Health and Wellbeing Board

Date **Friday 15 November 2013**
Time **9.00 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies for Absence

2. Substitute Members

3. Declarations of Interest

4. Minutes of the Meeting held on 21 June 2013 (Pages 1 - 10)

5. Planned Changes to Urgent Care - Update - Joint Report of Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Chief Operating Officer, North Durham Clinical Commissioning Group (Pages 11 - 16)

6. Endorsement of the County Durham Tobacco Control Action Plan - Report of Director of Public Health County Durham, Durham County Council County Durham

   Tobacco Control Action Plan 2013-14 (Pages 17 - 44)

7. Public Mental Health Strategy - Report of Director of Public Health County Durham, Durham County Council County

   Durham Public Mental Health Strategy 2013 – 2017

   County Durham Public Mental Health Strategy 2013 - 2017 Executive Summary (Pages 45 - 114)

8. Social Care Funding Transferring from NHS England - Joint Report of Corporate Director, Children and Adult Services, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Chief Operating Officer, North Durham Clinical Commissioning Group (Pages 115 - 150)

9. Winterbourne View Concordat and Action Plan Implementation in County Durham - Report of Head of Commissioning, Children and Adults Services, Durham County Council (Pages 151 - 154)

10. 2010 Adult Autism Strategy "Fulfilling and Rewarding Lives" Evaluating Progress - The Second National Self-assessment Exercise - Report of Head of Commissioning, Children and Adults Services, Durham County Council Autism Self Evaluation (Pages 155 - 170)

11. Joint Health Wellbeing Strategy - 2nd Quarter 2013-14 Performance Report - Report of Head of Planning and Service Strategy, Children and Adults Services, Durham County Council

    Joint Health and Wellbeing Board Performance Scorecard: 2nd Quarter 2013/14

    Joint Health and Wellbeing Strategy: Completed Actions (Pages 171 - 196)

12. North Durham Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group Planning Process Update for 2014/15 - Joint Report of Chief Operating Officer, North Durham Clinical Commissioning Group and Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 197 - 228)

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

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

Part B

Items during which it is considered the meeting will not be open to the public (consideration of exempt or confidential information)

15. Pharmacy Relocation Applications - Report of Director of Public Health County Durham, Durham County Council (Pages 229 - 232)

16. 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
7 November 2013

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

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

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

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

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DURHAM COUNTY COUNCIL

At a Meeting of **Health and Wellbeing Board** held in Committee Room 1A, County Hall, Durham on **Friday 21 June 2013 at 9.00 am**

Present:

Members of the Board:
Councillors L Hovvels, O Johnson and M Nicholls and Nicola Bailey, John Bedlington, Dr Stewart Findlay, Graeme Greig (representing Anna Lynch), Carol Harries, Sue Jacques, Paul Newton (representing Martin Barkley), Neil O'Brien (representing Dr Kate Bidwell), Rachael Shimmin and Peter Tindall (representing Alan Foster)

Also in Attendance:
Councillors B Armstrong and R Todd.

1 Election of Chairman

Resolved:
That Councillor L Hovvels of Durham County Council be elected Chairman of the Board for the ensuing year.

Councillor L Hovvels in the Chair

2 Appointment of Vice-Chairman

Resolved:
That of Dr S Findlay be appointed Vice-Chairman of the Board for the ensuing year.

3 Apologies for Absence

Apologies for absence were received from M Barkley, Dr K Bidwell, A Foster, A Lynch and Dr D Roy.

4 Substitute Members

G Greig for A Lynch, N O'Brien for Dr K Bidwell, P Tindall for A Foster and P Newton for M Barkley.

5 Code of Conduct

The Board received a presentation from the Governance Solicitor, Durham County Council, informing them about the Code of Conduct that they must follow (for copy see file of Minutes). Members of the Board were asked to complete a Register of Interest form and return to Democratic Services.

6 Declarations of Interest

Mr J Bedlington declared an interest as a governor of Newcastle Upon Tyne NHS Trust.

7 Joint Health & Wellbeing Strategy Delivery Plan

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services regarding the Joint Health and Wellbeing Strategy delivery plan 2013-2017 (for copy see file of Minutes).

The Board were informed that consultation had taken place with the Shadow Board and members of the public. The Shadow Board had given approval in November 2012 setting out the strategic objectives within the Strategy. Governance arrangements were being utilised where appropriate in terms of lead responsibility for specific areas of work.

The Corporate Director, Children and Adults Services commented that a performance monitoring report would be presented in November 2013 to the Board.

Resolved:-

(i) That the JHWS delivery plan be agreed.

(ii) That a performance monitoring report to be presented to the Health and Wellbeing Board in November 2013 be agreed.

8 Disabled Children's Charter for Health and Wellbeing Boards

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services that provided details of the Disabled Children's Charter for Health and Wellbeing Boards and to evidence 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 (for copy see file of Minutes).

The Board were informed that the County Council had signed up to a previous Charter and by signing up to the new Charter it showed a continued commitment. Further areas of development were highlighted.

Resolved:-

(i) That the contents of the report be noted.

(ii) That signing up to the Disabled Children's Charter for Health and Wellbeing Boards, noting the further developments highlighted within the report, be approved.

(iii) That a response to Tadworth Children's Trust and Every Disabled Child Matters be agreed with the Chairman.

9 Durham Dales, Easington and Sedgefield Clinical Commissioning Group Local Priorities 2013/14

The Board considered a report of the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) regarding quality premium indicators for 2013/14 (for copy see file of Minutes).

Mr J Wrann, Commissioning Manager – Service Planning and Reform, North of England Commissioning Support informed members that following the Shadow Board in March, 3 local quality premium indicators were selected:-

- 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.

Mr Wrann highlighted how important it was for CCGs to have continual engagement with NHS England and as such NHS England had concern over the second indicator highlighted above due to the high level of variance over time.

The final submissions were agreed as follows:-

- 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

Resolved:-

(i) That the report be noted.

(ii) That to support DDES CCG in the selection of their local premium priorities be agreed.

10 Integration Pioneer Project

The Board considered a joint report of Corporate Director, Children and Adults Services and the Chief Operating Officer, North Durham Clinical Commissioning Group (ND CCG) about the Integration Pioneer Project (for copy see file of Minutes).

The Corporate Director, Children and Adults Services explained that this was an opportunity to apply as part of a pilot programme with health and social care working together in a co-ordinated way. It was explained that the redesign of intermediate care services would benefit the community. The Chief Operating Officer, ND CCG added that work had already begun in this area and the CCGs were committed to create a model equally applicable to everybody, giving everyone the same benefits.

Members of the Board were informed that progress would be reported at future meetings.

Resolved:-

(i) That the application process be supported.

(ii) That to be involved in the ongoing development of becoming a pioneer of health and social care integration be agreed.

(iii) That further reports on progress to be accepted.

11 Policy Update

The Board considered a report of the Strategic Manager – Policy, Planning and Partnerships, Children and Adults Services that gave an overview of key policy developments since March 2013 (for copy see file of Minutes).

Areas that were highlighted included:-
Draft Care Bill, Transforming Care: A national response to Winterbourne View Hospital and Joint Partner Statement, Adult Social Care Outcomes Framework 2013 to 2014, Integrated Care, Public Health England's priorities for 2013 to 2014, NHS CCGs – payments in respect of quality Regulation 2013, DDES CCG Prospectus and North Durham CCG Prospectus, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, Pharmaceutical Needs Assessments and Health and Wellbeing Improvement Support.

Resolved:-
(i) That the report be noted.
(ii) That the CCH prospectus documents for North Durham and DDES CCG be endorsed.

12 Review of Sustainable Community Strategy

The Board considered a report of Head of Partnerships and Community Engagement that gave an update on how work was progressing with the renewal of the Sustainable Community Strategy (SCS) and to identify cross thematic priorities across the County Durham Partnership (CDP) (for copy see file of Minutes).

The Head of Planning and Service Strategy, Children and Adults Services explained that the SCS was a 20 year overarching document for County Durham that was subject to a 3 year renewal programme, last approved in March 2010. The CDP had re-affirmed the Altogether Better Vision and 5 key priorities. Mr Appleton informed the Board that the SCS gives partners an opportunity to add value to cross cutting themes and requested that relevant priorities be identified and fed into the renewal process for the SCS.

Mr Greig informed the Board that there was a shared understanding and development element of the work required. He pointed out that there were more accidents involving children in deprived areas and that 20 mph limits had proved to be successful in some areas in reducing the number of accidents.

The Corporate Director, Children and Adults Services said that a Task and Finish Group had been established that were looking to recruit representatives, with Anna Lynch as Chair. She added that young people have said they do not feel safe because of parked cars and the speed of cars.

The Chairman said that the voluntary sector played a big role in terms of having access to external funding and in turn impacts on what we are trying to achieve together. The Head of Planning and Service Strategy added that good projects working on prevention are taking place with Area Action Partnerships (AAPs). The Chief Clinical Officer said that from CCG perspective they have been going out and talking with the voluntary sector and asking how we can help them. The Corporate Director, Children and Adults Services concluded that there would be regular reports to the Board showing a combination of work with the AAPs focusing on Health and Wellbeing. This would be extended to the Children's Trust and Safe Durham Partnership.

Resolved:-

(i) That the approach for the review of the SCS be agreed.
(ii) That further updates be agreed as appropriate.

13 Alcohol Harm Reduction Strategy 2012-15

The Board considered a report of the Consultant in Public Health, Children and Adults Services detailing the strategic aims and objectives of the Alcohol Harm Reduction Strategy 2012-15 and plans for 2013/14 (for copy see file of Minutes).

The Alcohol Harm Reduction Co-ordinator informed the Board that the strategy was about people making informed decisions and helping with prevention, control and treatment. The priorities for 2013/14 were highlighted.

Members of the Board commented that there had been a culture change with regards to alcohol consumption in that people drank at home, people had pre-drinks at home and young people drank to get drunk. They agreed that joined up working delivering a consistent approach and engaging with people was the way forward.

Resolved:-

(i) That the report be noted.
(ii) That receiving updates on the implementation of the Strategy be agreed.

14 Securing Quality in Health Services

The Board considered a report of the Project Director, Securing Quality in Health Services, Darlington Clinical Commissioning Group giving an update on the Acute Services Quality Legacy Project (ASQL) (for copy see file of Minutes).

The Shadow Board had received a report on the project in September 2012 and the overall objective was to enhance the commissioning of acute hospital services by reaching a consensus on the key clinical quality standards in acute hospital care that should be commissioned by CCGs. Five CCGs agreed to take this forward with Darlington to lead.
The key messages and recommendations from the Acute Services Quality Legacy Project were highlighted.

Dr Findlay commented that the whole medical profession was changing with more and more consultants working longer hours. Dr Guy agreed and said that 24/7 working would transform the way the system had to work. The Corporate Director, Children and Adults Services added that there needed to be a good line of sight in this area of work and that implications for the future needed to be understood going forward.

The Project Director concluded that there would be a feasibility analysis taking place over the summer in relation to implementation of the standards to be included in contracts.

Resolved:-
(i) That the report be noted.
(ii) That further reports be received as the project progresses.

15 Monitoring Provider Quality in the NHS

The Board considered a joint report of the Director of Clinical Quality and Primary Care Development, Durham Dales, Easington and Sedgefield Clinical Commissioning Group, the Director of Quality and Safety, North Durham Clinical Commissioning Group and the Medical Director, NHS England, Darlington and Tees Area Team giving an overview on how the new NHS architecture supports the monitoring of provider quality (for copy see file of Minutes).

Dr Guy explained that there was a five point plan in place to revolutionise the care that people receive from the NHS:-

- Preventing problems
- Detecting problems quickly
- Taking action promptly
- Ensuring robust accountability
- Ensuring staff are trained and motivated

The Corporate Director, Children and Adults Services said that this was a helpful report and showed a shared understanding on how quality will be monitored in the NHS. It was noted that there was a positive and proactive relationship in relation to safeguarding adults between the Council and CCGs.

Resolved:-
That the report be noted.

16 Providing Safe and High Quality Care leading up to the Opening of a New Hospital

The Board considered a joint report of the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and the Chief Executive, North Tees and Hartlepool NHS Foundation Trust about the consultation 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 (for copy see file of Minutes).

The Associate Director of Strategic Planning, North Tees and Hartlepool NHS Foundation Trust informed the Board that concerns had been raised by doctors at North Tees and Hartlepool NHS Foundation Trust that services could not continue to be provided safely until the new hospital opens in 2017, while meeting rising standards in care. Public consultation events had been held and key issues relating to transport were being explored.

The Chairman said that Members would be fully engaged and informed due to a Joint Health Scrutiny Committee being established.

Resolved:-

(i) That the report be noted.

(ii) That further reports be accepted as the project progresses.

17 Update on Winterbourne Review Concordat Implementation

The Board considered a report of the Strategic Commissioning Manager, Children and Adults Services giving an update on progress made in relation to Winterbourne View Concordat (for copy see file of Minutes).

The Corporate Director, Children and Adults Services informed the Board that work was well underway between the local authority and the NHS to deliver and implement the key milestones. The deadline for the 'Stocktake' to be signed off was 5 July and responsibility would need to be delegated to Durham County Council's Chief Executive, Chairman of Health & Wellbeing Board and a CCG representative. It was important for the Board to have a detailed understanding of the stocktake and it was highlighted that 10 service users had been identified as part of this work and that plans will be developed for each individual to enable their return to suitable local services by June 2014.

Resolved:-

(i) That the update be received and shared with relevant staff and Stakeholders.

(ii) That the 'Stocktake' return for the Department of Health to be agreed by named signatories from DCC (Chief Executive), CCG representative and the Chair of the Health and Wellbeing Board be noted.

(iii) That further updates including a detailed implementation plan at a future meeting in November 2013 be received.

18 Review of NHS Community Services

The Board considered a joint report of the Chief Finance and Operating Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Chief Operating Officer, North Durham Clinical Commissioning Group that provided 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 (for copy see file of Minutes).

Mr O'Brien, representing Dr Bidwell, summarised the progress made so far and highlighted the next steps. He advised that the first meeting of the Community Services and Care Closer to Home Group took place on 12 June 2013. Dr Findlay added that it is important to work in an integrated way in relation to primary care, community care and social care.

Resolved:-
That the report be noted and the Board receive future updates.

19 Any Other Business

The Chairman agreed that the following item was of sufficient urgency to warrant consideration:-

Healthwatch – Mr Bedlington explained that this was a new organisation developed in the County. He had visited 31 community groups with further meetings planned until September 2013. A free phone number had been set up and 58 queries had been received so far. He was regularly attending meetings with voluntary and statutory bodies and wanted to publicise that Healthwatch was a public voice.

The Chairman thanked Mr Bedlington for his update and hoped that this meeting would help strengthen the partnership.

20 Exclusion of the public

That under Section 100 A (4) of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A to the said Act.

21 Minutes of the Shadow Health and Wellbeing Board held on 6 March 2013

The minutes of the Shadow Health and Wellbeing Board held on 6 March 2013 were agreed as a correct record and noted by the Board.

22 Pharmacy Relocation Application

The Board considered a report of the Director of Public Health, Children and Adults Services, Durham County Council about a Pharmacy relocation application (for copy see file of Minutes).

Resolved:-
That the recommendations contained within the report be approved.

23 Any Other Business

The Chairman agreed that the following item was of sufficient urgency to warrant consideration:-

The Board were given further information relating to Monitoring Provider Quality in the NHS further to an External Quality Review being undertaken.

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Health and Wellbeing Board

15th November 2013

Planned Changes to Urgent Care - Update Report

Joint Report of Dr Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group

Purpose of Report

1. The purpose of this report is to provide the Health and Wellbeing Board with and update on urgent care. The report will cover County Durham and specific plans in both Clinical Commissioning Groups (CCGs).

Background

2. Both North Durham (ND) CCG and Durham Dales, Easington and Sedgefield (DDES) CCG have identified urgent care as a priority in their 2013/14 annual commissioning plan. These plans were developed as a continuum of significant work undertaken in County Durham in developing urgent care and services such as 111.

3. As has been reported nationally, there is increasing demand on unscheduled care and in particular within urgent care and emergency departments. The CCGs are currently working in collaboration with County Durham and Darlington NHS Foundation Trust (CDDFT), Tees, Esk and Wear Valley NHS Foundation Trust (TEWV), North East Ambulance NHS Foundation Trust (NEAS) and Durham County Council to respond to the immediate pressures in the system, plan for winter and develop longer term plans for urgent care.

4. NHS England in recognition of the pressure in urgent care and emergency department systems across England has asked CCGs to establish Urgent Care Boards in close collaboration with Local Authorities, Area Teams and Acute Trusts. Urgent Care Boards have responsibility for the overseeing urgent and emergency care and ensuring action is taken to address and manage pressures in the system and coordinate plans.

Urgent Care in County Durham

5. An Urgent Care Board has been established which is led by both CCGs and chaired by Dr Stewart Findlay, Chief Clinical Officer, DDES CCG. Membership includes the organisations referred to in paragraph 3 above and includes senior representations from North Durham CCG and Darlington CCG. The Urgent Care board is one of the sub-groups that supports the system wide Clinical Programme Board.

6. Detailed winter plans for 2013/14 have been developed and agreed for County Durham. These were discussed at the last Health and Wellbeing Board development session in September 2013. The Urgent Care Board has responsibilities for the coordination and oversight of the winter plan across County Durham. As part of these plans both CCGs are working closely with primary care, CDDFT, TEWV and NEAS to ensure there is increased capacity and capability in response to winter surge. For example North Durham CCG is supporting GP practices to open on weekends from October 2013 over the winter period and DDES also plan to open practices on weekends.

7. The local health economy was not identified nationally for funding to support winter planning activities. Both CCGs are however supporting winter through the use of targeted non-recurrent funding to support additional capacity for winter surge in CDDFT and TEWV providers in line with agreed plans.

8. Both CCGs are implementing a series of commissioner visits to the emergency departments. The purpose of the visits is to review the effectiveness of services, quality and safety, patient experience and understanding any system issues. The visits are led by the CCG Directors of Nursing.

9. There are a number of other areas of development that both CCGs are undertaking that support urgent and emergency care:

    - Intermediate care – both CCGs are involved in the service developments that will support the timely discharge of patients and prevent emergency admissions by ensuring that patients have access to consistent intermediate care (short term intervention).
    - GP practice variation – the purpose of practice variation is to use available data and support practices to look critically at variation such as emergency department attendances, emergency admissions and urgent care attendances. This process uses peer review and aims to change referral patterns that ensure patients access the appropriate pathway.
    - Long term conditions – both CCGs are implementing a range of schemes that aim to ensure that patients with long term conditions are managed effectively in their home or in community settings to avoid emergency admissions, for example chronic obstructive pulmonary disease.

Longer Term Urgent Care Planning

10. Both CCGs are currently in the process of either reviewing urgent and emergency care in their geographical area or developing plans for future implementation.

11. DDES CCG are currently undertaking a review of their urgent care arrangements and will be developing plans in the coming months.

12. North Durham CCG has completed its review of urgent and emergency care. The evidence and information collected as part of the review has indicated that a significant number of patients currently accessing urgent care in-hours could be seen in primary care. Similarly around 30 percent of patients currently attending the emergency department in-hours could be seen in primary care. A revised model has been proposed and an outline business case is being finalised along with a service specification. Consultation is planned to commence November 2013 on the outline business case. In summary the key elements of the North Durham model for urgent and emergency care are to improve and develop capacity in existing services:

    - Enhance the role, capacity and capability of primary care to enable patients to been seen in-hours within their local community. This includes consideration of a move towards 7 day working.
    - Ensure an integrated minor and major pathway in the emergency department providing urgent and emergency care ranging from minor injury to major trauma.
    - Ensure effective communication and coordination in the system through effective links with the existing 111 service to primary care and the emergency department.
    - Ensure effective unplanned care transport services that are integrated within the model.

13. Within the model outlined above North Durham CCG will be working closely with County Durham and Darlington NHS Foundation Trust and North East Ambulance NHS Foundation Trust to support the on-going improvement of urgent and emergency care services at University Hospital North Durham and Shotley Bridge.

