Strategy was launched in November 2012, during Alcohol Awareness Week.

3. The Strategy

In order to achieve the vision we have set eight key objectives under three themes:

Prevention

1 To use targeted approaches to raise public awareness in County Durham of the harm caused by alcohol by promoting consistent messages about drinking.

2 Provide specific targeted training and education to support individuals, professionals, communities and local businesses to address the harm caused by alcohol.

3 Engage with children and young people to develop age and gender specific information, activities, services and education to prevent alcohol related harm.

Control

4 Increase the gathering, sharing and use of intelligence to reduce the number of alcohol related incidents impacting upon communities.

5 Engage with licensees and target licensed premised where necessary to ensure that licensed premises are managed responsibly.

6 Ensure a coordinated approach to policy development, planning and adoption of legislation.

Treatment for recovery

7 Commission and deliver effective treatment and recovery services in line with national guidance and undertake work to identify the needs of particular groups where the data is limited e.g. pregnant women.

8 Involve and support young people, families and carers (including young carers) living with alcohol related issues in order to break the cycle of alcohol misuse.

The Executive Summary of the Strategy is available to view at Appendix 2. Comprehensive action plans underpin the strategy and ensure that the strategic vision is translated into operational delivery.

The Strategy is also aligned to the Joint Health and Wellbeing Strategy 2013-17 which makes specific reference to alcohol.

4. Priorities for 2013/14

Recognising that the strategy is a three year strategy the Alcohol Harm Reduction Group has identified priority group/actions for 2013-14; these include:

- Males age 25-44
- Pregnant Women
- Older people

- Young people in transition
- Dual diagnosis
- Children and families – proxy sales/provision of alcohol and out of sight drinking
- Licensing including Cumulative Impact Assessment, DCC Licensing Policy review, introduction of EMROs/Late Night Levy's

As a result of the identified priorities, the Alcohol Harm Reduction Group has re-structured and is changing the way it delivers on the strategy. The Group has adopted a task and finish approach based on the priorities rather than the prevention, treatment and control themes.

5. Recommendations

The Health and Wellbeing Board are recommended to:

- note the contents of this report
- receive updates on the implementation of the Alcohol Harm Reduction Strategy in the future.

Contact:	**Kirsty Wilkinson, Alcohol Harm Reduction Coordinator**
Tel:	**03000 265 445**

Background papers: Alcohol Harm Reduction Strategy 2012-15 Executive Summary

Appendix 1: Implications

Finance
An Action Plan has been developed to support the delivery of the Alcohol Harm Reduction Strategy. The alcohol prevention budget allocated by the former Health and Wellbeing Partnership is no longer available to help with the implementation of the strategy. Funding will be required for implementing any social marketing particularly in relation to the 25-44 year old males priority.

Staffing
The Plan will be implemented using existing resources.

Risk
No adverse implications.

Equality and Diversity
An impact assessment has been undertaken on the Alcohol Harm Reduction Strategy 2012-15.

Accommodation
No adverse implications.

Crime and disorder
The Alcohol Harm Reduction Strategy 2012-15 Control objectives outline the priorities for tackling alcohol related crime and disorder in County Durham.

Human rights
No adverse implications.

Consultation
Statutory consultation with the community and stakeholders was been undertaken as part of the plan's refresh.

Procurement
No adverse implications.

Disability Discrimination Act
No direct adverse implications.

Legal Implications
No implications.

Appendix 2

The Safe Durham Partnership

Altogether safer

Alcohol Harm Reduction Strategy

2012-2015

Executive Summary

Vision

Our overall vision for this strategy is:

To reduce the harm caused by alcohol to individuals, families and communities in County Durham while ensuring that people are able to enjoy alcohol responsibly.

Key Objectives

In order to achieve the vision we have set eight key objectives under three themes.

Prevention

1. To use targeted approaches to raise public awareness in County Durham of the harm caused by alcohol by promoting consistent messages about drinking.
2. Provide specific targeted training and education to support individuals, professionals, communities and local businesses to address the harm caused by alcohol.
3. Engage with children and young people to develop age and gender specific information, activities, services and education to prevent alcohol related harm.

Control

4. Increase the gathering, sharing and use of intelligence to reduce the number of alcohol related incidents and alcohol related offending impacting upon communities.
5. Engage with licensees and target licensed premised where necessary to ensure that licensed premises are managed responsibly.
6. Ensure a coordinated approach to policy development, planning and adoption of legislation.

Recovery Treatment

7. Commission and deliver effective treatment and recovery services in line with national guidance and undertake work to identify the needs of particular groups where the data is limited e.g. pregnant women.
8. Involve and support young people, families and carers (including young carers) living with alcohol related issues in order to break the cycle of alcohol misuse.

Alcohol Profile in County Durham

The Cost of Alcohol Harm in County Durham *(Source: Balance)*
Nationally alcohol misuse is estimated to cost society around £22.1 billion per year. The estimated cost in County Durham is £189.73million with a cost per

head of population at £371. This is broken down to NHS £48.94m, Crime £59.63m, workplace £63.61m and Social Services £17.55m.

Prevalence of Alcohol Harm in County Durham

County Durham has high levels of hazardous, harmful and binge drinking. Hospital admission rates as a result of alcohol has been rising steadily, however the rate of the increase is starting to slow down. Hospital admission rates as a result of alcohol are significantly higher for both males and females compared to the rate for England but are not as high as the regional average. Alcohol misuse is greater among men than women. County Durham also has one of the highest rates of alcohol specific hospital admission for young people under the age of 18 years nationally; the rank for County Durham is 315/326 Local Authorities. The mortality rate, as a result of alcohol in County Durham is not significantly different to England or the North East.

Alcohol related crime has risen slightly from 8.5% in 2010/11 to 9.5% in 2011/12. Alcohol related anti-social behaviour (ASB) reported to Durham Constabulary accounted for approximately 16% of all recorded anti-social behaviour in the last 3 years. The number of ASB incidents is reducing but the percentage of alcohol related ASB is increasing. Recent perception data captured via the Police Confidence Survey shows that 15.4% of residents in County Durham perceive drunk rowdy behaviour as a problem.

Some of the social Impacts of alcohol include poor parenting, family breakdown, domestic abuse and worklessness. Alcohol also continues to have strong links with sexual violence, drink driving and road traffic accidents

Particular priority groups include:

Older people, children and young people, some ethnic groups, veterans, lesbian, gay, bisexual and trans communities (LGBT), homeless, those with dual diagnosis together with substance misuse or mental health problems, pregnant women and offenders.

Examples of Achievements from 2009-12 include:

- 3591 frontline staff trained in alcohol screening and delivery of brief advice.
- a social marketing plan was developed to target specific segments of society. For example a campaign was targeted at females aged 25-44 years concerned with weight and calories in relation to alcohol.
- the development of a Fire Death Protocol resulted in the Community Alcohol Service referring direct to the Fire & Rescue Service
- 88% of GP practices within County Durham participated in the Locally Enhanced Service. Since 2008/9 GP's have screened 26507 patients and delivered 2911 brief interventions.
- a referral pathway for any young people admitted to hospital or attending A&E due to alcohol has been developed with the County Durham and Darlington Foundation Trust.

- the Community Alcohol Service (CAS) has been reviewed to ensure it is working effectively, meeting the needs identified within the Alcohol Health Needs Assessment and able to respond to the national recovery agenda. Since the launch of the last strategy in 2009, 1478 adults have successfully completed treatment.
- Durham Recovery and Wellbeing Centre (DRAW) opened in September 2011. It promotes wellbeing and supports people to stay in recovery; the centre offers a community drop in facility that promotes mutual aid and further development of the new social networks.
- an Alcohol Treatment Scheme was implemented for those subject to Alcohol Treatment Requirement Orders. The aim is to divert people from custody to an alcohol structured programme delivered jointly by Durham Tees Valley Probation Trust and NECA. This scheme received national recognition from the Butler Trust.
- the Alcohol Education team in HMP Durham and HMP Low Newton offers alcohol specific information on risks to health, offending and family issues.
- a Community Alcohol Partnership (CAP) is currently being piloted in the Stanley area. It tackles harm caused by alcohol through joint working between alcohol retailers, local stakeholders, such as trading standards, police, local authority licensing teams, schools and health networks.
- alcohol arrest referral work has been running as a pilot in County Durham for those who have been arrested as a result of alcohol.
- there is a new co-located Alcohol Harm Reduction Unit (comprising of Trading Standards, Durham County Council, Police Licensing and Environmental Health). It will share intelligence to reduce the harms caused by alcohol.
- Best Bar None is a national award scheme aimed at reducing alcohol related crime and disorder in a town centre by building positive relationships across the licensed trade, police and local authorities.
- Drink Driving leaflets have been developed by the partnership and distributed throughout the Christmas period by Traffic Police to individuals found to be below the legal limit but still with alcohol in their system.
- Operation StaySafe has operated across the County by Neighbourhood Policing Teams together with Partners. These operations are used to target young people who may be vulnerable due to taking alcohol / drugs. A young person is taken to a place of safety and their parent/carer is contacted to collect them, they also receive brief intervention advice from 4Real- the Young Persons' Drug and Alcohol Service.
- in December 2011 a campaign was launched across the County to highlight the impact that one drunken punch can have on both the victim and offender. 'Punched Out Cold' was launched in Bishop Auckland in the lead up to Christmas and was expanded to cover the rest of County Durham in early 2012.