14. DDES CCG has started a similar piece of work reviewing urgent care provision across its area including all urgent care centres and access to GPs outwith the current working hours. This work is due to complete by the end of November 2013. Work is currently concentrating on making better links between the doctors working in the urgent care centre and the patient's own GP as this is felt to be an area that needs urgent improvement. There may be a requirement to consult further with the public if changes are felt to be required to the urgent care centre operating model.

15. Both CCGs are aware of the current national review of urgent care being led by Professor Keith Willett. Early indications from this national review are in line with the proposals being put forward by the CCGs, but the CCGs will adapt plans as further information becomes available.

Recommendations

16. It is recommended that the Health and Wellbeing board:
    - Note the content of this report regarding urgent care.

Contact: Michael Houghton, Director of Commissioning and Development, North Durham CCG, email: Michael.houghton@nhs.net, Tel 0191 6053168

Gill Findley, Director of Nursing, Nurse Advisor DDES CCG, Email: gillian.findley@nhs.net, Tel 0191 3713214

Background papers: None

Appendix 1

Finance The local health economy was not identified nationally for funding to support winter planning activities. Both CCGs are however supporting winter through the use of targeted non-recurrent funding to support additional capacity for winter surge in CDDFT and TEWV providers in line with agree plans.

Staffing N/A

Risk N/A

Equality and Diversity / Public Sector Equality Duty N/A

Accommodation N/A

Crime and Disorder N/A

Human Rights N/A

Consultation N/A

Procurement N/A

Disability Issues N/A

Legal Implications N/A

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Health & Wellbeing Board

15 November 2013

Endorsement of the County Durham Tobacco Control Action Plan

Report of Anna Lynch, Director of Public Health County Durham, Durham County Council

Purpose of the Report

1. The purpose of the report is to present and request Health and Wellbeing Board support for the County Durham Tobacco Control Alliance Action Plan.

Background

2. In 2011 the government published the White paper 'Healthy Lives, Healthy People: A Tobacco Control Plan for England'. This is a five year plan which, under the leadership of local authorities, the Department of Health expects to see the development of partnerships in tobacco control with relevant organisations. In implementing comprehensive tobacco control in their communities, local authorities are encouraged to maximise local involvement by building tobacco control alliances.

3. While the public health outcomes framework will provide the key source of information about progress on reducing tobacco use, the government has set three national ambitions to focus tobacco control work across the whole system:

    - Reduce smoking prevalence among adults in England: To reduce (aged 18 or over) smoking prevalence in England to 18.5 % or less by the end of 2015, meaning around 210,000 fewer smokers a year
    - Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12% or less by end of 2015
    - Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015

4. The aim of tobacco control is to make smoking less desirable, accessible and affordable. Locally this means improving health and reducing health inequalities by reducing the number of smokers (preventing the uptake of smoking and assisting those who want to quit).

5. Delivering evidence based tobacco control requires long term strategic commitment to ensure the mechanisms are in place to drive the agenda forward. The vehicle to deliver this relies on the commitment of a range of partners understanding and supporting the evidence, and coming together in the form of a local tobacco control alliance.

6. Reducing smoking prevalence and reducing the use of tobacco will help to:
   - Cut costs to local public services
   - Protect children from harm
   - Boost the disposable income of the poorest people
   - Reduce health inequalities
   - Drive real improvement across key measures of population health

7. There needs to be a long term commitment to reduce the overall prevalence of smoking across County Durham. This means a commitment to improving health and reducing health inequalities by focusing on the death, disability and disease caused by smoking.

8. The council have supported tobacco related initiatives for many years, in partnership with a range of organisations. The Environment, Health and Consumer Protection Service deliver a programme of:

   - Intelligence led and targeted interventions to ensure compliance with smokefree legislation.
   - Annual enforcement programme to target interventions to tackle illicit, counterfeit, bootlegged and smuggled tobacco. This is in conjunction with the police
   - Intelligence led and targeted enforcement programme to reduce availability and supply of tobacco to children
   - Links with the Community Action Team (CAT) to deliver community based tobacco control initiatives covering the 3 Multi-Agency Problem Solving Groups (MAPS) areas

   The Council communications team support promotion of national, regional and local tobacco control campaigns: e.g. 'No Smoking Day', 'Stoptober', 'Keep it out', 'Every breath'. This is both to staff as well as the wider community.

   The Regeneration & Economic Development service grouping support housing associations to identify policies that will support the smokefree families initiative to protect children from second hand smoke in the home.

9. The Tobacco Control Alliance partners of County Durham have an ambition that by 2030 smoking prevalence in County Durham is reduced to 5%, and amongst routine and manual groups reduce smoking prevalence to 10%. This ambition is driven by a vision to make children the future focus for protection and the statement below is the commitment to this:-

   "The tobacco-free generation is a vision well worth striving for – that a child born now in any part of County Durham will reach adulthood breathing smokefree air, being free from tobacco addiction and living in a community where to smoke is unusual. We owe it to our children to make this happen"
   (Adapted with kind permission from ASH Scotland - 2013)

10. The Smokefree Tobacco Control Alliance for County Durham brings together partners from across the county to work together to implement action locally. It will use the ASH (2012) Clear Thinking, Excellence in local tobacco control as a driver.

11. The alliance is jointly chaired by Councillor Audrey Laing, Support Member for Councillor Lucy Hovvels (Safer & Healthier Communities) Durham County Council and Anna Lynch, Director of Public Health, County Durham. The alliance must deliver on all key strands:-

- Developing infrastructure, skills and capacity at local level and influencing national action
- Reducing exposure to second hand smoke
- Helping Smokers to quit
- Media communications and social marketing
- Reducing the availability of tobacco products and reducing supply of tobacco
- Reducing the promotion of tobacco
- Tobacco Regulation
- Research, Monitoring and evaluation

This alliance plan covers activity for year one, 2013/14, of a five year medium term plan that supports a long term plan to 2030.

12. The plan was provisionally signed off by the Health Improvement Partnership on 11th July 2013.

Partners signed up to the alliance:-

Durham County Council
County Durham and Darlington NHS Foundation Trust
North Durham CCG
Durham Dales, Easington and Sedgefield CCG
Tees Esk and Wear Valleys NHS Foundation Trust
County Durham Health Networks
County Durham Area Action Partnerships (AAP)
County Durham and Darlington Fire and Rescue Services
County Durham FE Colleges
Fresh

Recommendations

13. The Health and Wellbeing Board is requested to:

- Receive and support the tobacco control alliance plan.

Background Papers
Joint Health and Well Being Strategy www.durham.gov.uk/jhws

Contact: Dianne Woodall, PH Portfolio Lead
Email: Dianne.woodall@durham.gov.uk Tel: 03000 267671

Appendix 1: Implications

Finance
Budgets are currently in place to deliver on actions from the plan over the next two years. However longer term commitment is needed to sustain delivery of some actions

Staffing N/A

Risk
Smoking accounts for 20% of new cases of cancer (23%M and 16%F). Tobacco causes nearly 1 in 5 deaths in England annually. For each death, 20 more suffer tobacco-related illnesses. Local authorities have a duty to promote the health of their population and comprehensive tobacco programmes (local alliances action plans) deliver the framework for this. Failure to deliver a comprehensive tobacco programme will impact on the Joint Health and Well-being Strategy 2013 – 2017 where tobacco control actions/targets are embedded within.

Equality and Diversity / Public Sector Equality Duty N/A

Accommodation N/A

Crime and Disorder N/A

Human Rights N/A

Consultation N/A

Procurement N/A

Disability Issues N/A

Legal Implications N/A

Making Smoking History in County Durham

Smoke Free County Durham
Tobacco Control Action Plan

The Vision

"The tobacco-free generation is a vision well worth striving for – that a child born now in any part of County Durham will reach adulthood breathing smokefree air, being free from tobacco addiction and living in a community where to smoke is unusual. We owe it to our children to make this happen

(Adapted with kind permission from ASH Scotland - 2013)

2013/14
Year one of a five year plan 2013 – 2017

Signed off by the Health Improvement Partnership 11th July 2013
Agreed by Cabinet 30th October 2013

Tobacco Control - The Challenge

An ambition to reduce smoking prevalence in County Durham to 5% by 2030

Smoking is the biggest preventable cause of death globally, killing half of all smokers prematurely. In the 20th century, the tobacco epidemic killed 100 million people worldwide. During the 21st century, it could kill one billion. Smoking causes 50 different conditions and costs the NHS £2.7 billion to treat every year. Tobacco is a leading cause of health inequalities and is responsible for half the difference in life expectancy between rich and poor.

The tobacco control movement seeks to address the death, disability and disease caused by smoking and can be seem a global response to the greatest public health threat the world has ever faced.

To counteract the tobacco epidemic, the tobacco control movement needs to recruit advocates who can engage politicians, opinion leaders and the public in the smoking debate. The main aims of tobacco control activities include reducing exposure to secondhand smoke, the use of proven treatments of tobacco addiction, promoting effective health campaigns, banning tobacco marketing and promotion, increasing tobacco taxation and tackling illicit trade in tobacco products.

Tobacco is unique. It is the only product that kills when it is used entirely as intended. Tobacco is not abused. It is marketed by the tobacco industry to be smoked and inhaled. In doing this, it kills half of its consumers.
(Tobacco Control Advocacy toolkit – A guide to Planning Advocacy activity to tackle tobacco 2010)

In 2011 the government published the White paper 'Healthy Lives, healthy People: A Tobacco Control Plan for England'. A five year plan which under the leadership of local authorities, the government want to encourage the development of partnerships in tobacco control where anyone who can make a contribution is encouraged to get involved. In implementing comprehensive tobacco control in their communities, they encourage local authorities to maximise local involvement by building tobacco control alliances that include civil society.

While the Public Health Outcomes Framework will provide the key source of information about progress on reducing tobacco use, the government is setting three national ambitions to focus tobacco control work across the whole system:

- *Reduce smoking prevalence among adults in England: To reduce (aged 18 or over) smoking prevalence in England to 18.5 % or less by the end of 2015, meaning around 210,000 fewer smokers a year*

- *Reduce smoking prevalence among young people in England: To reduce rates of regular smoking among 15 year olds in England to 12% or less by end of 2015*
- *Reduce smoking during pregnancy in England: To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015*

These national ambitions will not translate into centrally driven targets for local authorities. Rather, they represent an assessment of what could be delivered as a result of the national actions described in the plan, together with local areas implementing evidence-based best practice for comprehensive tobacco control. Local areas will decide on their own priorities and ways of improving health in their communities, in line with the evidence base and local circumstances.
(HM Government 2011 Healthy Lives, Healthy People: A Tobacco control Plan for England)

Smoking and young people
Smoking among young people is associated with a range of factors, operating at the individual, social, community and societal levels which increase children's and young people's risk of becoming smokers. In particular, smoking uptake is linked to disadvantaged social, educational and economic trajectories. Young people are most at risk of becoming smokers if they grow up in families and communities where smoking is the norm and where they have access to cigarettes. Children whose parents and/or siblings smoke are more likely to become smokers.

Exposure to Secondhand smoke
Disadvantaged children, young people and adults are also likely to be exposed to higher levels of second-hand smoke (SHS) than those from more privileged backgrounds. This is due to lower levels of smoking restrictions in the home. More action is needed to protect these vulnerable groups from SHS exposure where they live, and in cars. Action is needed to prevent smoking uptake in children, to help vulnerable adults to quit and to protect children and adults from SHS.

Smoking Prevalence in County Durham
Smoking prevalence in county Durham aged 18+ years is 20.9% (Integrated Household Survey 2011/12). Amongst Routine and Manual Groups this rises to 26%. (See table 1. Tobacco Control Profiles).

Smoking and impact on County Durham

How much is smoking costing County Durham?

The total annual cost of smoking in County Durham is **£27,934,868**, which can be broken down as:

NHS Costs: £21,062,653
Costs to businesses (productivity losses): £6,558,163
Passive smoking costs: £303,744 (adults: £215,838; children: £87,906)

How does this relate to NHS events (e.g. number of hospital admissions?)

The £21,062,653 in annual NHS costs are the result of:
£94,267 GP consultations;
£26,433 practice nurse consultations;
£18,089 outpatient visits;
£4,970 hospital admissions; and
£52,414 prescriptions.

The Local Tobacco Control Profiles for England provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities.

The tool allows local authorities to compare against other local authorities in the region and benchmark against the England average. The table below compares County Durham with the England average. The red circles show where County Durham is worse than the England average.

Table 1. Tobacco Control Profiles for England County-Durham results

Compared with benchmark: Better Similar Worse Not compared

Benchmark Value
Worst/Lowest 25th Percentile 75th Percentile Best/Highest

Indicator	Period	Co Durham		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Smoking attributable mortality	2008 – 10	3,378	275.1	272.8	210.6	371.8		125.2
Smoking attributable deaths from heart disease	2008 – 10	422	38.5	37.0	30.3	58.4		14.6
Smoking attributable deaths from stroke	2008 – 10	138	11.9	11.7	9.8	19.2		4.8
Deaths from lung cancer	2009 – 11	1,213	49.9	53.4	37.2	70.3		20.9
Deaths from chronic obstructive pulmonary disease	2009 – 11	1,026	37.4	34.7	25.3	51.6		12.1
Lung cancer registrations	2008 – 10	1,516	64.4	67.2	46.6	86.2		25.1
Oral cancer registrations	2008 – 10	177	9.0	10.8	9.5	16.6		3.4
Smoking attributable hospital admissions	2010/11	6,748	1,883	2,066	1,420	2,536		726
Cost per capita of smoking attributable hospital admissions	2010/11	13,442,833	44.4	49.0	36.9	61.7		14.5
Smoking prevalence – routine & manual	2011/12 Q1 – 2011/12 Q4	–	26.0%	29.1%	30.3%	49.0%		7.5%
Smoking Prevalence (IHS)	2011/12 Q1 – 2011/12 Q4	–	20.9%	21.2%	20.0%	29.4%		8.2%
Smoking status at time of delivery	2011/12	1,216	21.3%	20.7%	13.2%	29.7%		2.9%

Public Health England (2013) Local Tobacco Control Profiles for England
The values relate to per 100,000 of population.

The County Durham Joint Strategic Needs Assessment (JSNA) contains health profiles which relate to smoking and health and therefore supports the evidence of the need to address tobacco as a high priority for County Durham.

Reducing smoking prevalence in county Durham

The aim of tobacco control is to make smoking less desirable, accessible and affordable. Locally this means improving health and reducing health inequalities by reducing the number of smokers (preventing the uptake of smoking and assisting those who want to quit).

Delivering evidence based tobacco control requires long term strategic commitment to ensure the mechanisms are in place to drive the agenda forward. The vehicle to deliver this then relies on the commitment of a range of partners understanding and supporting the evidence and coming together in the form of a local tobacco control alliance.

Reducing smoking prevalence and reducing the use of tobacco will help County Durham to:

- Cut costs to local public services
- Protect children from harm
- Boost the disposable income of the poorest people
- Cut health inequalities
- Drive real improvement across key measures of population health

To reduce smoking prevalence in County Durham, there needs to be a long term commitment to achieve a vision of *Making Smoking History*. Making Smoking History in County Durham means a commitment to improve health, reduce health inequalities by reducing the death, disability and disease caused by smoking.

The Tobacco Control Alliance partners of County Durham have an ambition that by 2030 smoking prevalence in County Durham is reduced to 5%, and amongst Routine and Manual Groups reduce smoking prevalence to 10%.
This ambition is driven by a vision to make children the future focus for protection and the statement below is the commitment to this:-

"The tobacco-free generation is a vision well worth striving for – that a child born now in any part of County Durham will reach adulthood breathing smokefree air, being free from tobacco addiction and living in a community where to smoke is unusual. We owe it to our children to make this happen"

(Adapted with kind permission from ASH Scotland - 2013)

This tobacco action plan therefore supports this vision over a five year interim plan 2013 – 2017 that aspires to reducing smoking prevalence each year by 1%. The County Durham Tobacco Control Action Plan supports the County Durham Strategies

- Sustainable Community Strategy
- Joint Health and Wellbeing Strategy
- Children, Young People & Families Plan

Effective tobacco control requires three domains; **C**hallenge tobacco control services; Local **lea**dership and **R**esults demonstrated by outcomes.

Taken from ASH (2012) **CLeaR** Thinking Excellence in local tobacco control

The Smokefree Tobacco Control Alliance for County Durham brings together partners from across the county to work together to implement action locally. It will use the Clear Thinking approach as a driver. The alliance is jointly chaired by Councillor Audrey Laing, Support Member for Councillor Lucy Hovvels (Safer & Healthier Communities) Durham County Council and Anna Lynch Director of Public Health County Durham.

The alliance must deliver on all key strands.

1. Developing infrastructure, skills and capacity at local level and influencing national action.
2. Reducing exposure to second hand smoke
3. Helping Smokers to quit
4. Media communications and social marketing
5. Reducing the availability of tobacco products and reducing supply of tobacco
6. Reducing the promotion of tobacco
7. Tobacco Regulation
8. Research, Monitoring and evaluation

This alliance plan covers activity for year one 2013/14, of a five year medium term plan that supports a long term plan to 2030 to reduce smoking prevalence to 5%.