Future plans include:

- utilise social marketing techniques to raise awareness about the harms of alcohol and instigate behaviour change amongst priority groups

- support the 3 Towns Area Action Partnership (rural communities) to implement the community action plan to address anti-social behaviour linked to underage drinking funded nationally by Baroness Newlove
- work with Durham's Local Safeguarding Children's Board to deliver work on the relationship between alcohol and sexual exploitation
- implement a social norms approach to change perceptions and behaviour related to alcohol and reduce demand for alcohol amongst children and young people
- work with schools and families to promote awareness of the risks associated with alcohol use by young people
- support Health Networks and the Voluntary and Community Sector to implement local alcohol related activities
- ensure that activities for young people are developed and/or sustained to divert young people from drinking alcohol
- develop plans to address the issue of proxy sales based on local research
- support workplaces to address alcohol use amongst their workforce
- improve the quality of data capture to understand the full impact of alcohol on anti-social behaviour, crime, offending and re-offending, including in accident and emergency settings
- use intelligence led approaches to inform effective multi-agency based problem solving around people, premises and places
- make effective and appropriate use of enforcement powers
- carry out a co-ordinated and targeted approach to the "policing" of the night time economy
- improve the flow of intelligence between treatment services and the Alcohol Harm Reduction Unit
- Commission an alcohol diversion scheme for binge drinkers who are arrested with an eligible alcohol related offence
- continue to develop Best Bar None
- support the Police to implement their action plan on alcohol to improve Durham Constabulary's response to alcohol related crimes and incidents including the development of alcohol champions across the Constabulary and acting as a national pilot for the development of alcohol tactical advisors
- further develop the understanding on the links between alcohol and child sexual exploitation
- ensure that we target premises where irresponsible drinks promotions are taking place
- develop a multi-agency policy and operating procedures for dealing with under 18 events in licensed premises
- manage process required to implement new legislation including Early Morning Restriction Orders, the Late Night Levy and cumulative impact policies
- Work with the Police and Crime Commissioner to ensure that funding is allocated to reduce alcohol related crime and anti-social behaviour
- target service development towards priority groups to improve access to treatment including males within the 25-44 age group

- undertake further work to understand alcohol misuse in particular groups such as older people, gypsies and travellers, homeless, pregnant women, those with dual diagnosis, LGBT and veterans
- improve the quality of data recording in all settings including the recording of attendances for alcohol misuse in accident and emergency departments
- increase the number of adults and young people accessing and successfully completing treatment
- ensure a seamless transfer of the commissioning of alcohol services into Durham County Council and seize opportunities for alignment with drugs services
- listen to the views of users and carers to continually improve the quality of services
- support County Durham and Darlington Foundation Trust to implement the hospital based alcohol action plan
- evaluate projects including alcohol screening and delivery of brief advice in primary care and pharmacy settings and the Durham Recovery and Wellbeing Centre (DRAW)
- work with Clinical Commissioning Groups to raise the profile of alcohol and provide increased support for those individuals who are repeatedly admitted to hospital as a result of alcohol
- Further develop the work on recovery including recruiting, training and supporting peer mentors
- undertake work to understand the transition of young people to adult treatment services

Governance and Performance Management Framework

The performance management framework aligns to the priorities identified by the Safe Durham Partnership. Each of the priorities is supported by a thematic group with responsibility for delivering improvements. The Alcohol Harm Reduction (AHR) group is a sub group of the Safe Durham Partnership. It also reports on a six monthly basis to the Children and Families Trust and progress of the strategy will also be reported to the Health and Wellbeing Board.

The Alcohol Harm Reduction Group considers a quarterly performance report which contains a range of indicators. The Alcohol Harm Reduction Group maintains an action plan appropriate to the issues raised from the performance report. Any key issues are escalated to the Safe Durham Partnership Board. Further information is provided within the alcohol harm reduction performance framework and actions plan which is available separately.

Health and Wellbeing Board

21st June 2013

Securing Quality In Health Services

Report of Rosemary Granger, Project Director, Securing Quality in Health Services, Darlington Clinical Commissioning Group

Purpose of Report

1. The purpose of this report is to update the Health and Wellbeing Board on the Acute Services Quality Legacy Project. (ASQL)

Background

2. In September 2012, County Durham Shadow Health and Wellbeing Board received a report and presentation on the Acute Services Quality Legacy Project. The project was part of the process for Primary Care Trusts to transfer commissioning responsibility to Clinical Commissioning Groups (CCGs) and it covered the PCT clusters across County Durham and Darlington and Tees Valley.

3. The overall objective of the project was to enhance the commissioning of acute hospital services by reaching consensus on the key clinical quality standards in acute hospital care that should be commissioned by CCGs. The project aimed to produce a report that would describe the agreed clinical quality standards in the context of the financial and workforce resources that are expected to be available to support implementation of the standards.

4. The project report was received at the final meetings of the PCT clusters in March 2013.

Acute Services Quality Legacy Project - Final Report - Summary of key messages and recommendations

5. Both commissioners and providers of acute services face a similar set of challenges over the next five to ten years. Our population will be older, with more long term conditions being treated by a state funded NHS that is ultimately tied to the performance of the national economy. These services will also be operating as part of a wider system with social care which itself faces significant challenges related to national financial constraints.

6. We are fortunate however to start from a strong starting position. Our current main providers consistently deliver high quality services, meet national performance targets related to waiting times and cleanliness and operating efficiently within their means. Having said that, we know that we can do better. In this process we have looked to our clinical community to define what the best possible care should look like in our hospitals and begin to outline the next steps of how we should go about delivering them, given the likely financial future and the workforce that will be available to us.

7. The findings and recommendations set out in the report have implications that range from potential changes to be made to provider contracts through incorporating the agreed clinical quality standards, to potential service reconfiguration across County Durham and Tees Valley.

Key Messages from ASQL Project

8. The main key messages are as follows:

- Following years of growth, demand for acute services is currently high for both elective and non-elective care.

- There will be a significant increase in prevalence across the major long term conditions over the next ten years and a greater proportion of the population will be over the age of 65.

- This will have an impact on the utilisation of acute services to a varying degree in the different service areas.

- This growth will put pressure on commissioners' allocations over the next ten years as an older population with more co-morbidity will consume more health resource, unless effective demand and long term condition management are implemented. This analysis does not take into account potential increased spend on high cost drugs and new medical technologies in the acute setting that may require further investment from commissioners.

- Forecasts show that providers can maintain a financially stable position over the next five years as long as cost improvement plans deliver to target. Failure to deliver these targets will have implications for Trusts' operating surplus/deficit position and ultimately the length of time they can rely on cash savings to keep them solvent.

- This means that new funding is unlikely to be available to expand the access to services of the very highest quality as providers look to maintain the current levels of quality within the resources they have access to.

- Even if commissioners were to receive increases to their allocations and providers had efficiency requirements at pre-Comprehensive Spending

Review levels, national and regional workforce constraints may have more impact on the ability to deliver higher quality standards.

- These national and regional workforce considerations are further compounded by supply and demand of particular grades and skills of the current and future workforce within the acute sector in County Durham, Darlington and Tees.

Recommendations from ASQL Project

9. The overall recommendations for the ASQL project board from key clinical areas are set out below. These recommendations were identified in the context of the wider financial and workforce contexts, the underlying health data, views of the clinical advisory groups and the specific workforce risks and opportunities

Acute Paediatrics, Maternity and Neonatal Services

10. Endorse the Royal College of Obstetricians and Gynaecologists (RCOG) standard of 168 hours (24/7) consultant presence as the ultimate goal for maternity services across County Durham Darlington and Tees. This standard was supported by the majority of the Clinical Advisory Group (CAG) but there was a minority view that 98 hours consultant presence should be established as the standard for units with less than 4000 deliveries a year. The Project could not find enough evidence to inform a recommendation that goes against the Royal College standard, therefore the Project supports the RCOG standard and majority view of the CAG. Given the scale of this challenge however, there is a recognition that this needs to be delivered in a staged way, with 98 hours as an interim step for units with less than 4000 deliveries a year as part of a phased approach to implementation.

11. Endorse the key quality standard of 1:1 Midwife care for women in established labour.

12. Ask Clinical Commissioning Groups to consider the steps they may take in the next contracting round to address some of the gaps in quality standards through the use of CQUIN incentives and agreeing small scale service improvement work with individual trusts.

13. Agree to a further feasibility analysis to understand the implications of implementing the standards across County Durham, Darlington and Tees. This assessment should take into account the role of Midwife Led Units and how best to support an increase in home-births.

14. Agree to inform the LETB – Local Education and Training Board to adjust commissioning plans to increase the numbers of midwife training places to mitigate against risks in future workforce shortages.

Acute Care

15. Endorse the key quality standards recommended by the CAG as those that define high quality care, for example: Emergency admissions seen and assessed by a relevant consultant within 4 hours (in hours) and 12 hours (out of hours); Emergencies to have access to key diagnostics 24/7: for critical cases – imaging and reporting within 1hour of request, for non-critical cases – imaging and reporting within 12 hours of request.

16. Endorse the recommendation for acute trusts to collaborate in establishing an interventional radiology service available 24/7.

17. Agree that the critical care element of the Acute Care CAG continue until final recommendations can be made.

End of Life Care

18. Endorse the key quality standards recommended by the CAG as those that define high quality care, particularly those that relate to the 24/7 availability of an appropriately trained nurse to provide practical support, responding within one hour, with access to necessary medicines and home equipment for End of Life cases. In addition the CAG recommends the appropriate use of the Liverpool Care Pathway in all care settings including the sharing of results

19. Endorse the recommendation for collaboration across the acute trusts to establish a 7 day per week service providing specialist palliative care advice.

Long Term Conditions

The overall recommendations of the Acute Services Quality Legacy Project in relation to long term conditions are as follows:

20. Given the scale of the likely challenge ahead due to the ageing population, the rising prevalence of LTCs and the wider membership of organisations involved, a new project focusing on LTC management should be initiated across health and social care. This project should include community services, mental health and primary care providers as well as acute trusts.

21. The project will add value to the existing work on long term conditions led by CCGs, by establishing a consensus on the scale of intervention needed and the quality standards to be achieved.

22. Further work in this area would include more detailed work on the financial and workforce challenges to provide a better understanding of the required scale of transformation and the development of concrete plans to achieve this, learning from success locally, regionally and nationally.

Planned Care

The overall recommendations of the Acute Services Quality Legacy Project in relation to planned care are as follows:

23. CCGs should review the Planned Care Briefing Paper to identify and continue to understand unexplained variations in referrals from Primary Care and clinical practice in secondary care

24. Where appropriate CCGs should look to use information to inform patient choice and commissioning levers to encourage competition to drive quality in Planned Care. This includes the introduction of new providers into the market to stimulate innovation

25. CCGs should however consider the financial implications for current providers that any movement of activity away from them may have (either to other current or new providers) when making changes to elective pathways.

Next steps

26. CCGs have agreed to build on this legacy work and will take this work forward in line with the duty placed upon them to commission high quality sustainable services. It has been agreed that this work will continue to be a commissioning led process and as such, Darlington CCG will lead the work on behalf of the six CCGs across County Durham, Darlington, Tees and Hambleton, Richmondshire and Whitby(the latter CCG is involved due to the scale of their patient flows into the Tees Valley area). The project will also feed into, and be supported by, the work of the Area Team of NHS England.

27. The objectives for the next phase of work which is expected to be complete by the end of the summer 2013, are to assess the feasibility of, and options for, implementing the standards and progressing implementation.

Recommendations

28. It is recommended that the Health and Wellbeing Board:
    - Accept this report for information
    - Agree that further reports will be submitted to the Health and Wellbeing Board as the project progresses.

Contacts: Rosemary Granger, Project Director, Securing Quality in Health Services Darlington Clinical Commissioning Group.
rosemary.granger@nhs.net

Background Papers:
County Durham and Tees Valley Acute Services Quality Legacy Project –Final Report

Appendix 1 - Implications

Finance – There are no funding or financial implications at this time of Securing Quality in Health Services

Staffing – There are no staffing implications of Securing Quality in Health Services

Risk – There are no risks attached to Securing Quality in Health Services at this time

Equality and Diversity / Public Sector Equality Duty – Under provisions in the Health and Social Care Act, the Clinical Commissioning Groups will have a duty to reduce health inequalities and assess the impact of any potential service changes for protected groups.

Accommodation – There are no accommodation implications that need to be considered

Crime and Disorder – N/A

Human Rights – There are no direct implications.

Consultation – If the outcome of the feasibility analysis of the implications of implementing the standards leads to a decision by the CCGs to reconfigure services consultation with the public, staff, and Elected Members will be undertaken

Procurement – There are no direct implications

Disability Discrimination Act – There are no direct implications at this time

Legal Implications – There are no direct implications

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Health and Wellbeing Board

21st June 2013

Monitoring Provider Quality in the NHS

Report of Dr Dinah Roy, Director of Clinical Quality and Primary Care Development, Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Dr Ian Davidson, Director of Quality and Safety, North Durham Clinical Commissioning Group

Dr Mike Guy, Medical Director, NHS England, Darlington and Tees Area Team

Purpose of the Report

1. To provide the Health and Wellbeing Board with an overview on how the new NHS architecture supports the monitoring of provider quality.

Background

2. Quality is systemic; a patient's journey often cuts across primary and secondary care, health and social care, and involves multiple professionals. It is a collective endeavour that requires collective effort and collaboration at every level of the system in order to safeguard patients and drive continuous quality improvement.

3. The appalling failures at Mid Staffordshire NHS Foundation Trust and at independent hospital, Winterbourne View, provide stark reminders that when the NHS fails in its responsibilities in respect of quality that the consequences for patients, service users and their families can be catastrophic. As a result of these failings the NHS has organised itself around a single definition of quality; care that is effective, safe and provides as positive an experience as possible.

4. This simple yet powerful definition is now enshrined in legislation and is embedded within the NHS Outcomes Framework.

5. The NHS Outcomes Framework sets out the national outcomes that all providers of NHS funded care should be contributing towards. The framework builds on the definition of quality through five overarching domains which capture what the NHS should be striving to achieve for patients. It is a catalyst for driving quality improvement.

6. The fundamental culture change that is required is not just across health but also the social care economy. The second Francis report (Mid Staffordshire NHS Foundation Trust) highlights that excellence should be at the heart of all actions taken. The report proposes the following 5 point plan to revolutionise the care that people receive from the NHS with the aim of:

7. **Preventing problems:** by creating a culture of compassion and caring and embedding a safety culture. A Chief Inspector of Hospitals will be appointed to drive change through fundamental standards and national ratings. The measures such as radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the action needed to revitalise the culture of the NHS around a consistent focus on the needs of the patients.

8. **Detecting problems quickly:** through the availability of timely and accurate information, publication of speciality outcomes, expert inspections and penalties for disinformation. There will be a statutory duty of candour on providers to inform people if they believe treatment of care has caused death or serious injury. There will be a new Chief Inspector of Social Care who will be charged with rating care homes and other local care services, promoting excellence and identifying problems. A review of best practice on complaints will ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement.

9. **Taking action promptly:** with simpler fundamental standards which make explicit the basic standards beneath which care should never fall. Commissioners will have oversight of improvement regimes and there will be a failure regime if no improvement is seen. A methodology will be developed for assessing hospital to ensure a single set of expectations on hospitals of what is required of them.

10. **Ensuring robust accountability:** by introducing clarity of responsibility, criminal sanctions, implementation of faster professional regulation and the introduction of a national barring list for unfit managers.

11. **Ensuring staff are trained and motivated:** by exploring introduction of requirement to have HCA training before nursing and other qualifications and a code of conduct and minimum training for HCAs. A nursing revalidation will be introduced to ensure all practising nurses are up to date and fit to practise. The Chief Inspector of Hospitals will assure, as part of inspections, that all hospitals are meeting their legal obligations to ensure that unsuitable healthcare assistants are barred from future patient care by properly and consistently applying the Home Office's barring

regime. The NHS leadership academy role will be expanded to attract professional and external leaders to senior management roles.

12. All NHS Foundation Trust members of the Health and Wellbeing Board, have ensured that reports have been presented to their Board meetings in relation to outlining their response to the Francis Inquiry and detailed action plans have been developed.

13. In addition, NHS Foundation Trusts as providers of services are also required to publish an annual 'Quality Account' to report their performance on the quality of care and services they provide, this is a useful tool for commissioners as it highlights the key areas that providers will focus on and outlines their commitment to some key quality improvements.

14. Both CCGs are also statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect.

15. North Durham and DDES CCGs are members of the Local Safeguarding Children Board (LSCB) and local Safeguarding Adults Board (SAB), working in partnership with the local authority and the Health and Wellbeing Board to ensure that safeguarding responsibilities are met and that robust processes are in place. NDCCG host both the safeguarding adult and children CCG teams, managed through a memorandum of understanding, to ensure they each meet their statutory requirements.

16. The 'Monitoring of Quality' is also supported by the introduction of HealthWatch whose role ensures that the CCGs and partner organisation are made aware of the views and concerns that patients have about their local health and social care services, in order that improvements to services can be made if so required.

Next Steps

17. The Health and Wellbeing Board are requested to note the following as part of this process:

    - All NHS organisations are required to implement the recommendations of the Francis 2 report
    - All NHS hospital trusts are required to set out how they intend to respond to the Inquiry
    - An annual progress report will be produced by the government
    - Locally the oversight of quality to be coordinated by Quality Surveillance Groups hosted and coordinated by NHS England Area Teams and on which the CQC will have an increasingly prominent role

- CCG quality teams to be fundamental in the local determination and assessment of quality

18. Appendix 2 provides further detail into how Clinical Commissioning Groups in County Durham, as commissioners of services, are monitoring providers to ensure that care is safe and effective and that patients receive a positive experience during their episode of care.

Recommendations

19. The Health and Wellbeing Board is recommended to:

- accept this report for information.

Contact: Dr Dinah Roy, Director of Clinical Quality and Primary Care Development, Durham Dales, Easington and Sedgefield Clinical Commissioning Group, dinahroy.ddes@nhs.net and Dr Ian Davidson, Director of Safety and Quality, North Durham Clinical Commissioning Group CCG, iandavidson2@nhs.net.

Appendix 1: Implications

Finance: Not applicable

Staffing: CCGs have identified staff to monitor and take forward the quality agenda with support from the local commissioning support unit.

Risk: Failure to have effective quality monitoring systems in place may compromise patient safety and the effectiveness of the services being delivered.

Equality and Diversity / Public Sector Equality Duty: There are no implications to equality and diversity

Accommodation: This report has no implications on accommodation.

Crime and Disorder: Not applicable

Human Rights: This report has no implications on human rights.

Consultation: Public and patient engagement and wider stakeholder feedback is part of this process.

Procurement: Not applicable

Disability Issues: Not applicable

Durham Dales, Easington and Sedgefield Clinical Commissioning Group — NHS

North Durham Clinical Commissioning Group — NHS

Monitoring Provider Quality in the NHS

1.0 Introduction

A single definition of quality for the NHS was first set out in 'High Quality Care for All' in 2008, following the NHS Next Stage Review led by Lord Darzi. It set out three three dimensions to quality, all three of which must be present in order to provide a high quality service:

- Clinical effectiveness : quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
- Safety: quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and
- Patient experience: quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

2.0 Francis 2

In February 2013, the second Francis Report was published on the subject of the catastrophic failure of care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report presents a picture of profound systemic failure at Mid Staffordshire Hospital: failure that produced, above all, appalling care for patients and service users, but that also represented a wholesale failure of 'checks and balances' within the NHS and wider care system and questioned the NHS approach to Quality.