Partners signed up to the alliance:-
Durham County Council
County Durham and Darlington NHS Foundation Trust
North Durham CCG
Durham Dales, Easington and Sedgefield CCG
Tees Esk and Wear Valley NHS Foundation Trust
County Durham Health Networks
County Durham Area Action Partnerships (AAP)
County Durham and Darlington Fire and Rescue
County Durham Further Education Colleges
Fresh

Reduce Smoking Prevalence – County Durham Baseline 20.9% (Integrated Household Survey 2011/12)
Routine and Manual Groups – County Durham Baseline 26% (integrated Household Survey 2011/12)

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
Healthy Lives, Healthy People: A Tobacco Control Plan for England 2011 – 15. County Durham Joint Health and Wellbeing Strategy. Sustainable Community Strategy. Children, Young People and Families Plan Safe Durham Partnership Plan	**Developing infrastructure, skills and capacity at local level and influencing national action.**	A sustainable 5 year interim TC alliance plan for County Durham with engagement and representation from key partners. The plan will support the National Tobacco Plan (NTP) and align to Governments three national ambitions Reduce smoking prevalence among adults 18 year + Reduce smoking prevalence among young people (15 year olds) Reduce smoking during pregnancy Support the longer term ambition to reduce smoking prevalence to 5% by 2030	Dec 2013 April 2014	Draft plan submitted to Health Improvement Partnership (HIP) in July Action Plan developed and signed off by the new Health Improvement partnership (HIP) Action Plan presented to H&WB Board Integrated Household Survey	Dianne Woodall DCC Dianne Woodall DCC Anna Lynch		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Partner organisations support WHO Framework Convention Tobacco Control - Protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry Cease British American Tobacco BAT Pensions investments No sign up in support of Tobacco Front Groups	March 2017	Disinvest DCC pension in BAT	Association of North East Councils (ANEC) All partners		
		Commit to a sub national Tobacco Programme.	April 2013 - 2017	Five year funding commitment	North East Local Authorities		
		Comprehensive review of alliance via the ASH Clear Thinking model 'Excellence in local tobacco control' Undergo a one day peer-based challenge	March 2014	Peer Assessment held, report produced and actions identified	Dianne Woodall DCC		
		Link alliance with Regional Networks.	June 2013 Sept 2013? Dec 2014 March 2014	Alliance member attendance at Smokefree North East Network meetings. Submit quarterly alliance updates	Dianne Woodall DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Trained advocates versed in local tobacco vision identified key advocates to be trained		number of elected members trained number of key advocates trained	Fresh		
		Input to local strategic and decision makers forums	July 2013 Jan 2014	Six monthly report/attend HIP group. Presentations to CCGs	Dianne Woodall DCC		
		Engage/involve AAPs and Health Networks when community based tobacco control activity is undertaken and when TC action is required	Quarterly	HN/AAPs input on the tobacco control agenda/action plan?	PH portfolio leads linked to AAP Health Network chairs		
		Alliance partner organisations commit to share Intelligence to support wider tobacco control e.g. Tab houses Proxy sales Non-compliance with Smokefree (SF) law Non-compliance with local policies	Quarterly	Reporting noted And actions taken	All partners		
		Implement Making Smoking History programme in Further Education colleges	March 2014	No. of colleges implementing programme	Dianne Woodall DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
	Reducing exposure to secondhand smoke (SHS) To reduce exposure to SHS for children, vulnerable adults and workers	Establish a baseline of the impact of the Smoke Free Families Initiative (to include training sessions) in two targeted communities in County Durham. Work in partnership with local community groups and agencies to run an awareness campaign on the risks of second hand smoke to children and young people	June 2013 Sept 2013 Dec 2013 March 2014	Measure knowledge of risks before and after campaign Number and type (if any) of changes in smoking behaviour following the campaign.	Ruth Bennett CDDFT		
	De-normalise smoking by increasing public support for SF areas	Support/lobby for legislation for SF cars carrying children MP support and Elected Members	As and when required		Dianne Woodall		
	"	Implement local policy for SF children's play areas	2015		Oliver Sherratt DCC		
	"	Improve compliance with Smokefree hospital grounds	June 2013? Sept 2013? December 2013 March 2014	Policy review and reports against compliance	Claire Matthews CDDFT		
	"	Deliver a programme of intelligence led and targeted interventions to ensure compliance with smoke free legislation in premises and vehicles (including taxis).		No. of awareness campaigns, visits and enforcement actions.	Joanne Waller DCC Michael Yeadon /John Benson DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Improve compliance with smokefree policy on DCC grounds	March 2014 Policy review 2014	Compliance improvement	Kim Jobson DCC		
		Smoke Free Families (SFF) incorporated into Durham Housing Associations. Identify policies that will support SFF project. Identify 20 staff who require training	Sept 2013	Number of staff trained in SFF	Simon Bartlett DCC		
		Gather intelligence from a variety of sources relating to the existence of shisha and water pipe cafes and undertake targeted interventions to ensure compliance with relevant legislation.	none	No. of targeted interventions	Joanne Waller DCC Owen Cleugh / Chris Cooper DCC		
	Supporting smokers to stop	Achieve 5066 quitters	Q1 (Sept 13) Q2 (Dec 13) Q3 (March 14) Q4 (June 14)	Quitters Q1 =1215 Q2 =1063 Q3 = 914 Q4 =1874	Dianne Woodall DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		'Stop before the Op' campaign with GPs	September 2013 December 2013 March 2014	Action plan to implement campaign	Darcy Brown CDDFT		
		Review smoking support within Mental Health settings. Pilot one area of TEWV inpatient area	March 2014	Systems in place to support inpatients	Iain Miller CDDFT Jacqui Dyson TEWV		
		Reduce number of women smoking in pregnancy Baseline for County Durham 2006/7=24% 2012/13 year to date = 19.9%	Sept 2013 (Q1 data 2012/13) Dec 2013 (Q2 data 2012/13) March 2014 (Q3 data 2012/13	Smoking at time of delivery data Target for 2013/14=20.9%	Anne Holt CDDFT		
		Commission Support for young people within substance misuse settings	March 2014	Pilot project with 4Real service	Dianne Woodall DCC		
		Monitor referrals from partners organisations via brief intervention (BI) training	June 2013 Sept 2013 Dec 2013 March 2013	Number of BI delivered Number of referrals	Iain Miller CDDFT		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
	Media, communications, social marketing and education	Develop a MARCOMS plan to support local, regional and national campaigns Support national and Regional Media campaigns:- Keep it out Stoptober Every Breath No Smoking Day **PHE campaigns** Secondhand Smoke - Smokefree homes and cars Stoptober New Year Harms **Need to link to Fresh campaigns** Smokefree Cars Smoking and Pregnancy	June 2013 September 2013 December 2013 March 2014	No. of Campaigns supported:- Number of articles in media, newspapers, radio etc, internal and external news bulletins	Chris Woodcock Karen Stewart DCC		
		Deliver the MARCOMS plan ensuring that publicity and marketing activity is targeted on those areas of high smoking prevalence and / or illegal tobacco activity.	In line with MARCOMS plan	Positive marketing outcomes? Feedback from illicit tobacco steering group	Chris Woodcock Karen Stewart DCC		
		Media Launch of the TC alliance action plan	Sept 2013	Plan launched and disseminated	Chris Woodcock DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Secondary Care support to above campaigns Stop before the Op campaign	September 2013 Dec 2013 March 2014	Internal communications	Paul Scott CDDFT		
		No Smoking Day (NSD):- Deliver a County wide co-ordinated NSD smoking campaign and support activities relating to No Smoking Day	March 2014	NSD action plan meeting No Smoking Day activity	Karen Stewart Chris woodcock DCC		
		Development of a Youth Advocacy approach to tobacco control and alcohol.	Sept 2013 March 2014	Commissioned organisation to deliver project	Dianne Woodall Kirsty Wilkinson DCC		
		Continuing to publicise the dangers of using smoking materials and the part they play in fires. Support specific No Smoking campaigns by providing 'quotes' for articles/press releases.	Sept 2013 Dec 2013 March 2014	No. of press releases	Andrew Allison CDDFR		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Ensure implementation of NICE Guidance on smoking prevention and preventing uptake of smoking Deliver tobacco programme e.g. drama/ workshops to support schools deliver evidence	March 2014	No. of Schools achieving smokefree schools quality standards Commission providers to deliver drama support in schools	Suzanne Irvine CDDFT Dianne Woodall DCC		
		Use online tools to gain public support/insight on TC issues/agendas	Sept 2013 March 2014	Response reports produced	Chris Woodcock DCC		
		Incorporate tobacco as part of the Alcohol led social norms work in schools	Sept 2013	First Smoking Prevalence data of young people in County Durham	Dianne Woodall DCC		
		Develop a bank of client case studies for media purposes	Quarterly	No. of case studies	Karen Stewart DCC		
		Smoking in the movies. Develop actions to raise awareness e.g. paid smoking ads prior to films depicting smoking in Co Durham cinemas	2013 - 2017	TBC	Dianne Woodall DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Awareness of Childhood Initiation and tobacco industry recruiting young people		Tobacco control delivered to Local councillors etc	Anna Lynch		
	Reducing availability and supply of tobacco products-licit and illicit and addressing the supply to children	Deliver an intelligence led and targeted enforcement programme to reduce availability and supply of tobacco products to children	Annual enforcement programme March 2014	% failure in test purchasing. No of complaints No of enforcement actions	Joanne Waller DCC Owen Cleugh / Chris Cooper		
		Deliver staff and community awareness raising through MAPS, AAP's and Housing Associations in order to increase reporting and gain community intelligence concerning illicit, counterfeit, bootlegged and smuggled tobacco products	Sept 2013 Dec 2013 March 2014	4 awareness raising messages delivered – one in each Q.	Grahame McArdle DCC		
		Working In partnership and using local, regional and intelligence sources to plan and deliver special operations and targeted interventions tackling illicit, counterfeit, bootlegged and smuggled tobacco products.	Annual enforcement programme March 2014	No of enforcement actions and quantity of tobacco products seized.	DCC / Durham Constabulary / HMRC Owen Cleugh / Chris Cooper		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Ensure representation on regional Steering Group concerning Illicit Tobacco	Quarterly	Feedback to the Alliance	Chris Cooper DCC Owen Cleugh DCC		
	Tobacco Regulation	Actions to Support Tobacco Regulation Ensure partner involvement in lobbying activity when required in response to tobacco regulation issues • Standardised packaging • Consultation on E-cigarettes • Support for licensing of tobacco sales • Tobacco Taxation	March 2014		Dianne Woodall DCC		
	Reduce tobacco promotion	Ensure partner involvement in lobbying activity when required in response to tobacco promotion issues	March 2014 March 2015 March 2016 March 2017		Dianne Woodall DCC		
		Exposure of the Tobacco Industry tactics, how they promote to young people Use local networks/media/ training opportunities		No. of training sessions offer	All Partners		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Prevent the tobacco industry targeting young people Ensure compliance with tobacco promotions in pubs and clubs	June 2013 March 2014	Include tobacco control measures as part of Best Bar None (BBN) Review Reporting of any non compliance	Carol Feenan DCC Town Centre manager and BBN manager		
	Research, Monitoring and evaluation	Ensure County Durham tobacco Alliance is delivering effectively.	June 2013 Sept 2013 Dec 2013 March 2014	Quarterly reports to Tobacco Control Partnership	Dianne Woodall DCC		
		Health Equity Audit on the Stop Smoking Service	Sept 2013	Audit report produced and circulated	Michael Fleming DCC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Develop links with the Community Action Team (CAT) and deliver a community based tobacco control initiative involving a range of partners including statutory, voluntary and community groups	Two year rolling CAT programme covering 11 LMap areas, subject to further review in 2015 Project Initiation Document (PID) and key outcomes TBC in line with Tobacco Alliance Action Plan Feedback / Performance reviewed at end of each 8-10 week area initiative.	No Interventions undertaken Media / Awareness campaigns Enforcement actions / seizures Community intelligence incident reports Smoking cessation service uptake Level of retailer compliance	Dianne Woodalll / Joanne Waller DCC Various Partner organisations		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Track smoking prevalence 2011/12 England prevalence 20% North East prevalence 21.2% **County Durham 20.9%** Amongst Routine and Manual workers England 30.3% North East 29.1% **County Durham 26%**	March 2014	Integrated Household Survey	Dianne Woodall DCC		
		Establish smoking prevalence baseline for 15 years olds Reduce smoking prevalence amongst this age group	2014 2014 - 2017	Social norms data “	Dianne Woodall DCC		
		Involvement in UK Centre for Tobacco Control Studies ‘Start2Quit’ Study to increase uptake to stop smoking support	Sept 2013 Dec 2013 March 2014	Evaluation of study produced and circulated	Iain Miller DCC		.
		Implement tobacco programme in secondary schools as part of the norms programme		Social norms results	Cornforth Partnership		
		Evaluate long term outcomes of NHS Stop Smoking Service	2013 - 2017	Percentage quit at 12 weeks	Iain Miller CDDFT UKTCRC		

Strategy	Theme / programme area	Objective	Milestone End of Quarter	Performance measure	Lead officer / Delivery partner	Performance RAG	Update Reports Quarter One
		Monitor investment on tobacco control	2013 - 2017	NICE ROI (Return on investment tool)	Dianne Woodall DCC		
		Baby Clear project Increase uptake to stop smoking support amongst pregnant smokers Baseline 2012/13 9.9% conversion rate	March 2014	Number referred to service and number setting a quit date	Iain Miller CDDFT		
		Monitor County Durham's population health via the tobacco control programme Baselines (see Tobacco Control Profiles page 5)	March 2013 - 2017	Tobacco Control Profile Indicators	Tobacco Alliance		
		Reduce children's exposure to second hand smoke Establish baseline of children exposed Monitor yearly results	March 2013 – 2017 March 2014 2015 - 2017	Social norms questionnaire results	Dianne Woodall DCC		

DCC =Durham County Council
CDDFT = County Durham and Darlington Foundation Trust
HIS = Health Improvement Service of CDDFT
UKTCRC Tobacco Control Research Centre

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Health and Wellbeing Board

15 November 2013

Public Mental Health Strategy

Report of Anna Lynch, Director of Public Health County Durham, Durham County Council

1. Purpose of the Report

This report aims to present the Public Mental Health Strategy to the Health and Wellbeing Board. The primary purpose of the strategy is to reduce the number of people developing mental health problems through promotion of mental health, prevention of mental ill-health and improving the quality of life for those with poor mental health through early identification and recovery. This forms a key strand of the County Durham Mental Health Framework which will come to the Health and Wellbeing Board at a later date.

2. Background

The Public Mental Health Strategy for County Durham was developed by the Public Mental Health Strategy Development Group over the last year consisting of key partners, service users and carers. It is based on comprehensive identification of needs and evidence based practice to promote good mental health.

Public mental health encompasses both mental health improvement and suicide prevention, recognising that mental health improvement is a vital tool in the prevention of suicide. This strategy outlines the implications for public mental health in light of the recent mental health strategy, *No Health Without Mental Health* and *Preventing Suicide in England, A Cross Government Strategy to Save Lives*. Taking a life course approach, it recognises that the foundations for lifelong wellbeing are being laid down before birth. It aims to prevent mental ill health, intervene early when it occurs and improve the quality of life for people with mental health problems and their families. It is for people of all ages – children and young people, working age adults as well as older people.

3. Mental Health Profile

Mental illness has a range of significant impacts with 20% of the total burden of disease in the UK attributable to mental illness (including suicide), compared with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that mental illness is not uncommon. Levels of mental illness are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%,

from 8.65 million in 2007 to 9.88 million. However, this does not take account of the current economic climate which may increase prevalence.

4. Public Mental Health Strategy: Vision and Objectives

The vision: Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing.

Key Objectives

Promoting Mental Health

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

Prevention of Mental Ill-Health

- Objective 2: Prevention of mental illness and dementia through targeted interventions for groups at high risk

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

- Objective 4: Improve physical health of people with poor mental health through integration of mental health into existing programmes and targeted approach to those experiencing mental ill-health

- Objective 5: Reduce stigma and discrimination towards people who experience mental health problems by raising awareness amongst the general public, workplaces and other settings

- Objective 6: Prevent violence and abuse through interventions which promote mental health and target interventions for those in high risk groups.

Early Identification of those at risk of Mental Ill-Health

- Objective 7: Improve early detection and intervention for mental ill-health across lifespan

- Objective 8: Promote mental health and prevent mental ill-health through targeted intervention for individuals with mild symptoms

- Objective 9: Increase early recognition of mental ill-health through improved detection by screening and training the workforce

Recovery from Mental Ill-Health

- Objective 10: Improve recovery through early provision of a range of interventions including supported employment, housing support and debt advice.

5. Key Points

A key action of the Public Mental Health strategy is reducing social isolation and loneliness. There are a number of population groups vulnerable to social isolation and loneliness, (e.g., young care-leavers, refugees and those with mental health problems). Older people (as individuals as well as carers) have specific vulnerabilities owing to loss of friends and family, loss of mobility or loss of income. Perhaps not surprisingly, social isolation and loneliness impact on quality of life and wellbeing, with demonstrable negative health effects including lonely individuals having higher blood pressure than their less lonely peers.

Durham County Council has a key role in implementing No Health Without Mental Health and improving the mental health and wellbeing within local communities. Part of this commitment includes the recent identification of an elected member, Councillor Hovvels, as mental health champion whose role will include promoting wellbeing and initiating and supporting action on public mental health.

6. Strategic Framework

The County Durham Mental Health Partnership Board has agreed to lead the development of a strategic framework for County Durham to ensure the local implementation of *No Health Without Mental Health*. The Mental Health framework will include all key strands including the need to intervene early, involve people with mental health problems and their carers in service design and delivery, ensuring access to evidence based treatments which are high quality. The mental health framework will provide a structure for related strategies and plans including the Dementia strategy and the Children's and Young People's Resilience strategy.

The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board. Progress on delivery of the strategic objectives and action plan will be reported on a six monthly basis.

The Public Mental Health Strategy Group considers a quarterly performance report which contains a range of indicators which can be found in Appendix 1 of the strategy document. The Public Mental Health Strategy Group maintains an action plan appropriate to the issues raised from the performance report. Any key issues are escalated to the County Durham Mental Health Partnership Board.

7. Recommendations

The Health & Wellbeing Board is asked to:

- note the current and projected mental health needs within County Durham.
- note that the County Durham Joint Health and Wellbeing Strategy specifies a strategic action to develop and implement a multi-agency Public Mental Health Strategy including Suicide Prevention for County Durham
- note that the Public Mental Health Strategy will form a key strand on the Mental Health Framework for the County
- note that the Public Mental Health Strategy has been developed by a multi-agency group that involved stakeholders service users and carers
- endorse the County Durham Public Mental Health Strategy
- note that there is a detailed action plan, with timescales and named leads to ensure implementation of the strategy.

Contact: Catherine Richardson, Public Health Portfolio Lead
Email: Catherine.richardson@durham.gov.uk Tel: 03000 267667

Background papers:
Public Mental Health Strategy
Public Mental Health Executive Summary

Appendix 1: Implications

Finance
Services which impact on public mental health are commissioned through CCG's and local authority

Staffing
There is a wider workforce implication for the delivery of the strategy to ensure a quality, safe workforce in place.

Risk
Improving mental health and wellbeing is likely to reduce the rate of suicide and self-harm

Equality and Diversity / Public Sector Equality Duty
Impact on protected groups who are more likely to experience poor mental health. Mental health is a protected factor under legislation. Equality impact assessment completed.

Accommodation
No

Crime and Disorder
No

Human Rights
Impact on protected groups

Consultation
Key partners, service users and carers have been members of the strategy development group.

Procurement
No impact

Disability Issues
Impact on protected groups

Legal Implications
Mental health is a protected factor under legislation

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County Durham
Public Mental Health Strategy

2013 - 2017

Contents

Foreword

The Public Mental Health Strategy for County Durham was developed by the Public Mental Health Strategy Development Group consisting of key partners, service users and carers. It is based on comprehensive identification of needs and identifying evidence based practice to promote good mental health.

Public mental health encompasses both mental health improvement and suicide prevention, recognising that mental health improvement is a vital tool in the prevention of suicide. This strategy outlines the implications for public mental health in light of the recent mental health strategy, *No Health Without Mental Health*[1] and *Preventing Suicide in England, A Cross Government Strategy to Save Lives*[2]. Taking a life course approach, it recognises that the foundations for lifelong wellbeing are being laid down before birth. It aims to prevent mental ill health, intervene early when it occurs and improve the quality of life for people with mental health problems and their families. It is for people of all ages – children and young people, working age adults as well as older people.

Good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work, and to achieving our potential. Good mental health is the foundation for well-being and the effective functioning of individuals and communities. It impacts on how individuals think, feel, communicate and understand. It enables us to manage our lives successfully and live to our full potential. Communities with greater social capital can be shown to have higher level of good mental health. Through promoting good mental health and early intervention we can help to prevent mental illness from developing and mitigate its effects.

The strategy aims to build a healthier, more productive and fairer society which builds resilience, promotes mental health and wellbeing and challenges health inequalities.

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Public Mental Health Strategy: Vision and Objectives

The vision: ***Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing.***

Key Objectives

Promoting Mental Health

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

Prevention of Mental Ill-Health

- Objective 2: Prevention of mental illness and dementia through targeted interventions for groups at high risk

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

- Objective 4: Improve physical health of people with poor mental health through integration of mental health into existing programmes and targeted approach to those experiencing mental ill-health

- Objective 5: Reduce stigma and discrimination towards people who experience mental health problems by raising awareness amongst the general public, workplaces and other settings.

- Objective 6: Prevent violence and abuse through interventions which promote mental health and target interventions for those in high risk groups.

Early Identification of those at risk of Mental Ill-Health

- Objective 7: Improve early detection and intervention for mental ill-health across lifespan

- Objective 8: Promote mental health and prevent mental ill-health through targeted intervention for individuals with mild symptoms.

- Objective 9: Increase early recognition of mental ill-health through improved detection by screening and training the workforce.

Recovery from Mental Ill-Health

- Objective 10: Improve recovery through early provision of a range of interventions including supported employment, housing support and debt advice.

Introduction

This strategy adopts the *Mental Illness and Mental Health: The Two Continua Model Across the Lifespan*[3] (figure 1) This model moves past the concept that mental health is the absence of mental illness and believes that mental health can be enhanced regardless of a diagnosis of mental illness. Delivering mental health improvement programmes to those with mental illness requires moving beyond a simplistic categorisation of people as either mentally healthy or mentally ill. In many cases, symptoms of acute mental illness are episodic in nature and surrounded by periods of recovery or wellness. A person can experience mental well-being in spite of a diagnosis of mental illness or, conversely, be free of a diagnosed mental illness but still be experiencing poor mental health.
Figure 1 demonstrates a model with four possible options which individuals may experience.