In the words of Francis a 'fundamental culture change is required, one "that will put patients where they are entitled to be - the first and foremost consideration of the system and everyone that works in it." The NHS has been absorbing and acting on the failures:

- a culture which focused on the system, and not on the patient;

- a culture which preferred to focus on positive information about services not that which perhaps would have highlighted problems;
- the methods utilised to measure compliance and service provision failed to focus on the experience of patients;
- high tolerance of poor standards and risks to patients;
- failure of communication between and within organisations;
- assumptions that monitoring, performance management and intervention were the responsibility of someone else;
- a failure to tackle the imperative and challenges of building a positive clinical culture;
- a failure to acknowledge and mitigate the risks of multi-level reorganisations, and the impact on services.

This fundamental culture change that is required is not just across health but also the social care economy. The report's recommendations provided a framework that supports the NHS and stakeholders in promoting a culture that puts patients, and quality of care, first.

As a result NHS England, Durham Dales Easington and Sedgefield clinical commissioning group (DDES CCG) and North Durham CCG (NDCCG) have established a number of quality systems and processes that are open, transparent, accountable, and in which fundamental standards of care are understood and upheld. However in order for these systems to be effective and sustainable they need to be monitored.

3.0 CCG approach to Quality

Strategically both DDES CCG and North Durham CCG have a shared objective; that of ensuring patients have access to high quality clinical care, delivered in a timely and effective way. Assurances are sought from providers to ensure that they place quality at the heart of their systems and processes to support patient and public engagement, enable clinical leadership and focus, promote equality and diversity and reduce inequality.

The CCGs have put in place a Clinical Quality Strategy, supported by a quality framework that ensures systems and processes are in place across the CCGs to monitor, maintain, improve and safeguard the quality of care commissioned and that this is encouraged and supported by all members of the CCGs. The strategy outlines clear lines of responsibility and accountability for the overall delivery of the quality of clinical care, and supports a comprehensive programme of quality improvement activity across the CCG.

As DDES CCG and ND CCG commission a significant volume of care from the same providers a collaborative arrangement has been put into place

(along with Darlington CCG), to enable and support the monitoring of the quality of services. This arrangement is effectively supported by a joint Quality Forum, held monthly to assist with the combined monitoring arrangements, sharing of hot spots and perceived risks and to avoid unnecessary duplication.

Across DDES CCG and ND CCG clinical leadership has firmly been embedded within the quality governance structure. In order to ensure that clinical quality and accountability is clearly understood CCG wide clinical quality groups have been established. In DDES CCG this is known as the clinical quality working group (CQWG), in NDCCG, it is entitled the quality research and innovation sub-committee (QRI). Both meetings are held monthly and bring together key representatives of the health and social care economy to discuss pertinent quality issues across the CCGs and commissioned providers, and also retain a focus on improving quality in primary care.

Due to the geographical localities within DDES CCG, locality clinical quality meetings are held bi-monthly and are steered by GP locality quality leads. These groups are pivotal to DDES CCG in monitoring what is happening in commissioned services as GP practices are very much the “eyes and ears” of the system. Meetings promote the need to report incidents and soft intelligence and to share good practice, ideas and innovations.
In ND CCG a similar role is carried out by the GP Constituency Leads who attend the QRI Meetings and report back to and accumulate quality ‘intelligence’ from their local general practices.

Both CCGs are also statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect.

North Durham and DDES CCGs are members of the Local Safeguarding Children Board (LSCB) and local Safeguarding Adults Board (SAB), working in partnership with the local authority and the Health and Wellbeing Board to ensure that safeguarding responsibilities are met and that robust processes are in place. NDCCG host both the safeguarding adult and children teams, managed through a memorandum of understanding, to ensure they each meet their statutory requirements.

The CCGs have purchased elements of commissioning support, from the North of England Commissioning Support Unit (NECS). Through a service level agreement, NECS provide a support service for the CCGs in the area of quality and facilitate efficient working on the development, maintenance and monitoring of clinical quality systems and processes.

4.0 Monitoring Quality

Overall the monitoring of quality is achieved through a variety of means; contracts, reports, commissioner assurance visits and investigations, audit and self assessments all of which are reviewed carefully through the Clinical Quality Review Group (CQRGs) meetings.

The CQRG meetings are held bi-monthly for both the local acute and mental health trusts. For independent providers a combined Quality / Contract meeting is held based on the aims and objectives of the quality review groups.

The CCGs have very recently established a similar CQRG for the North East Ambulance Service, which includes 111 services, in collaboration with other CCGs in the region.

CQRGs are pivotal to the monitoring processes for providers, their purpose is to:

- Monitor and seek assurances regarding the safety, patient experience and clinical effectiveness of services provided.
- Monitor and agree the direction for clinically led continuous quality improvement in the health and wellbeing of the populations providers serve.
- Challenge areas of poor performance
- To monitor discuss and agree actions to address quality and patient safety issues raised through the CQRG, and/or brought to the attention of the Commissioners; for example: concerns around the management and treatment of Learning Disability patients, high incidence of falls resulting in serious harm.
- To provide assurance to CCG Boards.
- To develop, monitor and review progress of CQUINs

To support the monitoring of quality within commissioned providers, the CCGs together with NECS have ensured that provider contracts fully reflect CCG requirements for clinical quality. The 2013/2014 contracts now contain a list of indicators centred at measuring clinical quality and patient safety requirements from the service. These indicators are monitored through agreed systems and processes and require providers to supply information on a regular basis.

This information is presented to the CCGs through a variety of methods including dashboards, performance scorecards and relevant and timely quality reports which provide transparency as to the quality of care being delivered.

Running alongside the contract is a penalty scheme, which enables the commissioner to be able to apply financial penalties to areas of poor performance, such as the occurrence of a Never Event or delays in discharge information to primary care.

Assurances; regarding the quality of care that is being delivered by providers is also monitored through monthly and quarterly reports prepared by NECS. The CQRGs receive the monitoring information for discussion and action; however the reports are also shared with CCG wide quality fora, governing bodies and boards.

Mindful of the lessons learned from Mid Staffordshire DDES and ND CCGs have also introduced a process to capture and collate soft intelligence; this includes patient experience data, from practices, public and patient engagement forum and wider stakeholder feedback. The intelligence is triangulated with other information for example complaints, litigation, incidents to identify any theme or concerns that may point to failings within a providers service so that action can be taken to minimise any risks to patient safety.

Regular information sharing meetings with partners, such as CQC and local authority, are in place to ensure that our patients are safe regardless of the care setting they are in. these meeting also benefit from input from the safeguarding adults team.

Commissioner assurance visits have been common practice across County Durham and Darlington for some time. This year, we have extended the programme to include community nursing and NEAS; members of the CCG governing bodies will participate in the visit programme.

The learning from complaints, litigation, claims and incidents is systematically monitored and analysed by NECS as part of the ‘early warning systems’ and is fed back into the commissioning process to support the effectiveness of patient pathways and drive continuous quality improvements.

Other methods of monitoring are that of announced and unannounced visits to providers. These are attended by representatives of the CCG and NECS and are key too observing first-hand, the quality of the services the CCG commissions.

In relation to clinical effectiveness, CCGs also monitor and seek assurances from providers on the implementation of national guidance from NHS England, National Institute for Health and Care Excellence (NICE) including the Quality Standards, the Care Quality Commission (CQC) and other national bodies.

In conjunction, the CCGs together with NECS have developed a ‘clinical audit forward plan’ that audits provider’s compliance against good practice and is also used to monitor and assess any system failings.

Providers are also required to publish an annual ‘Quality Account’ to report their performance on the quality of care and services they provide, this is a useful tool for commissioners as it highlights the key areas that providers will focus on and outlines their commitment to some key quality improvements.

The ‘Monitoring of Quality’ is also supported by the introduction of HealthWatch whose role ensures that the CCGs and partner organisation are made aware of the views and concerns that patients have about their local health and social care services, in order that improvements to services can be made if so required.

5.0 Incentives

The monitoring of quality is further supported by the introduction of a number of payments / incentives structured at encouraging quality improvement. The most significant being the Commissioning for Quality and Innovation (CQUIN) framework. This national framework commenced in 2009 with the purpose of rewarding excellence and encouraging a culture of continuous quality improvement in all providers and promoting clinical engagement.

Each provider of acute, ambulance, care home, community and mental health and learning disability services on the NHS standard contract is entitled to earn the nationally specified percentage of contract value subject to agreeing and achieving goals in a CQUIN scheme. CQUIN payment is currently worth 2.5% of the value of the contract. Performance against the schemes is monitored quarterly.

In addition, both CCGs have local quality improvement schemes that relate to primary care, encouraging reporting and proactive management of issues and incidents that arise in the primary care setting, and that raise concerns about our provider services. This is a new approach aimed at driving up quality in primary care.

6.0 Quality Surveillance Groups

The CCGs are also members of the newly established acute Quality Surveillance Groups, chaired by the NHS England Area Team, which bring together organisations from across the health and social care economy and review respective information and intelligence gathered on providers through

performance management, commissioning, and regulatory activities, to maintain quality in the system. One group is dedicated to overseeing mainly secondary care providers and a second group is just being established to oversee Primary Care. These are imperative to obtaining the holistic view on what is occurring within a provider organisation and ensures that quality is everyone's business.

7.0 Conclusion

This paper provides some insight into how CCGS are monitoring quality directly within providers. However it is vital that CCGs in County Durham continue to engage with partner organisations and agencies such as the local authority to monitor quality across both the health and the social care system so that patients remain safe and free from harm.

Health and Wellbeing Board

21st June 2013

Providing safe and high quality care leading up to the opening of a new hospital

Report of Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Alan Foster, Chief Executive, North Tees & Hartlepool NHS Foundation Trust

Purpose of Report

1. The purpose of this report is to inform the Health and Wellbeing Board of the consultation which is taking place in relation to providing safe and high quality care leading up to the opening of a new hospital in the North Tees area.

Background

2. In 2008, the then Hartlepool Primary Care Trust and North Tees Primary Care Trust and North Tees and Hartlepool NHS Foundation Trust began the *momentum: pathways to healthcare* programme.

3. The momentum: pathways to healthcare programme has 3 objectives:

   - changing and transforming the way the local health service works to provide better, safer care for patients

   - providing a network of community and town centre facilities

   - building a new hospital to replace the University Hospital of Hartlepool and the University Hospital of North Tees

4. The government offered public funding for the new hospital in March 2010, however, withdrew this funding in June 2010 and therefore new funding sources needed to be identified. This means that, instead of the new hospital being open in 2014 as planned, it is now expected to open in 2017.

Safety

5. Concerns were raised by doctors at North Tees and Hartlepool NHS Foundation Trust that services cannot continue to be provided safely until the new hospital opens in 2017, while meeting rising standards in care.

6. In response, Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Durham, Dales, Easington and Sedgefield Clinical Commissioning Group invited the National Clinical Advisory Team to provide independent advice on

reconfiguring services to ensure safe, effective and accessible services for patients.

7. The following recommendations were identified in the Clinical Advisory Team's report:

   - work with the trust to centralise emergency medical services and critical care to the University Hospital of North Tees as soon as possible
   - explain to the public what this means for them
   - ask their views about the things that they are concerned about, especially how they and their relatives get to hospital

Consultation Proposals

8. The main consultation proposal is to:

   - Centralise emergency medical and critical care services at the University Hospital of North Tees from October 2013

9. This will mean that patients with lots of medical problems will not be able to have planned operations like hip replacements at the University Hospital of Hartlepool. However, more low risk operations and treatments for local people are expected to be carried out at the University of Hartlepool.

10. A 12 week consultation period began on 20th May and ends on 11th August.

11. The following questions are included within the consultation document:

    1. What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?
    2. If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?
    3. What do you think are the main things we need to consider in putting the proposed changes in place?
    4. Is there anything else you think we need to think about?

12. The full 'Providing safe and high quality care leading up to the opening of the new hospital' consultation document is included at Appendix 2.

How it will work

13. Leading up to the proposed changes the following actions would be undertaken :

- open 120 beds at the University Hospital of North Tees to make sure there are enough beds and staff to look after patients from right across the area;

- make extra space in critical care to look after critically ill patients;

- gradually, close the beds in medicine and critical care at the University Hospital of Hartlepool and;

- transfer a number of staff from support services such as pharmacy, radiology and pharmacy and estates who need to come to the University Hospital of North Tees to support the new arrangements.

14. A Joint Health Scrutiny Committee of Hartlepool Borough Council, Stockton Borough Council and Durham County Council will be established by the end of June 2013 to formally respond to the consultation. Terms of reference and membership are currently being agreed. A report on this will be considered by the Adults Wellbeing and Health Overview and Scrutiny Committee on 3rd July 2013.

Recommendations

15. It is recommended that the Health and Wellbeing Board:
    - Accept the report for information
    - Accept further reports for information as the project progresses

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Contacts: Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group
e-mail stewartfindlay.ddes@nhs.net

Alan Foster, Chief Executive, North Tees & Hartlepool NHS Foundation Trust
e-mail alan.foster@nth.nhs.uk

Appendix 1 - Implications

Finance – There are no direct finance implications

Staffing – The proposal is to transfer a number of staff from the University Hospital of Hartlepool to the University Hospital of North Tees

Risk – The proposal intends to mitigate any existing risks to patient health.

Equality and Diversity / Public Sector Equality Duty – There are no implications to Equality and Diversity

Accommodation – The proposal is to transfer a number of services from University Hospital of Hartlepool to the University Hospital of North Tees and increase capacity at North Tees by 120 beds.

Crime and Disorder – There are no implications on crime and disorder.

Human Rights – There are no implications to human rights.

Consultation – A public consultation is taking place between 20th May and 11th August 2013.

Procurement – There are no procurement implications.

Disability Discrimination Act – There are potentially transport issues for disabled people that need to be considered.

Legal Implications – There are no direct legal implications.

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

North Tees and Hartlepool NHS
NHS Foundation Trust

Providing safe and high quality care leading up to the opening of the new hospital

Consultation document - 20 May - 11 August 2013

Providing safe and high quality care leading up to the opening of the new hospital

A consultation on how best to ensure people have access to the safest and best quality, acute medical and critical care they need, in the lead up to the opening of the new hospital by:

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Durham, Dales, Easington and Sedgefield Clinical Commissioning Group

North Tees and Hartlepool NHS Foundation Trust

Consultation begins 20 May and ends 11 August 2013

If you require this information in another language or format please contact us on 01642 666815

Arabic 01642 666815 إذا احتجت لهذه المعلومات بلغة أخرى أو تنسيق آخر، فالرجاء الاتصال بنا على

যদি আপনি এই তথ্য যে কোনো ভাষাতে বা ফর্মেটে চান তাহলে, অনুগ্রহ করে 01642 666815 নম্বরে আমাদের সাথে যোগাযোগ করুন। Bengali

若您需要本資料的其他語言版本或格式，請與我們聯絡，電話 01642 666815 Cantonese

यदि आपको यह जानकारी किसी अन्य भाषा अथवा फॉर्मेट में चाहिए तो कृपया 01642 666815 पर हमसे सम्पर्क करें। Hindi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫ਼ਾਰਮੇਟ ਵਿਚ ਚਾਹੀਦੀ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ 01642 666815 'ਤੇ ਸੰਪਰਕ ਕਰੋ। Punjabi

Urdu اگر آپ کو یہ معلومات کسی دیگر زبان یا شکل میں چاہئیں تو براے مہربانی ہم سے 01642 666815 پر رابطہ قائم کریں۔

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Why are we carrying out this consultation?

The commissioners' view

Dr Boleslaw Posmyk
Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG)

Dr Paul Williams
Stockton-on-Tees locality lead, Hartlepool and Stockton-on-Tees CCG and governing body member

Dr Mike Smith
Hartlepool locality lead, Hartlepool and Stockton-on-Tees CCG

Dr Stewart Findlay
Chief clinical officer, Durham, Dales, Easington and Sedgefield Clinical Commissioning Group

We are carrying out this consultation because the doctors who provide emergency medical and critical care services at North Tees and Hartlepool NHS Foundation Trust have told us they cannot carry on providing these services safely and to the expected quality standards on two sites until the new hospital opens in 2017.

We buy these services from the hospitals for local people and we are responsible for their safety and quality. As commissioners we cannot wait until a problem arises before acting. Our job is to look forward and try to prevent problems from happening because this is in the interest of patients and everyone we serve.

We asked the National Clinical Advisory Team to visit us to listen to the doctors, nurses and managers, patient representatives, politicians and other stakeholders so they could give us an independent view of the situation and what we should do about it.

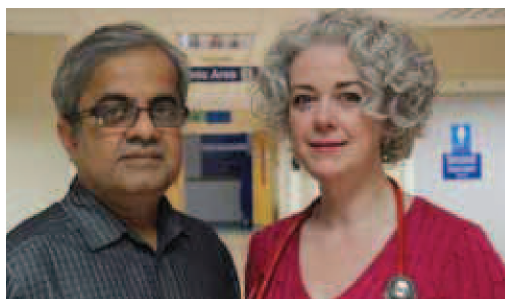
The National Clinical Advisory Team provide independent clinical expertise to support and guide the local NHS on service reconfiguration proposals to ensure safe, effective and accessible services for patients. Our team was lead by Dr Chris Clough from Kings College Hospital, London.

We now have a copy of the National Clinical Advisory Team report and this is why we are now holding this consultation.

The report said we should:

- work with the trust to centralise emergency medical services and critical care to the University Hospital of North Tees as soon as possible
- explain to the public what this means for them, which is why we are including a number of examples later in this document
- ask their views about the things that they are concerned about, especially how they and their relatives get to hospital

The provider's view



Dr Suresh Narayanan
clinical director for anaesthetics and critical care

Dr Jean MacLeod
clinical director for medicine

North Tees and Hartlepool NHS Foundation Trust

As the doctors who lead medicine and critical care in the trust, we are becoming increasingly concerned about our ability to provide safe services across our two hospital sites until the new hospital opens.

We are passionate about providing the safest, highest quality care possible and to meeting or exceeding the standards expected by the Department of Health, professional organisations, the deanery (which is responsible for organising the training of tomorrow's doctors) and most of all our patients.

While our services are safe and good quality today we want to ensure they will continue to be in the years to come. We want to ensure we can continue to provide excellent care for all our patients in the short, medium and long term – the type of care we would want for ourselves and our loved ones - but when our medical and nursing colleagues tell us they are concerned, then we have to act.

We raised these concerns at the highest level in the trust and, quite correctly, the trust raised these concerns with our commissioners who buy this care from our trust.

Together, as commissioners and provider, we are totally committed to ensuring that patients from the area we serve - Hartlepool, Stockton and parts of Easington and Sedgefield – can rely on the same standard of service regardless of where they live.

Had the new hospital opened its doors in 2014 as originally planned then we would have been bringing medical and nursing teams together now to be ready for the move to the new hospital. As things stand the new hospital is now expected to open in 2017 and we know things cannot stay as they are until then because:

- quite rightly, safety and quality standards continue to rise, but it is becoming increasingly difficult for us to keep pace with these requirement on two sites
- the way junior doctors are trained has changed and the deanery will not allow trainees to work in hospitals where they do not see enough patients to increase their learning and skills
- like the rest of the NHS we need to bring services together to ensure we can achieve the same standards of care for everyone living in the area served by our trust

Already, because of advances in medicine many patients from our area already go past their local hospital for their emergency medical care. For example:

- patients who have had a stroke are all taken to the University Hospital of North Tees where we can offer the latest treatments seven days a week, 365 days a year. We used to provide these services seven days a week at the University Hospital of North Tees but were only able to provide them Monday to Friday, 9am until 5pm, at the University Hospital of Hartlepool which was unfair on people from Hartlepool and Easington because strokes don't just happen in working hours. Because we have brought the skilled doctors who can carry out these treatments together we can now provide these services for everyone we serve.
- patients who have had certain types of heart attack are assessed at the scene and taken to The James Cook University Hospital in Middlesbrough to have the affected artery unblocked.