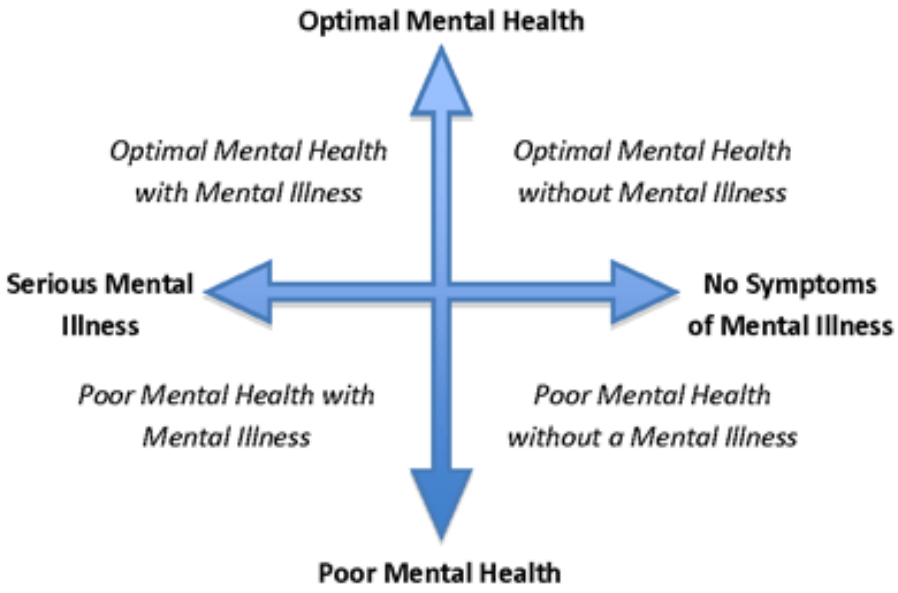


Figure 1: The Mental Health/Illness Continuum

This strategy aims to promote mental wellbeing and prevent the development of mental health issues. It will do this through increasing the resilience of the population in County Durham and reducing risk factors associated with poor mental health. There is a need to promote mental health and emotional well-being at individual and community level; improve the mental health and wellbeing of children and young people, and to reach out to the groups at greatest risk of poor mental health.

The strategy adopts core beliefs to ensure effective delivery including joined-up working between community and voluntary, statutory and business sectors; commitment to engagement and consultation with local community, service users and carers; commitment to achieving and sharing evidence based practice; population and targeted approach to delivering strategy.

DEFINITIONS

The terms 'mental illness' and 'mental wellbeing' are used in this document with the following definitions. This approach follows Joint Commissioning Panel for Mental Health report on Commissioning Public Mental Health Services:

Mental Health and Wellbeing refers to a combination of feeling good and functioning effectively. The concept of feeling good incorporates not only the positive emotions of happiness and contentment, but also such emotions as interest, engagement, confidence and affection. The concept of functioning effectively (in a psychological sense) involves the development of one's life, having a sense of purpose such as working towards valued goals, and experiencing positive relationships

Mental Illness and Mental Ill-Health refers to depression and anxiety (which may also be referred to as 'common mental disorder') as well as schizophrenia and bipolar disorder (which may also sometimes be referred to as severe mental illness)

Mental Health Early Intervention refers to secondary prevention which involves the early identification of mental ill health and early intervention to treat and prevent progression.

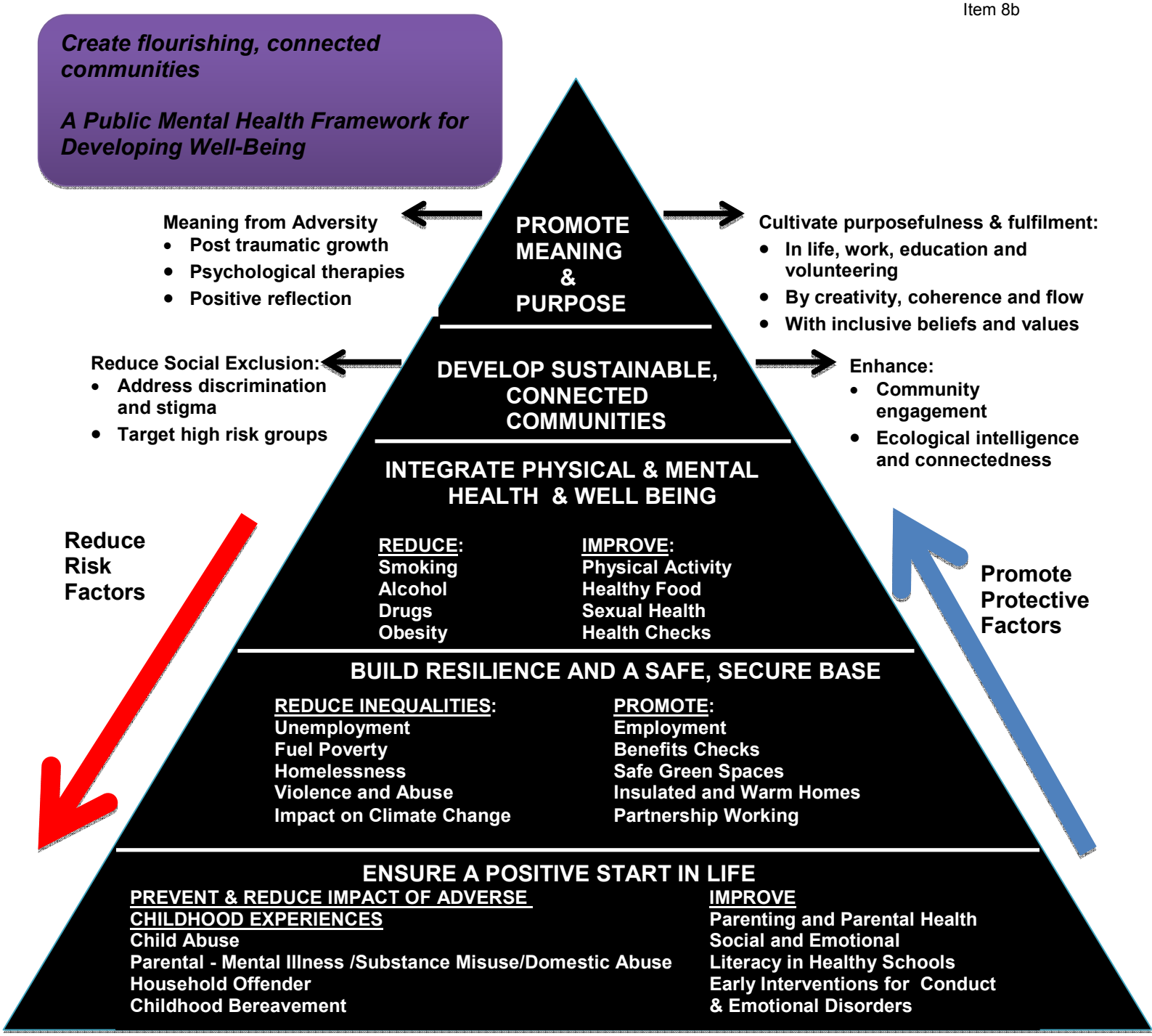
WHAT IS PUBLIC MENTAL HEALTH?

Public Mental Health is the emotional and spiritual resilience which enables us to enjoy life and survive pain, suffering and disappointment. It is a positive sense of wellbeing and an underlying belief in our and others' dignity and worth[4].

Public mental health:

- provides intelligence about levels of mental ill-health and wellbeing across populations, together with information about the risk and protective factors
- informs delivery of interventions which promote wellbeing, prevent mental ill-health, and which identify and treat it at the earliest possible opportunity
- contributes towards improved health and wellbeing and reduced mental ill-health
- improves a range of key outcomes (NHS, public health, and social care)
- reduces the costs of mental ill-health and increases the economic benefits of wellbeing both to the NHS and local authorities and to the wider national economy
- and achieves this through collaboration between the broad range of organisations and agencies whose activities are concerned with and/or influence mental health and wellbeing.

Public mental health is fundamental to public health and health improvement. As the title of the Government mental health strategy declares, there is "no health without mental health. Good mental health provides the bedrock for good physical health and for a range of other important life skills, capacities and capabilities[5]. Figure 2 identifies the factors that influence mental health and offers a framework for the developing wellbeing.



Nurse J [6]

Figure 2: A Public Mental Health Framework for Developing Well-being

Risk and protective factors for positive mental health

Whilst protective factors (Appendix 1) are associated with positive mental health outcomes, generally, they can be summarised as:

- Psycho-social, life and coping skills of individuals, for example increasing a sense of self-esteem and autonomy.
- Social support as a buffer against adverse life events, for example self-help groups, someone to talk to.
- Access to resources and services which protect mental well-being, for example increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

Risk factors increase the likelihood of experiencing poorer mental health and are associated with poorer outcomes for people with mental health problems. Generally, the risk factors can be summarised as:

- The incidence or the impact of negative life events and experiences for individuals, for example, abuse, relationship breakdown, long term illness or disability
- Social isolation and exclusion
- The impact of deprivation and structural inequalities in health

Through acknowledging a wider range of issues which impact on mental health, preventative action can be delivered more effectively.

Risk and protective factors for suicide and suicidal behaviour

Protective factors

Coping skills

A number of coping skills require an understanding of self as an individual capable of shaping motives, behaviour and future possibilities and appear to be protective against suicidal behaviour, including self-control and self-efficacy, social skills and positive future thinking.

Reasons for living

High levels of reasons for living, future orientation and optimism protect against suicide attempt among those with depression.

Physical activity and health

An attitude towards sport as a healthy activity and participation in sporting activity is protective against suicidal behaviour among adolescents.

Family connectedness

Good relationships with parents mitigate against suicide risk, especially in adolescents and including those who have been sexually abused. Positive family relationships also provide a protective effect for adolescents including those with learning disabilities and behavioural conditions.

Marriage is a protective factor against suicide. There is also evidence that marriage has a protective buffering effect against socio-economic inequalities related to suicide, particularly for men. Married men were less likely than non-married men to have problems with drugs, sex, gambling and having used or currently using psychiatric medicine.

Supportive schools

Supportive school environments, including access to healthcare professionals, are important protective factors among adolescents including those who have experienced sexual abuse, those with learning disabilities, behavioural conditions and those who identify as lesbian, gay, bisexual or transgendered.

Social support

Social support in general is protective against suicide among a range of population groups, including women who have experienced domestic abuse.

Religious participation

There is a wide range of evidence to suggest that religious participation may be a protective factor against suicidal behaviour.

Employment

Employment, especially full-time, has a protective effect against suicide [7].

Risk factors

Mental illness

Across all age groups, several diagnoses of mental illness, and a history of psychiatric treatment in general have been established as risk factors for completed suicide. The risk of suicide for some mental health diagnosis may be increased by additional risk factors, such as a history of suicide attempts, other psychiatric diagnoses, drug or alcohol misuse, anxiety, recent bereavement, severity of symptoms and hopelessness.

Substance misuse

Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated for mixed intravenous drug use is greater than that for alcohol misuse. The risk of suicide from alcohol misuse is greater among women than among men. Substance misuse in this country remains a significant factor in poor health outcomes, criminality and worklessness and continues to have far reaching effects upon individuals, families and society as a whole.

Attempted suicide

Those who self-harm have a much greater risk of dying by suicide compared with those who do not engage in this behaviour.

Suicide and older people

People over the age of 65 are more successful than any other age group at taking their own lives. Evidence from a growing body of research shows that suicide in older people is reasonably well understood; it results from complex social, psychological, biological and spiritual processes; depression, underlying physical ill health and frailty and social isolation are important markers.

Personality traits

There may be increased suicide risk associated with particular individuals or personality factors. Suicide risk is higher in a range of personality traits including hopelessness, neuroticism, extroversion, impulsivity, aggression, anger, irritability, hostility, anxiety, attention deficit hyperactivity disorder (ADHD) and eating disorders such as anorexia nervosa and bulimia; and low problem solving skills for example inability to identify and solve singular problems.

Unemployment

Unemployment is linked to increased risk of suicide. Occupational social class and suicide and deliberate self-harm are inversely linked: the lower the social class, the higher the risk of suicidal behaviour.

Poverty

Poverty and deprivation are linked to suicide risk. Areas with greater levels of socio-economic disadvantage have higher suicide rates.

The Economic Cost of Mental Illness

Nationally mental health problems effect one in four of us at some time in our lives. As well as being a major cause of distress for individuals and their families, there is a cost to society in terms of lost productivity and avoidable costs for the criminal justice system as well as the costs of care and support. Although the cost of mental ill health is forecast to double over the next 20 years, some of the cost could be reduced by greater focus on whole-population mental health improvement and prevention, alongside early diagnosis.

The financial costs of the adverse effects of mental health illness on people's quality of life are estimated at £41.8 billion per year in England[8]

Mental ill health is the single largest cause of disability in the UK, contributing up to 23% of the total burden of disease in the UK and 13.8% of NHS expenditure[1].

The economic costs of mental illness in England on the wider economy in terms of welfare benefits and lost productivity at work amount to £77 billion a year.[8]

11% of adult health care costs in the UK are attributable to physical symptoms caused or exacerbated by mental health problems[9].

Labour Force Survey data suggest that 11.4 million working days were lost on Britain 2008/09 due to work related stress, depression and anxiety. Average annual cost of lost employment attributable to an employee with depression is £7,230 and £6,850 for anxiety.

An estimated one million carers in the UK have given up work or reduced working hours to care, over two thirds of those who had given up work to care were more than £10,000 a year worse off as a result. 4 in 10 carers were in debt as a result of caring and the stress of money worries had affected the health of 1 in 2 of UK carers[10].

In England 4,400 people took their own lives in 2009. Suicide has a devastating impact on society and economic costs are also high, estimated at £1.7 million for each life lost for those of working age[11].

Nationally, only 24% of those with a mental health problem work, compared to 75% of the general population. In the North East this falls to around 16%[12].

The Cost Benefit of Public Mental Health

Public mental health interventions reduce the impact of mental illness and poor mental health and produce a broad range of benefits associated with improved wellbeing

Improving mental health impacts on wide range of domains which results in considerable cost savings.[13]

Evidence-based parenting support for families and at-risk children prevents mental health problems in later life and results in better outcomes in health, education, employment, education and relationships[14].

Interventions in families with children at higher risk of conduct disorder would cost £210 million but save £5.2 billion[15].

It is estimated that improved mental health support in the workplace could save UK businesses up to £8 billion a year[16].

Return to work after a period of sick leave for mental health reasons results in reduced welfare claims and reduced use of health and social services, including mental health[17].

Investment in improving access to talking therapies across England through the delivery of employment support, alongside treatment for common mental health problems such as depression and anxiety, can help people to stay in work or return to work[18].

Costs of mental health services can be reduced by half when people with severe mental health problems are supported into mainstream employment[19].

People with severe and long-term mental health problems who are given intensive support to return to the workplace report fewer and shorter subsequent hospital stays than people receiving usual mental health services[20].

The type of savings which can be made from public mental health interventions are highlighted by a recent Department of Health report. This found that for every £1 invested, the net savings were[21]:

- £84 saved – school-based social and emotional learning programmes
- £44 saved – suicide prevention through GP training
- £18 saved – early intervention for psychosis
- £14 saved – school-based interventions to reduce bullying
- £12 saved – screening and brief interventions in primary care for alcohol misuse
- £10 saved – work-based mental health promotion (after 1 year)
- £10 saved – early intervention for pre-psychosis
- £8 saved – early interventions for parents of children with conduct disorder
- £5 saved – early diagnosis and treatment of depression at work
- £4 saved – debt advice services.

National Policy Drivers

No Health without Mental Health[1]: the cross-Government mental health strategy for people of all ages takes a life course approach to improving mental health outcomes for people of all ages with a strong focus on early and effective intervention. The national mental health strategy sets out a clear and compelling vision for improving the mental health and wellbeing of England through six objectives which emphasise the importance of the wider influences on mental health including housing, education, criminal justice system, physical health and employment. Six objectives are:

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

In 2012 the Department of Health published the implementation framework which provides guidance on action at a local level and is designed to influence the full range of organisations whose work has an impact on people's mental health and wellbeing.

Preventing Suicide in England: A cross government outcomes strategy to save lives[22] focusses on six main areas for action:

- Reduce the risk of suicide in key high risk groups
- Tailor approached to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by suicide
- Support the media delivering sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

In December 2010 the government launched its new drug strategy, **Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life.**[23]

A major change to government policy, the 2010 Strategy set out a fundamentally different approach to preventing drug use in our communities, and in supporting recovery from drug and alcohol dependence. The strategy has recovery at its heart and:

- puts more responsibility on individuals to seek help and overcome dependency

- places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
- aims to reduce demand
- takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
- puts power and accountability in the hands of local communities to tackle drugs and the harms they cause

Drug addiction goes hand in hand with poor health, homelessness, family breakdown, and offending. Addicts use drugs compulsively, damaging themselves and those around them. Drug addiction is a complex condition, however, it is treatable.

Starting well

No Health without Mental Health[1] emphasises the crucial importance of early intervention in emerging emotional and mental health problems for children and young people. The social and biological influences on a child's health and brain development start even before conception and continue through pregnancy and the early years of life. Parental mental health is an important factor in determining the child's mental health. Better parental mental health is associated with better outcomes for the child, including better relationships, improved learning and academic achievement, and improved physical health.

Children and Young Peoples Outcomes Strategy[24] mental health thematic report describes the outcome indicators to support delivery of each of the six objectives from No Health without Mental Health[1] and identifies key areas including:

More children and young people will have good mental health

- Fewer children and young people will develop mental health problems by starting well, developing well, learning well, working and living well.

More children and young people with mental health problems will recover

- More children and young people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they needs for living and working, improved chances in education, better employment rates and a suitable and stable place to live as they reach adulthood.

More children and young people with mental health problems will have good physical health and more children and young people with physical ill-health will have better mental health

- There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term conditions.

More children and young people will have a positive experience of care and support

- Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give children and young people and their families the greatest choice and control over their own lives and a positive experience of care.
- Fewer children and young people will suffer avoidable harm
- Children and young people and their families should have confidence that care is safe and of the highest quality.
- Fewer children and young people and families will experience stigma and discrimination
- Public understanding of mental health will improve and, as a result, negative attitudes and behaviours to children and young people with mental health problems will decrease.

Developing Well

As part of the national strategy the Government has committed to take forward detailed plans to extend the Improving Access to Psychological Therapies (IAPT) programme to children and young people. This service transformation for children and young people's mental health care will embed best evidence based practice, training staff in validated techniques, enhanced supervision and service leadership and monitoring of individual patient outcomes.

Living Well

Healthy lives, healthy people: our strategy for public health in England[25] sets out a range of local approaches to improve physical and mental health and acknowledges that the community and environment in which we live can also strongly influence both population and individual mental health and wellbeing.

Approaches of particular importance include:

- reducing isolation, support during times of difficulty, and increasing social networks and opportunities for community engagement;
- providing easy access to continued learning;
- improving support for informal carers;
- warm homes initiatives;

- promotion of physical activity and physical health.

The refreshed carers strategy**, Recognised, Valued And Supported: Next steps for the Carers Strategy**[26], sets out the actions that the Government will take over the next four years to ensure the best possible outcomes for carers and those they support. These include:

- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;
- Enabling those with caring responsibilities to fulfil their educational and employment potential;
- Personalised support, both for carers and for those they support, enabling them to have a family and community life; and
- Supporting carers so that they remain mentally and physically well.
- Supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset, both in designing local care provision and in planning individual care packages;

Working Well

Being in work has important psychological and economic benefits. People who become unemployed are at increased risk of developing mental health problems. The longer a person is out of work, the harder it is for them to return to the job market. Early intervention can help to prevent deterioration of mental health and support job-seeking.

The **Health and Safety Executive Stress Management Standards**[27] set out what employers can do to limit work-related stress and create a culture in which the risks of stress are reduced. Some employers find it hard to understand the difficulties faced by people experiencing mental health problems. They may need advice in order to support employees to remain in or return to work.