Both of these advances in medicine give patients a better chance of survival and recovery. As doctors we want local people to have access to the very best care available. This does mean this care cannot always be on the doorstep but in the modern NHS we have to accept that, while we can have most of our straightforward care provided locally, we have to travel for more specialist care.

It's also important to remember that most of the care provided by the health service is already provided in GP surgeries, local clinics and in people's homes and, under the *momentum: pathways to healthcare* programme, this will continue. We are beginning to take advantage of new technologies like telehealth where people can monitor their own health at home supported by a highly skilled team of community nurses. We already have many excellent examples of where this is working well and preventing people from having to be admitted to hospital. Medicine is advancing all of the time and we want to ensure we can offer the latest and best services and technologies to local people.

We are working closely with our commissioners because they, as the people who buy your care, and we, as the people who provide your care, have the same aim; that is to make sure your care is of the very best standard, wherever you live in the area we serve.

The important thing for you to know is, once the changes have been made, you do not need to do anything different. If you are unwell you will either contact your doctor or ring 999, just as you would today. Ambulance paramedics will assess you when they arrive and, if appropriate, begin treating you. They will make sure you get to the right place and to the right experts for any further treatment and care you need.

This is why we are joining Hartlepool and Stockton-on-Tees Clinical Commissioning Group and Durham, Dales, Easington and Sedgefield Clinical Commissioning Group to explain why things need to change but also to listen to any concerns you may have so we can address them.

How did we get to where we are now?

In 2008 what were then Hartlepool Primary Care Trust and North Tees Primary Care Trust and North Tees and Hartlepool NHS Foundation Trust began the *momentum: pathways to healthcare* programme.

The programme came about because the then Secretary of State for Health carried out a large national public consultation to ask people how they would like health care to be in the future. The results of this large national consultation became the White Paper *Our health, our care, our say*

People said they wanted:

- to be kept fit and healthy and for the health service to step in early if people start to become ill
- care given close to or in their own homes
- a health service that fits in with their lives, not the needs of the health service
- only to go to hospital if they couldn't be looked after nearer home or at home

There were other reasons too:

- people are, fortunately, living longer but they are often living with a number of health problems and the local health service has to change the way it works to ensure it can provide the type of care local people need
- the doctors, nurses and other health professionals want to continually improve care and that means they have to change the way they work to do this by:
  - making waiting times shorter
  - providing more services in GP practices and town centre clinics
  - making services safer
  - working in increasingly specialised teams to make the best use of their skills and resources
- the way doctors are trained has changed and the organisation responsible for training will only send their doctors to work and train in areas where they will get the right experience to improve their skills

The *momentum: pathways to healthcare* programme is made up of three things:

- changing and transforming the way the local health service works to provide better, safer care for patients
- providing a network of community and town centre facilities
- building a new hospital to replace the University Hospital of Hartlepool and the University Hospital of North Tees

The new hospital

The new hospital is the final piece of the *momentum* jigsaw

The government offered public funding for the new hospital in March 2010. However the new government withdrew this funding in June 2010. The government said it realised there was a need to build the new hospital but the organisations who buy services on behalf of local people and the trust needed to find a different way to pay for it.

This means that, instead of the new hospital being open in 2014 as planned, it is now expected to open in 2017.

Doctors providing emergency medical and critical care at North Tees and Hartlepool NHS Foundation Trust told the commissioners that, while they could have made arrangements to keep the two hospitals' emergency medical wards and critical care open until 2014, they simply cannot do this until 2017. They said they want to take the interim step of centralising emergency medical wards and critical care at the University Hospital of North Tees until the new hospital opens to keep services to the high standards we all want and expect.

As commissioners and providers of care our main concern is safety and quality and we are becoming increasingly uncomfortable with the current situation because we know the services in the two hospitals are increasingly unequal. This is making it impossible to provide the levels of safety and quality we would all want in the longer term

We are doing our very best to minimise these inequalities but, because of the increasingly high standards of care required, this is becoming a major challenge and we all know we cannot keep providing the type of care patients deserve with things the way they are.

This is because:

- it is becoming more and more difficult to staff medical rotas on two sites
- the standards of care required are, quite rightly, rising continuously

Nurses Station

What we are proposing to do

After much discussion with health professionals, a review of alternative options and receiving the report from the independent National Clinical Advisory Team, which agreed with us that there are no viable safe alternatives, we are now proposing to centralise emergency medical and critical care services at the University Hospital of North Tees from October 2013.

Bringing these services together would affect some other services such as other parts of the medical directorate, pathology, radiology, pharmacy and other support services such as facilities and catering. It would mean that patients with lots of medical problems will not be able to have planned operations like hip replacements at the University Hospital of Hartlepool but we do not expect this would affect very many patients because modern anaesthetics are safer. We want to ensure that most health care in Hartlepool continues to take place locally so we will be looking at ways to provide more low-risk operations and other treatments in the University Hospital of Hartlepool for local people. However we always have to assess if this will be safe and it will be for that reason and that reason alone, that we would transfer high risk planned operations to the University Hospital of North Tees.

We know this proposal will worry and disappoint some people but as the organisations which are responsible for your services we cannot allow this situation to go on any longer and we know these changes should be made.

How it will work

Leading up to the proposed changes we would:

- open 120 beds at the University Hospital of North Tees to make sure we have enough beds and staff to look after patients from right across our area;
- make extra space in critical care so we can look after critically ill patients;
- we would then, gradually, close the beds in medicine and critical care at the University Hospital of Hartlepool and;
- transfer a number of staff from support services such as pharmacy, radiology and pharmacy and estates who need to come to the University Hospital of North Tees to support the new arrangements.

Patient stories

The National Clinical Advisory Team said we should set out how things would work in future if these proposals are implemented.

Here are some examples

Elsie's story

Elsie, 75, from Greatham is feeling unwell. She has had heart problems for a while but today she feels very short of breath, her daughter is worried about her and phones her GP. The GP calls at the house and decides Elsie needs to be in hospital. The GP tells the hospital he would like Elsie brought in during the next two hours. The ambulance arrives and takes Elsie to the emergency assessment unit at the University Hospital of North Tees where she is assessed by the doctor in charge. The doctors diagnosed an irregular heart beat and start Elsie on drugs to treat it. She is also put on a heart monitor and observed by nurses for the next 24 hours. The doctor says Elsie can go home and her daughter comes to collect her. The nurses make Elsie an appointment to see the heart specialist in outpatients at the University Hospital of Hartlepool the following week.

George's story

George, 80, from Hartlepool, has a painful swollen leg. He is worried about this and phones 999. The ambulance takes him to the ambulatory care unit which is part of the emergency assessment unit at the University Hospital of North Tees He is diagnosed with a deep vein thrombosis. While in the ambulatory care unit he is started on blood thinning drugs. A specialist nurse explains to George that he will have to take the drugs for several weeks. The doctor says George can go home. A nurse arranges for George to be taken home by ambulance. The district nurse visits George at home to see how is doing until he is fully recovered.

Jason's story

Jason, 45, from Easington, has diabetes had a fluttering feeling in his chest and was dizzy. He thought he was going to faint so he called 999. The ambulance paramedic carried out an ECG (a heart test) at Jason's house. The ECG showed that Jason wasn't having a heart attack but he did need medical attention so the ambulance brought him to the emergency assessment unit at the University Hospital of North Tees. Jason was put on heart monitoring equipment and was given drugs to stabilise his abnormal heart beat. The doctor said Jason could go home once he was stabilised on the treatment but he needed to see a heart specialist to get to the bottom of the problem so an appointment was made for him to see a heart specialist at the University Hospital of Hartlepool the following week.

John's story

John, 75, has diabetes. He was feeling ill because his diabetes was out of control and he phoned 999. The ambulance paramedic assessed him at home and then he was brought to the University Hospital of North Tees. A doctor specialising in diabetes was able to see him straightaway and he was given the appropriate drugs to stabilise his diabetes. He stayed in overnight for observation and was allowed home the next day. He saw the diabetes specialist in outpatients the following week to ensure his diabetes was stable.

Mary's story

Mary, 70, is taken ill and her son phones 999. The ambulance takes Mary to the University Hospital of North Tees where she is diagnosed with pneumonia. Mary becomes worse and she has to be transferred to critical care for intensive medical support. After two days Mary is improving and she is transferred back to the ward. After three days Mary is allowed to go home with support from the community team who give her intravenous (a drip) antibiotics every day for the next 10 days until she has fully recovered.

Sharon's story

Sharon, 47, from the Fens, Hartlepool, noticed her leg was red and sore. She also felt feverish. She went to her GP who said she needed to be seen by a hospital doctor. Her husband took her to the ambulatory care unit at the University Hospital of North Tees, part of the emergency assessment unit. A doctor assessed Sharon's leg and the soft tissue infection was diagnosed as cellulitis. She was started off on a drip of antibiotics while in the ambulatory care unit and after further observations she was allowed home four hours later. The unit arranged for the rapid response nurses to go to Sharon's home to give her intravenous antibiotics each day Three days later she came back to the ambulatory care unit to see the doctor who was happy with how the soft tissue infection was clearing up. He recommended intravenous antibiotics until the end of the week and the rapid response team came to Sharon's house daily to give the treatment until the infection cleared up. This saved Sharon and her husband several trips to hospital.