The link between employment and mental health is proven. Research shows that generally people enjoy better mental health when they are at work. Satisfying work can therefore play a vital role in improving everyone's well-being and mental health (**Working our way to better health**,[28]). By creating healthy workplaces and raising awareness of mental health issues, employers can reduce both sickness absence due to mental health problems and the costs associated with low productivity

The Government is committed to the health and welfare of people serving in the armed forces, both during and after their time in service. **The Military Covenant**[29] is the basis for government policy aimed at improving the support

available for the armed forces community. The covenant is a pledge made by the government to ensure that the armed forces are not disadvantaged as a result of their service. Mental health services have a key role to play in fulfilling this Covenant.

When individuals leave the armed forces, their healthcare needs become the responsibility of the NHS. For the great majority, that works well. However, for some veterans extra provision is needed because of their reluctance to seek help or because of difficulties navigating civilian health.

The Government has committed further resources in order to work with our strategic partners in ensuring the best treatment possible for veterans with mental health problems.

Ageing Well

As life expectancy increases, healthy life expectancy also needs to increase. By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million in 2008 to million. For those aged 85 and over, the projected increase is from 1.3 million in 2008 to 3.3 million in 2033.89

Depression is the most common mental health problem in older people and is associated with social isolation, long term physical health problems or caring roles, and living in residential care. Dementia affects 5% of people aged over 65 and 20% of those aged over 80.

National policy integrates mental health from the start, and takes into account how physical and mental health is interconnected.

Rapid improvement in dementia care, through local delivery of quality outcomes and local accountability for achieving them is the approach set out in **Living well with dementia: a National Dementia Strategy**[30] and associated compendiums.

Promoting Equality and Reducing Inequality

The **Government Equalities Office states that the Equality Act**[31] is intended to provide a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to deliver a simple, modern and accessible framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

Better mental health, mental wellbeing and better services must be better for all – whatever people's age, race, religion or belief, sex, sexual orientation, disability, marital or civil partnership status, pregnancy or maternity, or gender

reassignment status. These areas constitute the 'protected characteristics' or groups as set out in the Equality Act[31].

No Health Without Mental Health[1] sets out the Government's commitment to promoting equality and reducing inequalities in mental health in relation to the protected characteristics.

Public Health England will have a role in taking forward initiatives that can help tackle stigma and discrimination. People with mental health problems have worse life chances than other people. Part of this is a direct effect of the condition but a large part is due to stigma, ignorance, discrimination and fear surrounding mental health.

Local Policy Drivers

Public Mental Health strategy links to the following local strategies and plans:

- County Durham Joint Health and Wellbeing Strategy[32]
- County Durham Alcohol Harm Reduction Strategy[33]
- County Durham Domestic Abuse Strategy[34]
- County Durham and Darlington Dual Diagnosis Strategy[35]
- County Durham Children, Young People and Families Plan[36]
- County Durham Sexual Violence Strategy[37]

County Durham Joint Health and Wellbeing Strategy

The Health and Social Care Act[38] places clear duties on local authorities and Clinical Commissioning Groups to prepare a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy which will influence commissioning strategies for health and social care, to be discharged through the Health and Wellbeing Board. The County Durham Joint Health and Wellbeing Strategy is a document that aims to inform and influence decisions about health and social care services in County Durham so that they are focused on the needs of the people who use them and tackle the factors that affect health and wellbeing.

The County Durham Joint Health and Wellbeing Strategy[32] strategic objective 4 aims to improve mental health and wellbeing of the population through:

- Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles.
- Work together to find ways that will support ex-military personnel who have poor mental or physical health.
- 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.
- Develop and implement a multi-agency Public Mental Health Strategy including Suicide Prevention for County Durham.
- Continue to improve access to psychological therapies.
- 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).

Mental Health Profile - National

Mental illness has a range of significant impacts with 20% of the total burden of disease in the UK attributable to mental illness (including suicide), compared with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that mental illness is not uncommon

- At least one in four people will experience a mental health problem at some point in their life.
- One in ten children aged between 5-16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression. Over a third (34%) of people with mental health problems rate their quality of life as poor, compared with 3% of those without mental illness.
- 25% of older adults have depression requiring intervention
- Dementia affects 20% of people aged over 80

Levels of mental illness are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million[39]. However, this does not take account of the current economic climate which may increase prevalence.

Age and Mental Health

There is high incidence of mental health problems in older people in the UK. For every 10,000 people aged 65 or over, there are:

2500 people with a diagnosable mental illness
1350 people with depression (1135 receiving no treatment)
500 people with dementia (333 not diagnosed)
650 people with other mental illness[40]

Approximately 700,000 people in the UK have dementia, and this is predicted to rise to over one million people by 2025 [41]

Women and Mental Health

Recorded rates of anxiety and depression are between one and a half and two times higher in women than in men.

Rates of self-harm are two to three times higher in women than in men.

Men and Mental Health

One in eight men has a common mental health problem.

Men have measurably lower access to the social support of friends, relatives and community and are less likely than women to seek help for emotional health problems.

Three quarters of suicides are male.

Lesbian, Gay, Bisexual, Transgender and Mental Health

Gay men and lesbians report more psychological distress than heterosexuals, despite similar levels of social support and physical health as heterosexual men and women[42]

Anxiety, depression, self-harm and suicidal feelings are more common among lesbian, gay and bisexual people than among heterosexual people.
There is a strong association between homophobic bullying and mental ill health, including low self-esteem, fear, stress and self-harm[43]

Learning Disabilities, Behavioural Conditions and Mental Health

An estimated 25-40% of people with learning disabilities also have mental health problems[44] Mental health problems such as depression tend to be under-diagnosed in people with learning disabilities. Many symptoms of mental illness are wrongly regarded as challenging behaviour and so do not receive appropriate treatment[45].

Prevalence of anxiety and depression in people with learning disabilities is the same as for the general population, yet for children and young people with a learning disability, the prevalence rate of a diagnosable mental illness is 36%, compared with 8% of those who do not have a learning disability[46].

Physical Health and Mental Health

Life expectancy is on average 10 years lower for people with mental health problems due to poor physical health.

Physical illness increases the risks of poor mental health:

- there is a higher risk of depressive illness for a wide range of physical illnesses including hypertension, asthma, arthritis and rheumatism, back pain, diabetes, heart disease and chronic bronchitis[47]
- there is a 20% increase of depression or anxiety within one year of diagnosis of cancer or first hospitalisation with a heart attack[48].

Children and Young People and Mental Health

Children and young people with emotional disorders are almost five times more likely to report self-harm or suicide attempts; four and half times more likely to rate themselves or be rated by their parents as having 'fair/bad health', and over four times more likely to have long periods of time off school.

Comorbidity of disorders is common – children and young people frequently have both emotional and behavioural conditions and mental illness and physical health problems[4950].

Mental health and employment

At any one time, one in three people of working age in the UK is likely to be experiencing some kind of mental distress or mental health problem. One in six adults of working age in the UK experiences some symptom of mental distress (sleeplessness, irritability, worry) that does not meet the criteria for a diagnosis of mental ill health but can affect their ability to work

Mental health and offenders

Prisoners have been shown to have significantly higher rates of mental health problems than the general public. For example, 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems.

Housing is a key issue for prisoners and ex-offenders. A third of prisoners are homeless on entering prison, while a further third lose their accommodation because of their imprisonment.

Veterans and Mental Health

A number of UK studies have found links between active service and mental health problems in armed service personnel involved in recent conflicts. A very recent study[51] of 10,000 serving personnel (83% regulars; 27% reservists) found lower than expected levels of PTSD. Mental ill-health and alcohol misuse were the most frequently reported mental illnesses among UK armed forces personnel.

In particular, levels of alcohol misuse overall were substantially higher than in the general population.

Stigma and discrimination in mental health

Nearly 9 out of 10 people with mental health problems have been affected by stigma and discrimination and more than two thirds reported that they have stopped doing things they wanted to do because of stigma.

Public attitudes to mental ill health are gradually improving, with less fear and more acceptance of people with mental health problems.

However, according to the annual national surveys of attitudes to mental illness in England:

- 36% of people think someone with a mental health problem is prone to violence (up from 29% in 2003)
- 48% believe that someone with a mental health problem cannot be held responsible for their own actions (up from 45% in 2009)
- 59% agree that people with mental illness are far less of a danger than most people suppose

Direct social contact with people with mental health problems is the most effective way to challenge stigma and change public attitudes[52].

Carers and Mental Health

Carers provide unpaid care by looking after an ill, frail or disabled family member, friend or partner.
There are now 2.2 million people in UK alone caring for more than 20 hours per week and 1.4 million caring for more than 50 hours per week.
The number of carers is likely to increase in the future as proportion of older people in population increases and peoples life expectancy increases, coupled with the direction of community care policy a 40% rise in the number of carers could be needed by 2037 – an extra 2.6 million carers, meaning the carer population in the UK will reach 9 million.

Mental Health Profile for County Durham

Current information in relation to mental wellbeing is poor. Assessing need in relation to mental health and wellbeing is complex and there are a number of ways in which this challenging problem may be tackled. It is essential to consider sources of information which tell us who and where in our communities are receiving support for mental health issues alongside the range of wider determinants which impact on mental health wellbeing and cause individuals to be more vulnerable to poor mental health.

It is well recognised that social and health inequalities can both result in and be caused by mental ill health. Many of the acknowledged risk factors for mental illness are linked to deprivation. Measures of deprivation can help to identify geographical areas where the need for mental health services is likely to be greatest. County Durham has some of the most deprived areas in the country.

The North East Public Health Observatory published a Community Mental Health Profile for County Durham[53] which is designed to give an overview of mental health risks, prevalence and services at a local level.

Those at higher risk of suffering from poor mental health include:

- More deprived populations
- Those with poor educational attainment
- The unemployed
- Older people
- Those with long term conditions e.g. coronary heart disease
- People with learning disabilities

Mental Health and Deprivation

Nearly 30 % of the residents of County Durham live in the most deprived areas of England, while 10 % of residents live in some of the least deprived areas in England. Deprived areas have substantial levels of multiple deprivation, which helps to measure and identify health inequalities across England. Many studies have demonstrated the association between poor health and deprivation, for example all-cause mortality, smoking prevalence and self-reported longstanding illness are all correlated with deprivation. Any increase in inequalities in deprivation is likely to result in widening inequalities in health.

Mental Health and Housing

The causes of homelessness are complex. For some people homelessness may result from relationship breakdown, from leaving institutional care or because of financial difficulties. County Durham statutory homeless households rate per 1,000 households across all ages for 2010/11 is 1.76 which is significantly better

than England with a rate of 2.03. This indicator highlights a group that are amongst the most vulnerable in society.

Mental Health and Long Term Illness

Poor quality of life through physical illness is known to be closely related to mental health problems. People with mental health problems are twice as likely as the general population to experience a long term illness or disability. The percentage of the population aged over 65 with a limiting long term illness within County Durham (2001) was 23.5% compared to a national average of 16.9% of population.

Mental Health and Wellbeing of Children and Young People

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from mental health problems. County Durham is significantly worse than the England average with a rate of 7.5 per 1000 population compared to 6.2 nationally.

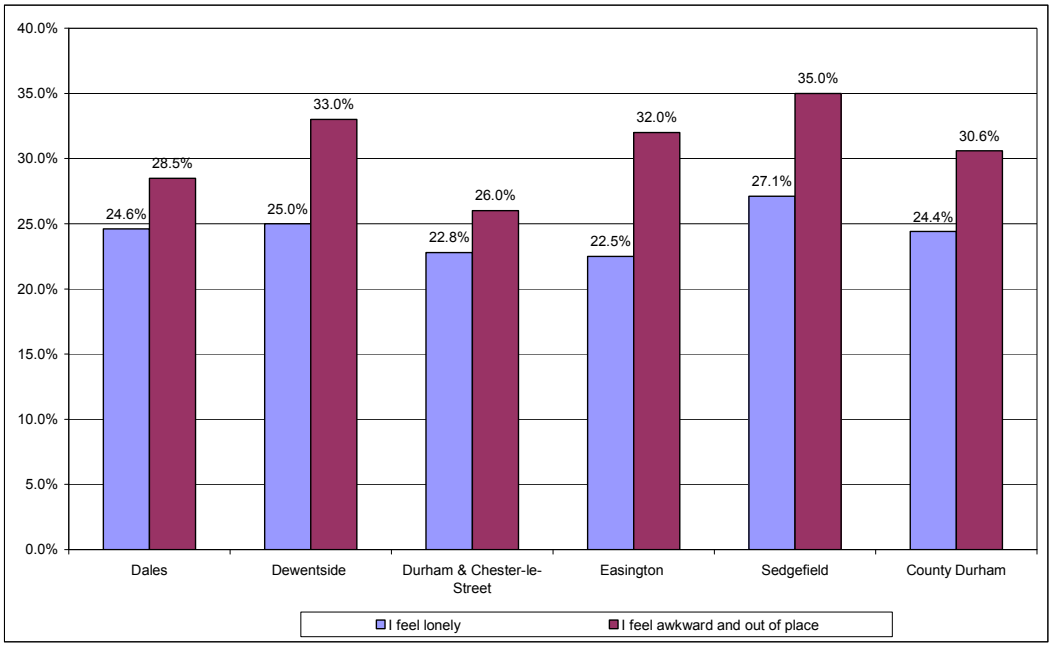
County Durham Children's Trust used the following definition when researching children and young people relationships (2008). Good relationships are when '*children state that they have one or more good friends, and state that they are able to talk about worries, talk to their parents and friends but not another adult'*.

- 56.3% of respondents in County Durham reported good relationships in 2009 compared to 60.3% in 2008.
- Derwentside experiences the highest rate of children and young people that report they have good relationships, 65.4%. Compared to the lowest in Easington, 54.4%

Percentage of children and young people that report they feel lonely, awkward and out of place (Figure 1)

- 24.4% of respondents felt lonely and 30.6% awkward and out of place.
- Sedgefield reported the highest proportion of children and young people feeling lonely 27% and awkward and out of place 35%. This was followed closely by Derwentside with 25% who felt lonely and 33% who felt awkward and out of place.

Figure 1: Percentage of children and young people that report they feel: lonely; awkward and out of place – Children and Young People's Survey.

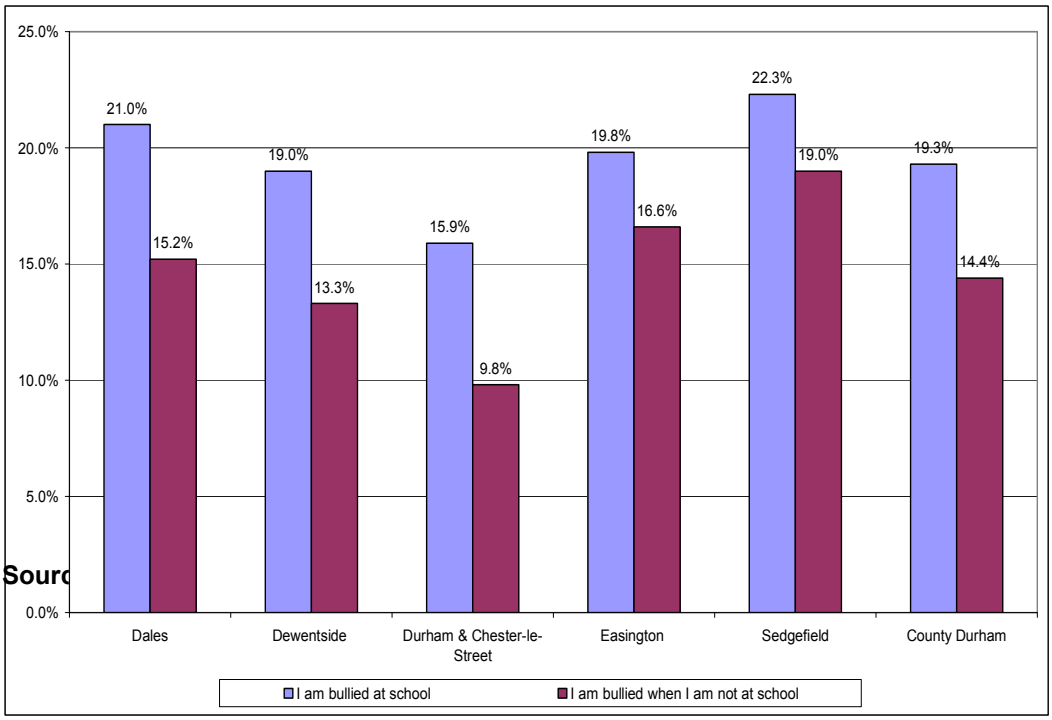


Source: County Durham Children's Trust Children and young people's survey.[54]

Percentage of children and young people that report they are bullied at school and bullied when not at school (Figure 2)

- All areas reported the majority of bullying occurred in school environment
- Sedgefield reported highest levels of bullying both in and out of school

Figure 2: Percentage of children and young people that report they are bullied at school and bullied when not at school – Children and Young People's Survey.



Hospital admissions caused by unintentional and deliberate injuries in under 18 year olds during 2009/10 are significantly higher than the national average at a rate of 123 per 1000 population. The hospital admissions indicator for under 18s is one of the key health improvement outcome measures. It aims to help people to live healthy lifestyles, make healthy choices and reduce health inequalities.

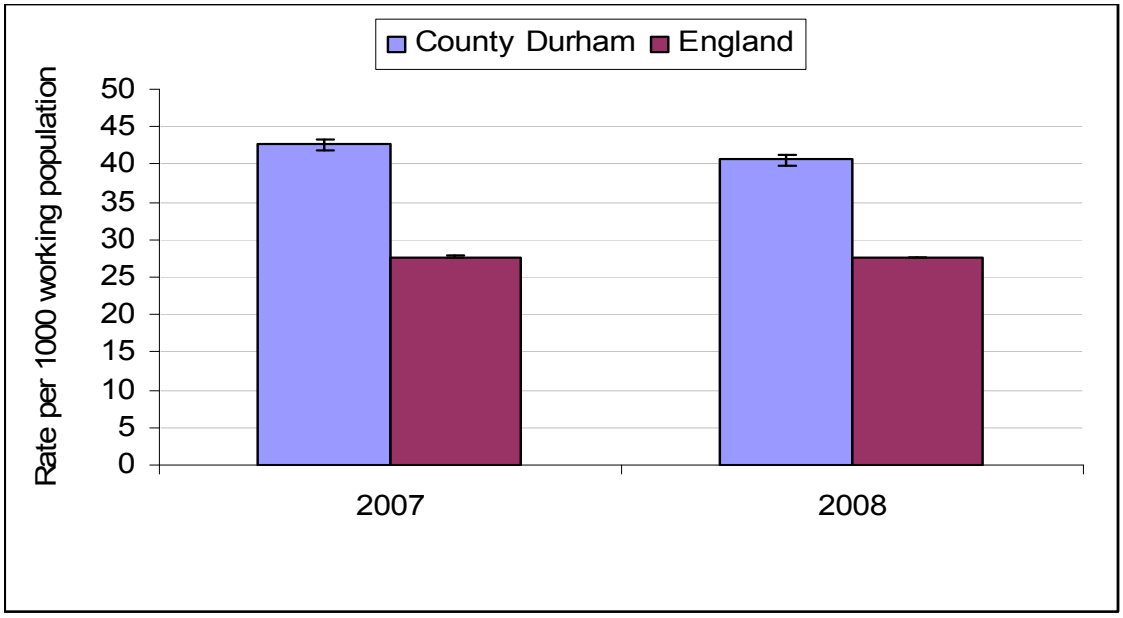
Mental Health and Employment

Long term worklessness is associated with poorer physical and mental health. County Durham rate per 1,000 population working age adults who are unemployed, (2010/11) is higher than England with a rate of 62.2 compared to England rate of 59.4.

Mental Health and Welfare Support

Rates of incapacity claimants (per 1,000 working age population) in County Durham were significantly higher than England in 2007 and 2008 (Figure 3)

Figure 3: Claimants of incapacity benefit with mental or behavioural problems per 1,000 working age population, with 95% confidence intervals, County Durham and England, 2007 and 2008.