Betty's story

Betty, 90, from Easington ,was confused and unable to get out of bed and her son called the GP. The GP thought Betty should be in hospital and asked for her to be admitted in the next two hours. The ambulance brought Betty to the emergency assessment unit at the University Hospital of North Tees where she was assessed by doctors. Betty had a urine infection which was making her confused so doctors started her on antibiotics. Doctors arranged for Betty to be transferred to the step down ward at the University Hospital of Hartlepool in a ward staffed by highly skilled nurses and therapists. It was becoming clear that Betty was having difficulty managing in her own home and discussions began so Betty could move to a home specially set up to meet her needs. Her family were pleased that they could visit her easily in the two weeks she stayed in hospital.

Transport

When the new hospital is built

Looking on a map, the new hospital (signified by the red dot) is centrally located in the area we serve. At the moment it is a green-field site on what we know is a very busy junction off the A19/A689. But the plans for the new hospital are supported by a comprehensive public and private transport plan and we are committed to ensure the new hospital is easily accessible for all.

As things are now

We know people may not find it easy to get to the University Hospital of North Tees for emergency care or to the University Hospital of Hartlepool for a planned operation. We know it can be difficult for people to visit their loved ones.

North Tees and Hartlepool NHS Foundation Trust's council of governors has a transport committee which is already working on improving transport for patients, visitors and staff.

So far the trust has:

- set up joint working with Hartlepool Borough Council to improve transport
- recruited a team of volunteer drivers to help people with transport problems to access hospital services
- ordered two 17-seater buses so it can increase the cross-site shuttle bus service

Please tell us about your concerns and if there's anything else we could be doing so we can try to address them.

Publishing the report

On 15 May we shared the report of the National Clinical Advisory Team with all the people the independent experts met when they visited the area in January.

At that meeting we listened to the questions and comments and we have added them to this document so we can ensure that we address all of these issues.

- People were disappointed that services could not stay in two separate sites and the doctors explained why this was the case. They also explained that they had done many things to try and preserve services on two sites but that was becoming increasingly difficult to do.
- The main concern was transport and people told us that it was very difficult for people to get to the University Hospital of Hartlepool from Stockton and to the University Hospital of North Tees from Hartlepool and Easington, especially by public transport. There were issues about the ambulance patient transport service which does not start until 8.30am. This is a problem for people who have early appointments and makes it impossible for people to get to hospital on time when they are already worried and distressed about their treatment. We promise we will look into this urgently.
- People wanted to know if we would scrap the plans if the public consultation resulted in local people being unhappy about the changes. We said we were going into the consultation with an open mind and we were not prepared to say what we would do until we had heard everyone's views at the end of the consultation.
- People thought we didn't try hard enough to put things right in Hartlepool. We explained that we had done as much as we possibly could to put things right and we were left with no option but to centralise services to keep them safe for the future.
- People thought the North Tees and Hartlepool NHS Foundation Trust paid different rates of pay and gave shorter contracts to doctors working at the University Hospital of Hartlepool. This is not true. All doctors working at the trust have a trust-wide contract and are expected to work at either hospital.
- People thought the people of Hartlepool were being let down. The doctors explained that they would be letting people down if they allowed the current situation to continue.
- People thought that no more joint replacements would be done at the University Hospital of Hartlepool. This is not correct. The trust's doctors explained that they intend to continue carrying out joint replacement at the University Hospital of Hartlepool with the only exception being where patients had many medical problems because those patients need the back up of critical care so the operation can be carried out safely.
- People thought that the people of Stockton might suffer if all of the services were brought together. The trust's doctors said things would actually improve for everyone if the services were brought together.
- People thought the consultation is a done deal. The clinical commissioning group explained that, while they believe the changes need to go ahead, they do want to listen to people's views.
- People thought the National Clinical Advisory Team were the hatchet men. The National Clinical Advisory Team is a team of independent medical experts who do not know the organisations and who come in, look at the evidence in front of them and speak to doctors, nurses, managers, patient representatives, politicians and other stakeholders. No health organisation can persuade the National Clinical Action Team to say anything it doesn't want to say.

What this consultation is about

We want to get your views on our proposals and understand your concerns about the proposed changes and we would particularly like you to answer the following questions for us:

1. What do you think are the advantages and the difficulties (or disadvantages) of the proposed changes?
2. If you still have concerns, what are you most concerned about and how could we help to reduce your concerns?
3. What do you think are the main things we need to consider in putting the proposed changes in place?
4. Is there anything else you think we need to think about?

We know for example that people could be concerned about how they get to the hospital to visit their loved ones. We promise we will listen to these concerns and we will work with the local authorities and others to do whatever we can to help.

Please use the time in the 12 weeks of the consultation to tell us your views. You can do this by:

Writing us an email and send it to: **communications@tees.nhs.uk** or,

Writing to:

Hartlepool and Stockton-on-Tees CCG
FREEPOST NEA9906
Middlesbrough
TS2 1BR

or by coming to one of the meetings we have organised, see the website at: **www.hartlepoolandstocktonccg.nhs.uk** for more details

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

NHS
Hartlepool and Stockton-on-Tees
Clinical Commissioning Group

North Tees and Hartlepool NHS
NHS Foundation Trust

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Health and Wellbeing Board

21st June 2013

Update on Winterbourne View Concordat Implementation

Report of David Shipman, Strategic Commissioning Manager, Children and Adults Services, Durham County Council

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Purpose of Report

1. The purpose of this report is to provide an update on progress made in relation to the Winterbourne View Concordat.

Background

2. The Shadow Health and Wellbeing Board received an initial report in relation to the Winterbourne View Concordat on 6th March 2013.

3. As outlined in that report, key milestones for the Concordat were as follows:
   - The identification of Adult Service Users in receipt of NHS funded care currently in assessment/treatment beds or private hospitals, with learning disability/autism/challenging behaviour, by the end of March 2013
   - The identification of all children in receipt of NHS funded care, people in forensic services and people in receipt of Continuing Health Care, by the end of March 2013
   - A programme of individual reviews for all of the first cohort to be in place by June 2013
   - A plan to return individuals in the first cohort to local services by June 2014

4. Health and Local Authority Officers are now working together to implement these actions, with lead officers from the North East Commissioning Support Unit (Donna Owens, LD Lead for Teesside, Durham and Darlington) and Durham County Council (David Shipman, Strategic Manager and Tracy Joisce Operations Manager) co-ordinating the activity in County Durham.

Progress to Date

5. The required register of relevant service users in County Durham has been compiled and was submitted to the Department of Health (DH) within the set timescales.

6. The register details have been shared with relevant Clinical Commissioning Group (CCG) officers and a full briefing has been provided to CCGs by Donna

Owens.

7. Guidance on the ‘Enhanced Reviews’ required has now been circulated by DH.

8. A clear governance structure has been established at national level, through the Joint Improvement Programme, with Local Government Association lead. It is envisaged that the work programme will have a two year lifespan from April 2013.

9. At regional level the work will be co-ordinated through the North East and Cumbria Learning Disability Clinical Networks, with the detailed work carried out in a Winterbourne Implementation Group. Donna Owens and David Shipman are both group members and attended the first meeting on 16th May 2013.

Next Steps

10. A local implementation group has been established to address the specific, individual case issues.

11. There are currently 10 relevant Service Users, six aligned to Durham Dales, Easington and Sedgefield CCG and four to North Durham CCG.

12. Explicit plans will then be developed for each individual to enable their return to suitable local services by June 2014.

13. Detailed consideration will also need to be given to a range of related issues, including the following:

    - Joint funding mechanisms and possible use of pooled budgets
    - Commissioning of additional advocacy services if there is insufficient capacity and availability within current contracts
    - Improved engagement with Public Health and community services
    - Market management and capacity building with providers
    - Whether it is possible to reduce the number of assessment/treatment beds commissioned in County Durham, in line with DH expectations.

14. To support the process there will be further work by the Joint Improvement Programme Board with Health Providers to examine service users and discharge processes.

15. The Joint Improvement Board will also be appointing four Health Improvement Advisors, to work across local areas in assisting with implementation of the Concordat.

16. Further monitoring of implementation by Department of Health will ensue. The first element of this will be a ‘Stocktake’ exercise to be completed jointly by each Local Authority and Health area and returned to Department of Health by 5th July 2013.

17. The ‘Stocktake’ focusses on the following areas:

- Models of Partnership
- Budget
- Case Management
- Current Review Programme
- Safeguarding
- Commissioning
- Developing Local Teams and Services
- Prevention and crisis response capacity
- Understanding the population who need/receive services
- Children and Adults – Transition Planning
- Current and Future Market Requirements and capacity

18. The response to the ‘Stocktake’ will be coordinated by Donna Owens and David Shipman and will be completed within the required timescales. It will not be possible to return the ‘Stocktake’ response to the Health and Wellbeing Board for formal sign off before 5th July 2013. It will be necessary for the Board to delegate the responsibility to named signatories from DCC (Chief Executive), CCG representative and the Chair of the Health and Wellbeing Board.

19. In addition, Winterbourne Implementation will be covered in the next Joint Health and Social Care Learning Disabilities Self Assessment Framework, due to be compiled in the Autumn 2013.

20. In May Normal Lamb, MP, Minister of State for Care and Support wrote to Chairs of Health and Wellbeing Boards, Council Leaders and Chief Executives, and Chairs and Chief Operating Officers for CCG’s – See appendix 2. The letter urges Health and Wellbeing Boards to take a full and active role in ensuring that the commitments made in the Winterbourne Concordat are delivered locally.

Recommendations

19. It is recommended that the Health and Wellbeing Board:
    - Receive this update and share it with relevant staff and Stakeholders.
    - Note that the ‘Stocktake’ return for the Department of Health will be agreed by named signatories from DCC (Chief Executive), CCG representative and the Chair of the Health and Wellbeing Board.
    - Receive a further update including a detailed implementation plan, at a future meeting in November 2013.

Contacts: David Shipman, Strategic Commissioning Manager, Children and Adults Services, 03000 267391

Appendix 1 - Implications

Finance – There are possible significant cost implications for both health and the Council.

Staffing – None – work carried out within current resources

Risk – No direct implications at this stage

Equality and Diversity / Public Sector Equality Duty – providing specialist services for people with learning disabilities and complex needs. Full consultation with affected service users and their families will be carried out.

Accommodation - Specialist accommodation will be developed within the County.

Crime and Disorder - No implications

Human Rights Consultation - Full consultation with affected service users and their families will be carried out.

Procurement – procurement will be carried out within existing procurement frameworks

Disability Discrimination Act – ensure people with complex needs have their needs met in appropriate local services

Legal Implications – Mental Capacity Act and Best Interest decision making processes will be followed.

From Norman Lamb MP
Minister of State for Care and Support

DH Department of Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

To: Chairs, Health and Wellbeing Boards
Cc: Council Leaders and Chief Executives
Chairs and Chief Operating Officers, GGCs

Dear Colleague,

Delivery of the Winterbourne View Concordat and review commitments

I am writing to you at the start of your taking on your statutory functions to stress the pivotal local leadership role that Health and Wellbeing Boards can play in delivering the commitments made in the Winterbourne View Concordat[1] which represents a commitment by over 50 organisations across the sector – including the Local Government Association, NHS England, the NHS Confederation, Royal Colleges and third sector organisations – to reform how care is provided to people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. There is widespread agreement across the sector that the care of this group of vulnerable people requires fundamental change.

The abuse of people at Winterbourne View hospital was horrifying. For too long and in too many cases this group of people received poor quality and inappropriate care. We know there are examples of good practice. But we also know that too many people are ending up in hospital unnecessarily and they are staying there for too long.

NHS England, NHS Clinical Commissioners, the Local Government Association, the Association of Directors of Adult Social Services and the Association of Directors of Children's Services each committed to working collaboratively with CCGs and Local Authorities to achieve a number of objectives by 1 June 2014, including that from April 2013, health and care commissioners will set out:

> *"a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of children, young people and adults with challenging behaviour in their area.*

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127312/Concordat.pdf.pdf

Department of Health

This could be undertaken through the health and wellbeing board and could be considered as part of the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy (JHWS) process;

- *The strong presumption will be in favour of supporting this with pooled budget arrangements with local commissioners offering justification where this is not done.*
- *We will promote and facilitate joint and collaborative commissioning by local authorities and CCGs to support these objectives.*

Health and wellbeing boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition in the plan and ensure that the right clinical and managerial leadership and infrastructure is in place to deliver the co-produced plan.

Health and wellbeing boards will, no doubt, also want to take an active interest in how far the other commitments in the Concordat, particularly those relating to care reviews having been completed by June 2013, have been achieved, as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings.

It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined-up services from the NHS and local councils in the future and see real change for this very vulnerable group.

Health and wellbeing boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individuals; which is closer to home and which will lead to a dramatic reduction in the number of inpatient placements and the closure of some large in-patient settings.

The Department of Health has supported the establishment of an NHS England and Local Government Association-led Winterbourne View Joint Improvement Board. This Board will be working closely with a range of partners to develop and implement a sector-led improvement programme working with local health and social care communities to deliver real and lasting change in the support and

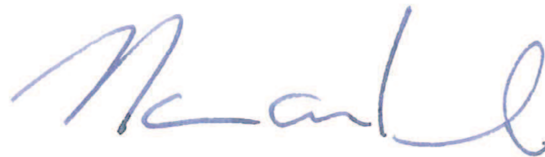
DH Department of Health

care for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging. It will shortly be in touch with you separately to take stock of progress in your area so that any appropriate level of support can be arranged.

Due to the very public nature of these failures in care, I am sure that you will want to ensure that your health and wellbeing board is able to provide transparent public information and assurance on progress locally.

Further information about the work of the improvement programme, including a recently issued framework for conducting reviews of care locally, is available on the LGA website. If you have any innovative practice to share, or views on how the programme can be designed and developed to ensure rapid progress and real and lasting change, please contact the programme chair via Chris.Bull@local.gov.uk

Yours sincerely,



NORMAN LAMB

We hope to publish progress around the country in meeting the commitments made in the Concordat in the Summer.

Thanks so much for your work on this incredibly important issue!

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Health and Wellbeing Board

21st June 2013

Review of NHS Community Services

Report of Mike Taylor, Chief Finance and Operating Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group / Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group

Purpose of Report

1. To provide the Health and Wellbeing Board with a high level summary update, on the development of the Health and Wellbeing Board and Clinical Programme Board subgroup for Community Services and Care Closer to Home. This update will summarise progress so far along with next steps for the sub group.

2. To propose a mechanism and frequency for reporting back to the Health and Wellbeing Board with updates for all Clinical Programme Board sub groups.

Structure

3. The Community Services and Intermediate Care Clinical Programme Board sub group was established on agreement by the County Durham and Darlington Clinical Programme Board. It was agreed that this sub-group should be merged with the Care Closer to Home Group, of which the Terms of Reference were under review.

4. This newly formed group will become the Community Services and Care Closer to Home Group. This group will be a sub group of both the Health and Wellbeing Board and the Clinical Programme Board. Proposed representation of this group is as follows:
    - NHS Foundation Trusts – Tees, Esk and Wear Valley, County Durham and Darlington, North Tees and Hartlepool, City Hospitals Sunderland
    - CCGs (Darlington, DDES, North Durham)
    - Local Authority – County Durham, Darlington
    - Primary Care Commissioning (NHS England Area Team)
    - Healthwatch County Durham and Healthwatch Darlington
    - North East Commissioning Support (NECS)
    - 3rd Sector representation

5. The first meeting of the Community Services and Care Closer to Home Group was on 12 June 2013.

6. The purpose of the Community Services and Care Closer to Home Group is to ensure a partnership focused approach to manage and coordinate the review,

development and delivery of local patient community based health and intermediate care services.

Progress

7. A 'Current State' report was written to give a brief overview of community services/intermediate care provision in County Durham and Darlington and to highlight initiatives identified by Darlington, Durham Dales, Easington and Sedgefield and North Durham CCGs in relation to improving community services and intermediate care within their localities and at a wider level.

8. Commissioning work plans for 2013/14 from the three County Durham and Darlington CCGs were categorised and aligned to the community contract service lines.

9. Further analysis on the community contract service specifications have been carried out to group associated services into broader service areas e.g. Cardiovascular Disease, Respiratory, etc. The measurable outcomes for each service area have been identified where possible, and reviews of the outcomes recommended as required.

10. A survey of GP practices in County Durham and Darlington to obtain their views of the district nursing service was carried out in 2012 and 2013. The results of the 2013 survey show improvements in all comparable questions including that:
    - The district nursing service works well for my patients
    - The district nursing service works well for me and my practice
    - I am clear what treatment and care that district nurses can offer my patients
    - I am clear what treatment and care that community matrons can offer my patients

11. A review of district nursing patients in County Durham and Darlington was also carried out in 2012 and 2013. The results show high levels of patient satisfaction within the service.

12. The CCG leads and the Community Services and Care Closer to Home Group Clinical Director agreed and carried out an initial process to ensure engagement with the staff. A series of seven sessions were held across the county between 17th and 31st May 2013. Feedback received will be incorporated into the overall review. Areas to note are:
    - Focus on Quality
    - Mobile Working
    - Integration
    - 7/7 Services

13. Peopletoo were jointly commissioned by County Durham and Darlington NHS Foundation Trust through the Community Services and Care Closer to Home Group to undertake an independent, high level evaluation of existing intermediate care services. They engaged with a range of stakeholders from CCGs, Durham County Council, County Durham and Darlington NHS Foundation Trust and GPs

to develop an outline business case for a proposed operating model to deliver intermediate care services in County Durham, which would meet the needs of key stakeholder groups. The outline business case highlights issues and limitations of current intermediate care services that were communicated by stakeholders and outlines a new model of service delivery that is agreed by all the organisations involved. As a result a detailed business case for the implementation of this model is being developed, this work is expected to be completed by September 2013.

Next Steps

14. The CCGs have identified several priority areas within the list of contracted services which mainly impact upon urgent care, intermediate care and community nursing. The Community Services and Care Closer to Home group will be setting up criteria for review and stakeholders required to progress this work.

15. Part of the review will consider models of care and service specifications from other areas to identify and incorporate best practice into the current commissioned services or to inform future services. An example of which is the IMProVE (Integrated Management and Proactive care for the Vulnerable and Elderly) project being implemented by South Tees CCG in partnership with South Tees Foundation Trust which focuses community services on delivering and improving outcomes on patient care.

Recommendations

16. It is recommended that the Health and Wellbeing Board note the contents of this report and agree to receive future updates.

Contacts:

Helen Stoker, Senior Commissioning Support Officer – Service Planning and Reform, North of England Commissioning Support (NECS). Tel (0191 3744152). E-mail h.stoker@nhs.net

Mike Taylor, Chief Finance and Operating Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group. Tel (0191 3713211). E-mail mike.taylor@nhs.net

Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group, email: Nicola.Bailey5@nhs.net, Tel: 0191 6053169

Appendix 1 - Implications

Finance – Implications for budgets need to be considered as part of the review.

Staffing – Relevant NHS staff will need to considered as part of the review

Risk – Risks will be managed as part of the review.

Equality and Diversity / Public Sector Equality Duty: There are no implications to equality and diversity

Accommodation: This report has no implications on accommodation.

Crime and Disorder: Not applicable

Human Rights: This report has no implications on human rights.

Consultation: Public and patient engagement and wider stakeholder feedback is part of this process.

Procurement: Not applicable

Disability Issues: Not applicable

Legal Implications – No implications

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of the Local Government Act 1972.

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