National Clinical Health Outcomes Database (NCHOD).[55]

Mental Health and Alcohol

Alcohol misuse leads to a range of public health problems and the long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions. Alcohol affects all of society, from the burden on the NHS in terms of hospital admission and treatment in primary care, the economic burden due to loss of employment and reduced capacity to work, through to other negative effects of alcohol on the social and behavioural welfare of communities. Rate per 1,000 population (2010/11) for hospital admissions for alcohol attributable conditions, County Durham is higher than England average at rate of 30.2 and England rate of 22.1.

County Durham local suicide audit has identified that over half of all suicides have over the legal drink drive limit of alcohol in their system at time of death.

People with Learning Disabilities and Behavioral Conditions

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence than found in those without learning disabilities. Percentage of adults aged 18 years and over with learning disabilities (2011/12) within County Durham is 0.57% which is higher than the England average of 0.45%.

The incidence of children with mild to severe learning disabilities is expected to rise by 1% year on year for the next 15 years due to a number of factors and 40% of these children have a diagnosable mental health problem. Across County Durham there are approximately 1000 children and young people with a learning disability and of these 390 will have mental ill-health, rising to 450 over the next 5 years.

A growth in the size of the population aged 65 years and over is expected which will increase the numbers of adults with a learning disability. As adults with a learning disability grow older, their carers will also grow older and will therefore be more likely to need services themselves. There is evidence that adults with a learning disability are more likely to be affected by dementia than people without a learning disability.

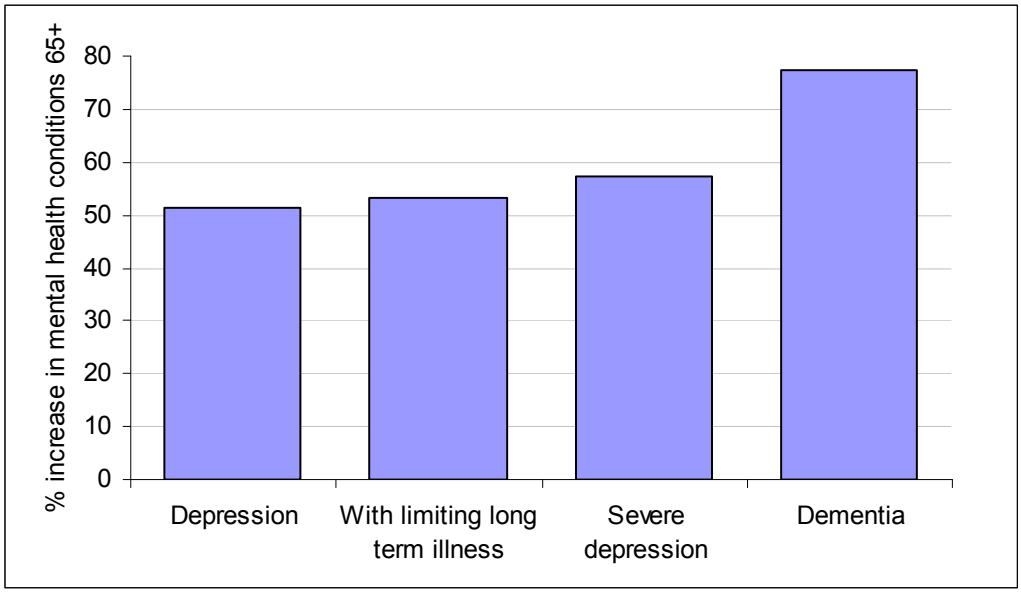
Diagnosed Mental Illness

Dementia is a syndrome characterised by catastrophic, progressive global deterioration in intellectual function and is a main cause of late-life disability. The prevalence of dementia increases with age and is estimated to be approximately 20 % at 80 years of age. In a third of cases, dementia is associated with other psychiatric symptoms such as depressive illness, generalised anxiety and alcohol related problems.

POPPI (2011)[56] predicts (figure 4) that in County Durham the number of people predicted to have:

- depression will rise from 7,986 to 11,869 (48.6%).
- limiting long term illness will rise from 52,734 to 79,188 (50.2%).
- severe depression will rise from 2,512 to 3,870 (54.1%).
- dementia will rise from 6,153 to 10,951 (78%)

Figure 4: Percentage increase in people aged 65+ predicted to have a mental health diagnosis, projected to 2030, County Durham



Source: Projecting Older People Population Information Systems (POPPI)[57]

Within County Durham the percentage of adults (18+) with depression during 2011/12 is almost 15% which is significantly worse than England average of 11.5%[58]. Depression is the most common mental health problem in older people. Some 25% of older people in the community have symptoms of depression that may require intervention. Older people with physical ill health, those living in residential care and socially isolated older people are at higher risk. Yet these problems often go unnoticed and untreated. Studies show that only 1 out of 6 older people with depression discuss their symptoms with their GP and less than half of these receive adequate treatment.
As well as the impact on quality of life, untreated depression in older people can increase the need for other services – including residential care.

By 2029 it is projected that 28.9% of the population in County Durham will be over the (current) pensionable age. An ageing population in County Durham will present several challenges for both health and social care. An increasingly older population will see rising prevalence of mental health conditions, dementia, increased levels of disability and long term conditions and will significantly increase the number of people needing to provide care to family members or friends.

Carers

Labour Market Profile for County Durham[59] estimate 6,060 carers in receipt of carers allowance within County Durham. However based on 2001 census data there are 57,225 carers living in the County Durham, of those:

- 14,000 are providing 50 hours or more of care a week
- 1000 carers from black and minority ethnic groups
- 6000 carers who are also full time workers

In light of an aging population the number of carers is expected to increase as is the scale of support needed across County Durham.

Suicide

Reliable, timely and accurate suicide statistics are essential to inform an effective Public Mental Health Strategy for County Durham. To facilitate this, a systematic suicide audit programme has been in place locally since 2002.

Demographically, 81% of those who took their own life between 2005 and 2012 were male, with a peak age of 40-49. 62.% were divorced and 32.% lived alone. Hanging was identified as the most common method used. A significant number of suicides were found to have diagnosed mental health problems (58.9%). Furthermore, 30% were recorded as alcohol dependent, 13% were recorded as users of illicit drugs, and 39.2% had a history of self-harm.

Triggers for suicide are complex and may be a combination of factors. Through the County Durham Suicide Audit some key factors were identified; 26% experienced a relationship or family breakdown; 17% recently bereaved and 12% were in financial difficulty..

Self Harm

Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk factor for subsequent suicide. Self-harm occurs in all sections of the population but is more common among those who are socio-economically disadvantaged or those who are single or divorced, live alone, are single parents or have a severe lack of social support. County Durham has a significantly higher self-harm directly standardised rate than England with 343 hospital admissions during 2010/11 compared to England average of 207.

Priority Groups

- **Children and Young People**
- **People with Learning Disabilities and Behavioral Conditions**
- **Those at high risk of Suicide and Self Harm**
- **People who are unemployed**
- **People who are Homeless**
- **People with co-morbidity of drug and alcohol misuse**
- **Carers**
- **Veterans**
- **people over 65 years**

Public Mental Health National Evidence of Effective Interventions

There is good quality evidence for the benefits of promoting mental health and the cost effectiveness of public mental health interventions which can:

- promote wellbeing and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles
- prevent mental illness, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and prevent suicide
- deliver improved outcomes for people with mental illness as a result of early intervention approaches.

An economic analysis of Public Mental Health identified the following 'best buy' interventions [60] :

- Supporting parents and early years: parenting skills training, pre-school education, home learning environment
- Supporting lifelong learning: health promoting schools and continuing education
- Improving working lives: employment and healthy workplaces
- Positive steps for mental health: diet, exercise, sensible drinking and social support systems
- Supporting communities: environmental improvements

In order to prevent health and social inequalities widening, these interventions need to be applied in a universally proportionate way. This means that those at higher risk receive greater levels of intervention.

Many of the interventions for parents and children are included in the Healthy Child Programme (HCP) which is a framework of good practice in evidence based interventions to promote the health and wellbeing of both children and parents[5].

Starting well promotion of parental mental and physical health, support after birth, breastfeeding support, parenting support, SureStart, Family Nurse Partnership.

Developing well

- pre-school and early education programmes (improved school readiness, academic achievement, positive effect on family outcomes)
- school-based mental health improvement programmes (reduced levels of mental illness, improved academic performance, social and emotional skills).
- childhood conduct and prevention of emotional disorder through reduced maternal smoking during pregnancy, parenting programmes, school and pre-school programmes (e.g. Family Nurse Partnership)
- maternal depression prevention through post-partum psychosocial support, home visitation, health visitor training and peer support

Living well

- improved housing and reduced fuel poverty
- neighbourhood interventions including activities which facilitate cohesion
- debt advice and enhanced financial capability
- physical activity through active travel, walkable neighbourhoods and active leisure
- interventions to enhance social interaction (capital) activities such as arts, music, creativity, learning, volunteering and time banks
- positive psychology and mindfulness interventions
- spiritual awareness, practices and beliefs.

Working well

- work-based mental health improvement
- work-based stress management
- support for unemployed people.

Ageing well

- psychosocial interventions
- socialisation and prevention loss
- interventions for ‘living well’
- depression prevention in older people through targeted interventions for groups at high risk
- dementia prevention via access to physical activities, social engagement, cognitive exercise and antihypertensive treatment.

Prevention of health risk behaviours including smoking, alcohol and drug misuse through:

- promotion of mental health and prevention/early intervention for mental illness prevents a large proportion of associated health risk behaviour
- integration and mainstreaming of mental health into existing programmes (including smoking, alcohol, drugs, obesity, nutrition and physical activity)
- interventions for different health risk behaviours with targeted approaches for those with mental ill-health
- interventions to prevent and intervene early with mental illness.

Prevention of inequality:

- addressing inequality can prevent mental illness
- inequalities which arise from mental illness can be prevented by
- prevention of mental illness and promotion of mental health
- addressing results of mental illness such as smoking
- increasing availability of early intervention for mental illness
- addressing inequalities in service provision.

Prevention of stigma and discrimination:

Mass media campaigns, social contact between individuals subject to discrimination and members of the public, educational programmes to increase mental health literacy, Time to Change.

Prevention of suicide through improved management of depression, general practitioner education, and population-based programmes to promote mental health.

Prevention of violence and abuse

- interventions which promote mental health and prevent mental ill-health
- school based programmes which can also prevent abuse
- targeted interventions for children with conduct disorder and adults with personality disorder, substance dependence and/or hazardous drinking
- targeted interventions for offenders and other high risk groups
- prevention of alcohol-related violence.

Strategic framework performance measures

The performance management framework aligns to the priorities identified within No Health Without Mental Health[1]. The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board (appendix 4). Progress on delivery of the strategic objectives and action plan will be reported on a six monthly basis to the Children and Families Trust and to the Health and Wellbeing Board.

The Public Mental Health Strategy Group considers a quarterly performance report which contains a range of indicators (Appendix 1). The Public Mental Health Strategy Group maintains an action plan appropriate to the issues raised from the performance report. Any key issues are escalated to the County Durham Mental Health Partnership Board.

Summary of Action Plan 2012-2017

Promoting Mental Health

Ensure commissioners and partners utilise the Mental Wellbeing Impact Assessment Tool which will enable organisations and communities to engage with and improve mental health and well-being and to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's mental well-being.

Develop interventions which aim to improve mental health and wellbeing of children and young people through:

- foster supportive relationships within families and other social networks
- promote 'peer counselling' interventions which build on the coping strategies identified by young people (e.g. physical activities, creative activities, engaging in pleasant activities)
- promote the importance of effective parenting
- promote the role of schools and colleges in delivering a 'whole school' approach to supporting all pupils' wellbeing and resilience
- address bullying both within school and community environment
- ensure children's workforce are aware of how mental health relates to their work

Through the delivery of local workplace health programme, employers will promote healthy workplaces for all, and tackle the causes of mental ill health at work.

Examine how interventions for older people can be extended to address social isolation, increase social interaction and promote greater, safer independent lives.

Ensure services promote equality and are accessible and acceptable to all. Public bodies meet their obligations under Equality Act[31] in relation to mental health and ensure quality of access and outcomes for groups with particular mental health needs, which may include the most vulnerable in society.

Local public health campaigns target people with mental health problems to tackle smoking, obesity and co-morbidities.

More individuals and organisations join the Time to Change and Mindful Employer campaigns[61]

Organisations challenge poor reporting and ensure consistent reporting of mental health issues in the media.

Develop capability and capacity within the wider workforce to deliver services which support and promote public mental health.

Prevention of Mental Ill-Health

Multi-year (interventions with young people that extend over many years of their lives), strategies to address high-risk behaviour in school including prevention, intervention and post vention (bereavement support after suicide) need to be developed and evaluated systematically.

Encourage collaboration in the delivery of effective public mental health approaches which recognise that illness, health and wellbeing are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of the life course.

Expand local provision of social prescribing options to include arts of prescription, leisure on prescription, learning on prescription, computerised CBT, books on prescription, and exercise on prescription.

Support carers in their caring role enabling them to have a life of their own and to stay mentally and physically well

Promote the delivery of the outcomes in the National Dementia Strategy[62]
Improve opportunities for people experiencing mental health issues or who may need extra support to access and retain employment, a place in education or training and other meaningful activity in the community.

Employment support organisations to use effective approaches to help people with mental health problems to find and keep work.

Increase provision of general bereavement support services and bespoke individual and group post-vention support

Provide access to local relationship support services

Ensure health and social care services consider the impact of domestic violence on mental health and wellbeing and provide support appropriately

Provide an integrated welfare rights and money/debt advice service targeted at people within County Durham experiencing mental health issues.

Improve access to lifestyle advice including stop smoking and weight management services within community venues for people with poor mental health.

Co-ordinate services to increase the physical health of people with poor mental health through the promotion of healthy lifestyles and reducing health risk behaviours.

Promote the delivery of physical health checks to improve the physical health of people with poor mental health.

Early Identification of those at risk of Mental Ill-Health

Through additional education and training, public services will recognise people, of all ages at risk of mental health problems and take appropriate timely action; recognise the wider determinants of mental health and wellbeing including how these differ for specific groups and address them accordingly.

Frontline workers, across the full range of services, are trained to understand mental health, principles of recovery and suicide prevention.

Develop a dual diagnosis strategy for people with dual mental health/learning disability and substance misuse issues.

Ensure early recognition of mental illness through improved detection by screening and health professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.

Recovery from Mental Ill-Health

Services work together to support people with mental health problems to maintain, or return to, employment.

Provide specialist employment support service for individuals' with mental illness, accessing primary care services, who are receiving sickness benefits or who are at risk of losing their employment as a result of mental health difficulties.

Provide specialist employment support for those with severe mental illness, utilising the evidence based model of Individual Placement and Support

Improve access for individuals into support and recovery through early provision of activities such as supported employment, housing support, and debt advice.

Appendix 1 Protective Factors for Positive Mental Health

Individual	Community	Workplace	Societal/Structural
Feeling safe	Stable and supportive environment	Feeling safe, not bullied or harassed	Socio-economic conditions: income, financial security
Self-determination	Participation and influence: local democracy	Decision-making latitude	Participation and influence
Resilience and problem solving skills	Cultural life		Tolerance and trust Absence of discrimination
Feeling in control	Opportunities for lifelong learning	Job control	Respect for diversity
Confiding relationships	Social capital: networks, supports and resources	Reasonable adjustment	
Access to social networks	Tolerance and trust	Social support - vertical and horizontal	
Financial security	Amenities and services	Effort reward balance	Economic stability Absence of marked social and economic inequalities
Meaningful activity and roles	Hopefulness	Opportunities for development and learning	
Creativity	Opportunity for arts and creative activities		
Spirituality	Access to faith groups	Respect for diversity	Tolerance and respect for diversity

(Equal Minds, 2005)[63]

Appendix 2 Key Performance Indicators

Indicator	Latest Performance	2013/14 Target
Emotional Wellbeing		
Emotional and behavioural health of looked after children	15.9% (2012/13)	Tracker
Percentage of children and young people who report that they make friends easily - Primary	91.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they make friends easily - Secondary	92.9% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they are happy - Primary	97.7% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they are happy - Secondary	96.1% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel awkward and out of place - Primary	31.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel awkward and out of place - Secondary	37.4% (2011/12 Ac Yr)	Not set
Percentage of children and young people who report that they feel lonely – Primary	26.1% (2011/12 Ac Yr)	Tracker
Percentage of children and young people who report that they feel lonely – Secondary	22.6% (2011/12 Ac Yr)	Tracker
Percentage of children in Reception with height and weight recorded who have excess weight	23.6% (2011/12 Ac Yr)	Tracker
Percentage of children in year 6 with height and weight recorded who have excess weight	38.4% (2011/12 Ac Yr)	Tracker
Self-reported wellbeing - people with a low satisfaction score	26.1% (2011/12)	Tracker
Self-reported wellbeing - people with a low worthwhile score	21.6% (2011/12)	Tracker
Self-reported wellbeing - people with a low happiness score	34.7% (2011/12)	Tracker
Self-reported wellbeing - people with a high anxiety score	43.3% (2011/12)	Tracker
Maintaining Independence		
Percentage of adults receiving secondary mental health services known to be in settled accommodation	89% (2012/13)	85%
Proportion of adults with learning disabilities who live in their own home or with their family	86% (2012/13)	
Trust and Safety		
Repeat incidents of domestic violence (referrals to MARAC)	12.6% (2012/13)	Less than 25%
Dealing with concerns of Anti Social Behaviour and crime issues by the local council and police	59% (Jan-Dec 2012)	Tracker

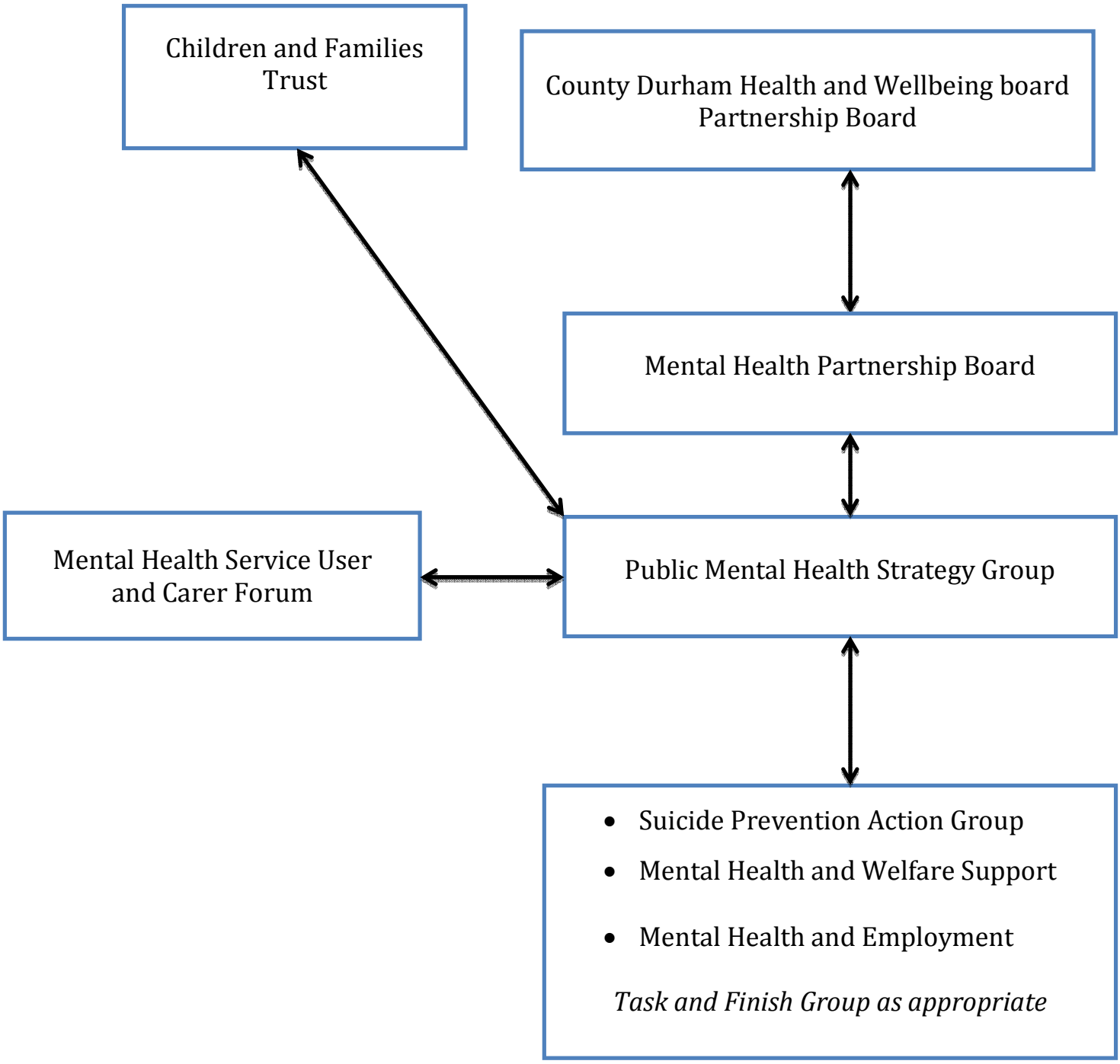
Indicator	Latest Performance	2013/14 Target
Perceptions of ASB	44.5% (April 2013)	Tracker
Number of hate incidents	222 (2012/13	Tracker
Percentage of children and young people reporting that they are bullied when they are at school – Primary	16.6% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are at school – Secondary	14.6% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are not at school – Primary	16.3% (2011/12 Ac Yr)	Not set
Percentage of children and young people reporting that they are bullied when they are not at school – Secondary	5.7% (2011/12 Ac Yr)	Not set
Substance Misuse		
Alcohol harm related hospital admission rates	2,483 (2011/12)	Tracker
Percentage of successful completions of those in drug treatment – opiates	8% (2012/13)	11%
Percentage of successful completions of those in drug treatment - non-opiates	33% (2012/13)	48%
Percentage of young people who drink alcohol	33.9% (2011/12 Ac Yr)	Not set
Percentage of young people who take drugs	3% (2011/12 Ac Yr)	Not set
Learning & Development		
Achievement of 5 or more A*-C grades at GCSE or equivalent including English and Maths	62.5% (2011/12 Ac Yr)	63.0% (2012/13 Ac Yr)
Percentage of pupils on Level 3 programmes in community secondary schools achieving 2 A levels at Grade A*-E or equivalent	99.1% (2011/12 Ac Yr)	98.1% (2012/13 Ac Yr)
16 to 18 year olds who are not in education, employment or training (NEET)	10.4% (2012/13)	Tracker
Care leavers in education, employment or training	82% (2012/13)	75%
Healthy Lifestyle		
Percentage of young people reached through youth work	23.6% (2012/13)	17%
Children and young people's participation in out-of-school sport - Primary	89.4% (2011/12)	Not set
Children and young people's participation in out-of-school sport - Secondary	78.4% (2011/12)	Not set
Percentage of children and young people who have taken part in an activity outside of school in the last 4 weeks - Primary	74.5% (2011/12 Ac Yr)	Not set
Percentage of children and young people who have taken	58.5%	Not set

Indicator	Latest Performance	2013/14 Target
part in an activity outside of school in the last 4 weeks - Secondary	(2011/12 Ac Yr)	
Prevalence of Chlamydia in under 20 year olds (per 100,000)	1,752 (2012)	
Under 75 all cause mortality rate per 100,000 population	302 (2010)	296.8 (2011)
Hospital admissions as a result of self-harm per 100,000 population	354.6 (2010/11)	Tracker
Economic Security		
Children in poverty	23.0% (2010)	Tracker
Proportion of adults with learning disabilities in paid employment	3.6% (2012/13)	
Proportion of adults in contact with secondary mental health services in paid employment	11% (2012/13)	9%
Gap between the employment rate for those with a long term health conditions and the overall employment rate	8.2% (2012)	Tracker
Access to Services		
Number of new referrals to Child and Adolescent Mental Health Services (CAMHS)		10% increase from previous year
Patient experience of community mental health services	88 (2012)	87
The percentage of service users reporting that the help and support they receive has made their quality of life better	94.9% (2012/13)	92%
Carer-reported quality of life	8.7 (2012/13)	
Suicides		
Suicide Rate per 100,000 population	11.4 (2009-11)	Tracker

Appendix 3 *Organisations* involved in the County Durham Public Mental Health Strategy and Implementation Group

BCTV
Breathing Space
British Legion
Canvas – Service user and carer group
CDDFT
Chester-Le-Street Mind
County Durham Carers
Countywide mental health service user and carer forum
Cruse North East
DDES CCG
DISC
Durham Coroners Office
Durham County Council
Durham Police
Durham University
East Durham Trust
Healthworks Easington
Home Group
If U Care Share
Ingeus
Jobcentre Plus
Living Mindfully
Mental Health Care
Mental Health Matters
Mental Health North East
Middlesbrough Mind
Mindful Employer North East
NECCS
New College Durham
NHS
North Durham CCG
PCP
Probation Services
Relate North East
RT Projects
Samaritans
SD Training Ltd
Shaw Trust
Success North East
Support and Recovery, DCC
Teesdale CAB
TEWV
Waddington Street Centre
Welfare Rights

Appendix 4 County Durham Public Mental Health Strategy Group Structure



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County Durham
Public Mental Health Strategy
Executive Summary

2013 - 2017

Contents

Public Mental Health Strategy: Vision and Objectives

The vision: ***Individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing.***

Key Objectives

Promoting Mental Health

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

Prevention of Mental Ill-Health

- Objective 2: Prevention of mental illness and dementia through targeted interventions for groups at high risk

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

- Objective 4: Improve physical health of people with poor mental health through integration of mental health into existing programmes and targeted approach to those experiencing mental ill-health

- Objective 5: Reduce stigma and discrimination towards people who experience mental health problems by raising awareness amongst the general public, workplaces and other settings.

- Objective 6: Prevent violence and abuse through interventions which promote mental health and target interventions for those in high risk groups.

Early Identification of those at risk of Mental Ill-Health

- Objective 7: Improve early detection and intervention for mental ill-health across lifespan

- Objective 8: Promote mental health and prevent mental ill-health through targeted intervention for individuals with mild symptoms.

- Objective 9: Increase early recognition of mental ill-health through improved detection by screening and training the workforce.

Recovery from Mental Ill-Health

- Objective 10: Improve recovery through early provision of a range of interventions including supported employment, housing support and debt advice.

Mental Health Profile

Mental illness has a range of significant impacts with 20% of the total burden of disease in the UK attributable to mental illness (including suicide), compared with 17% for cardiovascular diseases and 16% for cancer. This burden is due to the fact that mental illness is not uncommon

- At least one in four people will experience a mental health problem at some point in their life.
- One in ten children aged between 5-16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression. Over a third (34%) of people with mental health problems rate their quality of life as poor, compared with 3% of those without mental illness.
- 25% of older adults have depression requiring intervention
- Dementia affects 20% of people aged over 80

Levels of mental illness are projected to increase. By 2026, the number of people in England who experience a mental illness is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million[1]. However, this does not take account of the current economic climate which may increase prevalence

Those at higher risk of suffering from poor mental health include:

- More deprived populations
- Those with poor educational attainment
- The unemployed
- Older people
- Those with long term conditions e.g. coronary heart disease
- People with learning disabilities

Nearly 30 % of the residents of County Durham live in the most deprived areas of England, while 10 % of residents live in some of the least deprived areas in England.

People with mental health problems are twice as likely as the general population to experience a long term illness or disability. The percentage of the population aged over 65 with a limiting long term illness within County Durham (2001) was 23.5% compared to a national average of 16.9% of population.

Young people aged 16-18 years old who are not in education, training or employment (NEETS) are more likely to have poor health and die an early death. They are also more likely to have a poor diet, smoke, drink alcohol and suffer from

mental health problems. County Durham is significantly worse than the England average with a rate of 7.5 per 1000 population compared to 6.2 nationally.

Long term worklessness is associated with poorer physical and mental health. County Durham rate per 1,000 population working age adults who are unemployed, (2010/11) is higher than England with a rate of 62.2 compared to England rate of 59.4.

POPPI[2] (2011) predicts that in County Durham the number of people predicted to have:

- depression will rise from 7,986 to 11,869 (48.6%).
- limiting long term illness will rise from 52,734 to 79,188 (50.2%).
- severe depression will rise from 2,512 to 3,870 (54.1%).
- dementia will rise from 6,153 to 10,951 (78%)

Labour Market Profile for County Durham[3] estimate 6,060 carers in receipt of carers allowance within County Durham. However based on 2001 census data there are 57,225 carers living in the County Durham, of those 14,000 are providing 50 hours or more of care a week.

Priority Groups

- Children and Young People
- People with Learning Disabilities and Behavioral Conditions
- Those at high risk of Suicide and Self Harm
- People who are unemployed
- People who are Homeless
- People with co-morbidity of drug and alcohol misuse
- Carers
- Veterans
- People over 65 years

Summary of Action Plan 2012-2017

Promoting Mental Health

Ensure commissioners and partners utilise the Mental Wellbeing Impact Assessment Tool which will enable organisations and communities to engage with and improve mental health and well-being and to assess and improve a policy, programme, service or project to ensure it has a maximum equitable impact on people's mental well-being.

Develop interventions which aim to improve mental health and wellbeing of children and young people through:

- foster supportive relationships within families and other social networks
- promote 'peer counselling' interventions which build on the coping strategies identified by young people (e.g. physical activities, creative activities, engaging in pleasant activities)
- promote the importance of effective parenting
- promote the role of schools and colleges in delivering a 'whole school' approach to supporting all pupils' wellbeing and resilience
- address bullying both within school and community environment
- ensure children's workforce are aware of how mental health relates to their work

Through the delivery of local workplace health programme, employers will promote healthy workplaces for all, and tackle the causes of mental ill health at work.

Examine how interventions for older people can be extended to address social isolation, increase social interaction and promote greater, safer independent lives.

Ensure services promote equality and are accessible and acceptable to all. Public bodies meet their obligations under Equality Act[4] in relation to mental health and ensure quality of access and outcomes for groups with particular mental health needs, which may include the most vulnerable in society.

Local public health campaigns target people with mental health problems to tackle smoking, obesity and co-morbidities.

More individuals and organisations join the Time to Change and Mindful Employer campaigns[5]

Organisations challenge poor reporting and ensure consistent reporting of mental health issues in the media.
Develop capability and capacity within the wider workforce to deliver services which support and promote public mental health.

Prevention of Mental Ill-Health

Multi-year (interventions with young people that extend over many years of their lives), strategies to address high-risk behaviour in school including prevention, intervention and post vention (bereavement support after suicide) need to be developed and evaluated systematically.

Encourage collaboration in the delivery of effective public mental health approaches which recognise that illness, health and wellbeing are influenced by a broad range of social, cultural, economic, psychological, and environmental factors at every stage of the life course.

Expand local provision of social prescribing options to include arts of prescription, leisure on prescription, learning on prescription, computerised CBT, books on prescription, and exercise on prescription.

Support carers in their caring role enabling them to have a life of their own and to stay mentally and physically well

Promote the delivery of the outcomes in the National Dementia Strategy[6]. Improve opportunities for people experiencing mental health issues or who may need extra support to access and retain employment, a place in education or training and other meaningful activity in the community.

Employment support organisations to use effective approaches to help people with mental health problems to find and keep work.

Increase provision of general bereavement support services and bespoke individual and group post-vention support

Provide access to local relationship support services

Ensure health and social care services consider the impact of domestic violence on mental health and wellbeing and provide support appropriately

Provide an integrated welfare rights and money/debt advice service targeted at people within County Durham experiencing mental health issues.

Improve access to lifestyle advice including stop smoking and weight management services within community venues for people with poor mental health.

Co-ordinate services to increase the physical health of people with poor mental health through the promotion of healthy lifestyles and reducing health risk behaviours.

Promote the delivery of physical health checks to improve the physical health of people with poor mental health.

Early Identification of those at risk of Mental Ill-Health

Through additional education and training, public services will recognise people, of all ages at risk of mental health problems and take appropriate timely action; recognise the wider determinants of mental health and wellbeing including how these differ for specific groups and address them accordingly.

Frontline workers, across the full range of services, are trained to understand mental health, principles of recovery and suicide prevention.

Develop a dual diagnosis strategy for people with dual mental health/learning disability and substance misuse issues.

Ensure early recognition of mental illness through improved detection by screening and health professional education programmes as well as improved mental health literacy among the population to facilitate prompt help seeking.

Recovery from Mental Ill-Health

Services work together to support people with mental health problems to maintain, or return to, employment.

Provide specialist employment support service for individuals' with mental illness, accessing primary care services, who are receiving sickness benefits or who are at risk of losing their employment as a result of mental health difficulties.

Provide specialist employment support for those with severe mental illness, utilising the evidence based model of Individual Placement and Support

Improve access for individuals into support and recovery through early provision of activities such as supported employment, housing support, and debt advice.

Governance

The performance management framework aligns to the priorities identified within No Health without Mental Health. The Public Mental Health Strategy group is accountable to the County Durham Mental Health Partnership Board. Progress on delivery of the strategic objectives and action plan will be reported on a six monthly basis to the Children and Families Trust and to the Health and Wellbeing Board.

The Public Mental Health Strategy Group considers a quarterly performance report which contains a range of indicators. The Public Mental Health Strategy Group maintains an action plan appropriate to the issues raised from the performance report. Any key issues are escalated to the County Durham Mental Health Partnership Board.

Appendix 1 Bibliography

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Health and Wellbeing Board

15th November 2013

Social Care funding transferring from NHS England

Report of Rachael Shimmin, Corporate Director, Children and Adult Services
Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group

Purpose of the Report

1. Following discussion at the Health and Wellbeing Board development meeting on 25th September 2013, this report seeks agreement and ratification from the Board of the proposed use of the 2013/14 and 2014/15 allocations of social care funding and content for the associated Section 256 agreement.

Background

2. Social care funds of c£10.1m for 2013/14 and c£10.5m for 2014/15 are due to be transferred from NHS England to the local authority under a Section 256 agreement. This follows on from previously agreed Section256 agreements in 2011/12 and 2012/13 between the Council and the former PCT. The 2014/15 funding is the forecast position.

3. The Department of Health has recently issued updated guidance (letter dated 19th June Gateway Ref 00186) with regards to the use and governance of these funds. (Appendix 2)

4. The guidance also requires the Area Teams to ensure that the Clinical Commissioning Group/s and local authority take a joint report to the Health and Wellbeing Board to ratify what the funding will be used for.

5. Once the Health & Wellbeing Board ratifies the report a copy of the signed agreement is required by NHS England. When this is received Purchase Orders can be set up by the Area Team with the Local Authority that will confirm the precise financial arrangements.

6. The agreed Section 256 Agreement for ratification is at Appendix 3.

7. Our current understanding is that the allocation of this social care funding in 2015/16 is contained within the £3.8bn announced in the June spending round but the detailed guidance is still being developed.

Proposals

8. In line with this guidance work is being carried out to ensure the use of these existing funds, locally, complies. It is intended that spend is presented under 3 broad headings:

    - Eligibility (£4m)
    - Prevention (£3.1m)

- Short term assessment & intervention (£3m)

However for the purposes of expenditure plans the detail of these elements will be aligned to the categories/ service areas identified in the guidance letter (appendix 2, table 1).

9. Appendix 4 details examples of the initiatives funded under these 3 headings.

10. The decision to use a significant component of the £10m allocation in order to retain existing eligibility criteria was agreed by the former PCT in recognition of the impact on health budgets if the social care eligibility criteria is raised and thus has also been acknowledged by CCG colleagues who recognise the need to maintain the status quo with the identified investment. The allocation against eligibility is significantly less than would be the cost to Health if the criteria were raised.

11. These plans have been developed alongside and link to the recently published Joint Health & Wellbeing Strategy priorities and both Clinical Commissioning Groups commissioning intentions which have been agreed by all key partners and the Health & Wellbeing Board.

12. As we are now 8 months into the financial year there are concerns that the process of final sign off of these plans and payment to the Council will now carry us into November with the process for 2014/15 needing to commence in January 2014 to meet a March sign off date.

13. Although current indications are that the social care funding allocation will increase slightly in 2014/15 we have not received a confirmed figure. Nevertheless, the Council and the CCGs have agreed in principle that the Section 256 agreement attached is extended to cover the financial periods 2013/14 and 2014/15 as the proposed spending plans will not vary significantly and are waiting for confirmation from NHS England that this is acceptable.

Recommendations

14. The Health and Wellbeing Board is recommended to:

- Note the content of this report
- Agree the proposed options for use of the Social Care Funds
- Ratify the attached Section 256 Agreement

Contact: Nick Whitton, Head of Commissioning, Durham County Council
nick.whitton@durham.gov.uk

Background papers:
Department of Health guidance letter
Section 256 partnership agreement

Appendix 1

Finance Social care funds of c£10.1m for 2013/14 and c£10.5m for 2014/15 are due to be passported from NHS England to the local authority under a Section 256 agreement. This follows on from previously agreed s256 agreements in 2011/12 and 2012/13 between the Council and the former PCT. The 2014/15 funding is the forecast position. Appendix 2 sets out proposals for allocation of this funding in line with the priorities of the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

Staffing The use of this funding has staffing implications.

Risk Costs are being incurred by DCC currently. There is also the risk of potential cost shunt issues if not agreed.

Equality and Diversity / Public Sector Equality Duty Any change in service or development will be supported by a discreet equality and diversity assessment

Accommodation N/A

Crime and Disorder Funding included in this agreement supports services which impact on crime and disorder including homelessness and substance misuse services

Human Rights N/A

Consultation The proposals within the report and S256 are continuations of previous agreed developments have been subject to consultation with key stakeholders. The report and agreement have been through both the Council and CCG governance processes for agreement.

Procurement In order to afford the market some stability agreement of the S256 schedule to cover 13/14-14/15 is suggested. Procurements will be carried out under DCC policies and constitution

Disability Issues N/A

Legal Implications N/A

Appendix 2

Gateway Reference: 00186

Financial Strategy & Allocations
Finance Directorate
Quarry House
Leeds
LS2 7UE

Email address – England.finance@nhs.net
Telephone Number – 0113 82 50779

To:
Area Team Finance Directors
CCG Clinical Leads
CCG Accountable Officers

19 June 2013

Dear Colleagues

Re: Funding Transfer from NHS England to social care – 2013/14

1. With reference to the letter of 19 December 2012 from the Department of Health to Paul Baumann (DH Gateway Reference 18568), funding to support adult social care has been passed to NHS England as part of the 2013/14 Mandate.

2. This letter provides information on the transfer to local authorities, how it should be made, and the allocations due to each local authority under Section 256 (5A) (5B) of the 2006 NHS Act. It is noted that decisions may have already been made for the use of the funding and that this letter is formalising such arrangements.

Amount to be transferred
3. For the 2013/14 financial year, NHS England will transfer £859 million from the Mandate to local authorities. We have undertaken an exercise to map all local authorities to NHS England Area Teams, and the amounts to be paid to individual local authorities from the Area Teams are set out at Annex A.

Legal basis for the transfer
4. The payments are to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with each local authority and will be administered by the NHS England Area Teams (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

For reference, please find below the updated Directions, which set out the conditions, Memorandum of Agreement and Annual Vouchers for use:

https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions

In summary, before each agreement is made, certain conditions must be satisfied as set out below:

Use of the funding
5. The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

6. The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system. NHS England will ensure that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

7. In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that local authorities and CCGs have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

8. NHS England will also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

9. The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

10. The *Caring for Our Future* White Paper also sets out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

Governance

11. The Area Teams will ensure that the CCG/s and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measurable outcomes and the agreed monitoring arrangements in each local authority area.

12. The Health & Wellbeing Board then approves the report which has appended to it the agreed Section 256 agreement between the local authority and NHS England. The agreement is signed by both parties.

13. A copy of each signed agreement should be sent to NHS England Finance Allocations Team at england.finance@nhs.net so that a national review of the transfer can be undertaken.

14. Purchase Orders should then be set up by the Area Teams with each Local Authority that will confirm the precise financial arrangements.

Reporting

15. Area Teams will be supplied with specific budget codes to enable them to set up Purchase Orders, monitor the expenditure on this allocation and to drawdown the necessary cash required to pay local authorities on the agreed basis. Area Teams should use their specific cost centre (Annex B) and the local authority sub analysis 2 code (Annex C) to generate their purchase orders (using the non-catalogue request category 'XXX').

16. NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will also ensure that we can report on a consolidated NHS England position on adult social care expenditure.

Table 1: **Analysis of the adult social care funding in 2013-14 for transfer to local authorities**	
Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

Furthermore, as part of our agreement with local authorities, NHS England will ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Further considerations

17. Area Teams to copy this letter to their local government colleagues.

18. NHS England will not place any other conditions on the funding transfers without the written agreement of the Department of Health.

If you require any further information, please contact Tim Heneghan, Senior Finance Lead, Financial Strategy & Allocation on 0113 82 50779 or email tim.heneghan@nhs.net

Yours sincerely

Sam Higginson
Director of Strategic Finance

Annex A - 2013/14 Funding by local authority & Area Team
Annex B – List of Area Team Cost Centres
Annex C - List of Local Authority Sub Analysis 2 codes

Appendix 3

NHS ENGLAND
(DURHAM, DARLINGTON AND TEES)

AND

DURHAM COUNTY COUNCIL

PARTNERSHIP AGREEMENT
Section 256 of the NHS Act 2006

DATED 25th September 2013

Revenue grant agreement relating to
Social Care funding 2013/14- 2014/15

Transfer of funding from NHS England
to
Durham County Council

2013/2014- 2014/2015

This Agreement is made as a DEED on the 25th day of September 2013

BETWEEN

1. **Durham County Council**, whose principal office address is at County Hall, Durham City, DH1 5UL ("the Local Authority")

   and

2. **NHS ENGLAND (DURHAM, DARLINGTON AND TEES)**, whose principal office address is at The Old Exchange, Barnard Street, Darlington DL3 7DR ("NHS England"), which term shall include its statutory or legal successor to its functions and its permitted assignees.

   (individually known as a "Party" and together known as the "Parties")

LEGISLATIVE PROVISIONS AND BACKGROUND

A. Under section 256 of the 2006 Act and the Directions (as defined below) NHS England may make payments to a local authority in connection with expenditure on social services functions and/or health related functions of a local authority.

B. NHS England agrees to make grant payments to the Local Authority pursuant to section 256 of the 2006 Act in respect of revenue expenditure for costs associated with expenditure on social care functions and health related functions of the Local Authority.

C. This Agreement sets out the terms and conditions of the grant payments.

D. This Agreement seeks to fulfil the objectives set out in the Joint Commissioning Strategies of local NHS Commissioners (including Durham, Dales, Easington and Sedgefield Clinical Commissioning Group, North Durham Clinical Commissioning Group and NHS England) and the Local Authority.

E. Approval for this Agreement was agreed on behalf of the Local Authority and by NHS England by the Health and Wellbeing Board on the 25th day of September 2013.

F. NHS England is satisfied that the grant payments are likely to secure a more effective use of public funds than the deployment of an equivalent amount on the provision of services under section 3(1) of the 2006 Act.

G. The Parties have agreed to nominate officers to act on behalf of the Parties, who will monitor this Agreement, the performance of the Services, and report to the Health and Wellbeing Board (as defined below).

IT IS HEREBY AGREED BETWEEN NHS ENGLAND AND THE LOCAL AUTHORITY AS FOLLOWS:

1 DEFINITIONS AND INTERPRETATION

1.1 In this Agreement these words and expressions have these meanings where the context allows:

"2006 Act"	the National Health Service Act 2006;
"Agreed Costs"	the costs incurred by the Local Authority in connection with the Services in respect of which NHS England agrees to make payments in accordance with the terms of this Agreement as set out in Annex 5;
"Agreement"	means this agreement including all annexes;
"Health and Wellbeing Board"	means the Board that has responsibility for over sight of the working arrangements between NHS England and the Local Authority with particular reference to this Agreement;
"Commencement Date"	means the date agreed by each individual service through the reablement group;
"Directions"	means the Directions by the Secretary of State as to the conditions governing payments by health authorities to local authorities and other bodies under Section 28A of the National Health Service Act 1977 issued on 28 March 2000, which now apply to payments made under section 256 of the 2006 Act;
"FSA"	means the Financial Services Authority or such other body that has responsibility for the regulation of banks;
"Force Majeure"	means an act of God, fire, act of Government or state, war, civil commotion, insurrection, embargo, prevention from hindrance in obtaining raw materials, energy or other supplies and/or any other reason beyond the Parties' control;
"Good Industry Practice"	means the exercise of that degree of skill, diligence, prudence and foresight and operating practice that would reasonably and ordinarily be expected from a skilled and experienced person engaged as the case may be in the same type of undertaking as that of the Party in question under the same or similar circumstances;
"Interest Rate"	means one (1) per cent per annum above the base lending rate from time to time of the Bank of England or such other clearing bank as may be agreed between the Parties;
"Laws"	means all Legislation and any applicable judgement of the relevant court of law which sets a binding precedent;
"Legislation"	any Act of Parliament or subordinate legislation within the meaning of section 21(i) of the Interpretation Act 1978, any exercise of the Royal Prerogative and any enforceable community right within the meaning of section 2 of the European Communities Act 1972, in each case in the United Kingdom;
"Month"	means a calendar month;

"Nominated Officers"	means the group of officers appointed by the Parties which will act jointly to oversee the Agreement with powers being delegated by the Parties to whom the said officers will be accountable;
"Performance Indicators"	means the quality performance indicators agreed between the Parties and set out in Annex 3;
"Qualifying Persons"	means the persons receiving the Services under this Agreement as listed in Annex 4;
"Revenue Grant Payments"	the payments made under Clause 3 and detailed in Annex 5, which represents the funds designated by the NHS to support adult social care services that have a health benefit in 2013-14 (NHS England Gateway Reference 00186);
"Services"	means the [insert relevant services] to be provided or procured by the Local Authority for the Qualifying Persons by expenditure of the Agreed Costs, and set out in more detail in Annex 3;
"Service Levels"	means the level of Services as set out in Annex 3;
"Service Specification"	means the specification for the Services as set out in Annex 3;
"Working Day"	means Monday to Friday inclusive in any week but excluding statutory holidays applicable in England.

1.2 In this Agreement:

1.2.1 References to any Legislation, statute, statutory provision, statutory instrument or direction shall be construed as a reference to that Legislation statute, statutory provision, statutory instrument or direction as replaced amended extended or re-enacted from time to time and shall include any subordinate legislation made under any Legislation, statute or statutory provision.

1.2.2 The headings are inserted for convenience only and shall be ignored in construing the terms and provisions of this Agreement.

1.2.3 References in this Agreement to any clause or sub-clause Schedule or paragraph of a Schedule without further designation shall be construed as a reference to the clause sub-cause schedule or paragraph of the schedule to this Agreement so numbered.

1.2.4 Words importing the singular include the plural and vice versa.

1.2.5 Words importing any gender include any other gender.

1.2.6 When NHS England is succeeded by a successor entity (the "Successor Entity") then on and from the date of such succession NHS England shall be deemed to be replaced by the Successor Entity

2 COMMENCEMENT, REVIEW AND OPERATION

Commencement

2.1 This Agreement shall come in to force on the date it has been validly and properly executed by the Parties (the "Agreement Execution Date"), save where the Commencement Date is before the Agreement Execution Date in which instance, the Parties shall have begun to carry out any of its duties, obligations and/or responsibilities referred to or set out in this Agreement earlier than the Agreement Execution Date. In such an instance, this Agreement shall be deemed to have commenced from the Commencement Date.

2.2 This Agreement shall continue until the 31 March 2014 unless terminated in accordance with Clause 10 and/or Clause 17.3.

2.3 This Agreement may be extended until [31 March 2015] by written agreement of the Parties.

Review of this Agreement

2.4 This Agreement shall be reviewed by the Parties in a form and by such representatives of the Parties as may be agreed, initially 3 Months after the Commencement Date and thereafter at any time in accordance with the terms of this Agreement, save that all such reviews must be held within 6 Months of each other.

Operation of the Nominated Officers

2.5 The Parties agree that responsibility for the managing, planning and monitoring of this Agreement (including any performance of the Services) shall be discharged by the Nominated Officers.

2.6 The Nominated Officers shall meet in the timescales set out in Annex 6, and shall act in accordance with the terms of reference as set out in Annex 7, and will receive or deliver reports as provided for in Annex 8.

3 REVENUE GRANT PAYMENTS

3.1 The Parties agree that NHS England will exercise its powers under Section 256 of the Act to execute this agreement and following release of funding NHS England will within 30 working days make payments to the Local Authority for revenue expenditure in respect of the Agreed Costs.

3.2 The Revenue Grant Payments in respect of the Agreed Costs will be calculated, reviewed and paid in accordance with the arrangements described in Annex 5.

3.3 The Revenue Grant Payments are made on condition that the Local Authority:

3.3.1 Ensures, so far as is practicable, the most efficient and effective use of the Revenue Grant Payments;

3.3.2 Does not use the Revenue Grant Payments for any purposes other than expenditure on the Agreed Costs;

3.3.3 Provides or procures the Services in accordance with any Service Specifications and Service Levels as set out in Annex 3;

3.3.4 Maintains the Revenue Grant Payments in a UK based account of an FSA-authorised bank and notifies the details of such account to NHS England;

3.3.5 Signs the Memorandum of Agreement annexed in the form set out at Annex 1;

3.3.6 Completes and submits a monthly return of expenditure to NHS England in accordance with Clause 6.

3.3.7 Completes and submits an annual voucher in the form set out at Annex 2 in accordance with Clause 3.6.

3.4 In the event that the Local Authority fails to comply with any of the conditions contained in this Clause 3 the provisions of Clause 10.1.1 shall apply.

3.5 Save where expressly stated in this Agreement no interest is payable by the Local Authority upon the sums paid to the Local Authority under this Agreement.

3.6 The Local Authority shall complete an annual voucher in the form set out at Annex 2 and this shall be authenticated on behalf of the Local Authority by its Chief Financial Officer. The Local Authority shall pass the completed voucher to its external auditor by no later than 30 September following the end of the financial year in which the Local Authority receives the Revenue Grant under this Agreement. The Local Authority shall arrange for the voucher to be certified by an auditor appointed under

section 3 of the Audit Commission Act 1998 and submitted to NHS England by no later than 31 December of that year.

3.7 Where the Local Authority reduces the Services to be provided or procured under this Agreement, this shall be subject to the consent of NHS England. The Local Authority agrees to notify NHS England immediately of any circumstances which mandate the reduction of the Services under this Agreement and any variation to the terms of this Agreement shall take place in accordance with Clause 13.

4 FINANCIAL COMMITMENT BY THE LOCAL AUTHORITY

4.1 The Local Authority warrants to NHS England that it has available, and shall commit adequate funding and resources of its own, for the Services to the extent not funded by the Revenue Grant Payments for the duration of the Agreement.

4.2 The Local Authority shall ensure that any interest that accrues on the Revenue Grant Payments prior to the Revenue Grant Payments being fully expended on the Services is added to the amount of the Revenue Grant Payments remaining and used solely to contribute to the cost of the Services.

Overspending

4.3 The Local Authority warrants that any over spending in relation to the provision of the Services above and beyond the Revenue Grant Payments shall be the responsibility of the Local Authority.

Underspending

4.4 The Local Authority warrants that any under spending shall be used to fund services in accordance with this Agreement and as agreed with NHS England and ratified through the Health and Wellbeing Board.

5 RECORDS

5.1 The Local Authority shall keep full and accurate minutes of its expenditure of the Revenue Grant Payments and of every meeting held in relation to the Revenue Grant Payments.

6 PROVISION OF INFORMATION AND INSPECTION

6.1 The Local Authority shall, within four weeks of the end of each calendar month, provide NHS England with monthly financial and performance reports, setting out how the funding is being used against the agreed programme of expenditure and outcomes against individual schemes set out in Annex 3 in relation to the Revenue Grant payments. The Local Authority shall promptly provide NHS England and the Health and Wellbeing Board with such reports and information as it may reasonably request from time to time relating to the activities (including the performance management of the services) and finances of the Local Authority in relation to the Revenue Grant Payments, including but not be limited to, all internal and external audit reports relating to the Local Authority.

6.2 The Local Authority shall on reasonable request provide NHS England with access to a copy of the Local Authority's audited accounts promptly.

6.3 The Local Authority shall notify NHS England as soon as practicable and in any event within 7 (seven) days of it being unable, for whatever reason, to continue to provide or procure the Services.

6.4 The Local Authority shall allow NHS England on reasonable notice in writing to inspect all accounts, books, records, documents and other information as NHS England may reasonably require for the purpose of verifying:

6.4.1 the ability of the Local Authority to provide or procure the Services; and/or

6.4.2 the observance and performance of the conditions of the Revenue Grant Payments as set out in Clause 3.

6.5 The Parties agree to hold meetings to discuss matters arising in connection with the Revenue Grant Payments. The meeting schedule will as a minimum be set in accordance with the dates set out in Annex 6. Additional meetings will be convened at the reasonable written request of either Party at a time and place to be agreed.

7 PERFORMANCE MONITORING

7.1 NHS England, the Clinical Commissioning Groups and the Local Authority will meet quarterly during the period of the Agreement and beyond, or more often or less often, if necessary or agreed, to review whether the Local Authority is providing or procuring the Services in accordance with the agreed Service Levels, including the Performance Indicators and to monitor final outcomes as set out in Annex 3. Following each quarterly meeting the Local Authority will report the same to the Officers 'Group.

7.2 Where NHS England has a concern relating to the Local Authority's performance under the terms of this Agreement, NHS England will notify the Local Authority in writing of such concern and request that the concern be remedied. The Parties will meet within one (1) Month of the date the concern was raised to agree corrective actions to ensure performance of the Services improves to meet the appropriate standards, including the Performance Indicators, set out in this Agreement and to agree a reasonable timeframe for such improvement.

7.3 If the corrective actions agreed pursuant to Clause 7.2 do not result in any improvement in the performance of the Services within the agreed timeframe, NHS England may issue a performance notice to the Local Authority ("Performance Notice") setting out the matters giving rise to that Performance Notice and a reasonable timeframe within which the matters must be rectified.

7.4 The Local Authority will remedy the matters set out in the Performance Notice within the timeframe set out in the Performance Notice.

7.5 If the Local Authority disputes the matters set out in the Performance Notice, the Local Authority will notify NHS England of the reasons for the dispute and the Parties shall attempt to resolve the dispute in accordance with disputes resolution procedure set out in Clause 16.

7.6 Without prejudice to the rights of the Parties, if the Local Authority does not fulfil the requirements of the Performance Notice within the timeframe set out in the Performance Notice, then NHS England may serve (at its discretion) between 3 to 6 Month's written notice to the Local Authority to terminate this Agreement.

7.7 Notwithstanding any clause to the contrary in this Agreement, NHS England shall report to the Nominated Officers quarterly and annually in relation to NHS England's performance of the Services pursuant to the terms of this Agreement, and by reference to such other criteria as the Nominated Officers may require.

8 REPAYMENT OF REVENUE GRANT PAYMENTS

8.1 The Local Authority shall immediately repay to NHS England:

8.1.1 a sum equal to the amount of any part of the Revenue Grant Payments applied for any purpose other than the Agreed Costs together with, at the discretion of NHS England, interest at the Interest Rate to be charged on such sum calculated from the date such sum was applied for purposes other than the Agreed Costs until repayment;

8.1.2 any overpayment or erroneous payment received by it from NHS England;

8.1.3 where the Local Authority is served with notice of termination in accordance with clause 10.1, the total of the Revenue Grant Payments, less expenditure

already spent on the Services at the time of service of the notice of termination;

8.1.4 where a notice of termination is served pursuant to clause 17.3, the total of the Revenue Grant Payments, less expenditure already spent on the Services at the time of service of the notice of termination.

8.2 For the avoidance of doubt, repayment under clause 8.1 shall not prejudice NHS England's rights under clauses 3.7 and 10.

9 LOCAL AUTHORITY'S REPRESENTATIONS AND WARRANTIES

9.1 The Local Authority warrants and represents that:

9.1.1 it has the power to enter into and perform its obligations under this Agreement and has taken all the necessary actions to authorise the execution and delivery and performance of the Agreement; and

9.1.2 it has the power to provide or procure the Services; and

9.1.3 it is not aware of any act, matter or thing which will or is likely to affect adversely its ability to comply with its obligations under this Agreement; and

9.1.4 all information supplied to NHS England by it, its servants or agents prior to the date of this Agreement was true and accurate in all material respects.

10 TERMINATION

10.1 Without prejudice to any right or remedy it may possess NHS England shall be entitled to terminate the Agreement upon (at the discretion of NHS England) between 3 to 6 Months written notice to the Local Authority upon the happening of any of the following events:

10.1.1 the Local Authority fails to comply with the conditions of the Revenue Grant Payments as set out in Clause 3;

10.1.2 the Local Authority commits a material breach of this Agreement and either such breach is in the reasonable opinion of NHS England not capable of remedy or such breach is in the reasonable opinion of NHS England capable of remedy and is not remedied to NHS England's reasonable satisfaction within such time period as NHS England, acting reasonably, shall impose, such time period being not less than 30 days of receipt by the Local Authority of notice by NHS England requiring such remedy;

10.1.3 the Local Authority is served with notice of termination under Clause 7.6 (Performance Monitoring);

10.1.4 the Local Authority is served with notice of termination under Clause 12.1.3 (Amendment and Severance);

10.1.5 the Local Authority is served with notice of termination under Clause 14.1 (Prevention of Bribery);

10.1.6 where clause 17.3 applies; or

10.1.7 where the payment of the Revenue Grant Payment pursuant to the terms of this Agreement is deemed by NHS England (acting reasonably) to be ultra vires, void, voidable, illegal or otherwise unenforceable.

10.2 In the event of a termination or expiry of this Agreement, the Parties shall cooperate to ensure an orderly wind down of any joint activities arising out of or pursuant to the terms of this Agreement.

10.3 Without prejudice to the generality of the aforementioned, the Local Authority shall be responsible for winding down its own financial affairs arising out of the operation of this Agreement.

11 PAYMENT OF LEGAL COSTS

11.1 The Parties agree that each shall bear their respective legal costs incurred in connection with the preparation, negotiation and execution of this Agreement.

12 AMENDMENT AND SEVERANCE

12.1 If any condition of this Agreement is declared by any judicial authority or considered by the Parties to be void, voidable, illegal or otherwise unenforceable:

12.1.1 the Parties shall amend that provision in such reasonable manner as mutually agreed in accordance with Clause 13; or

12.1.2 at the discretion of the Parties that provision may be severed from the Agreement and the remaining conditions of this Agreement shall except where otherwise provided remain in full force and effect unless otherwise terminable; or

12.1.3 NHS England may at its absolute discretion terminate this Agreement by giving notice of termination to the Local Authority.

13 VARIATION

13.1 There shall be no variation to this Agreement without the prior written consent of the Parties.

14 PREVENTION OF BRIBERY AND COUNTER FRAUD AND SECURITY MANAGEMENT ARRANGEMENTS

Prevention of Bribery

14.1 If the Local Authority, any of its employees or officers or anyone acting on behalf of the Local Authority

14.1.1 makes a gift or some other consideration to any person with the intent of obtaining some benefit in relation to this Agreement; and/or

14.1.2 puts pressure on any person with the intent of obtaining some benefit in relation to this Agreement; and/or

14.1.3 commits any offence under the Bribery Act 2010; and/or

14.1.4 commits any other similar offence under any subsequent legislation

14.1.5 then NHS England shall have the right to terminate this Agreement by giving notice of termination to the Local Authority except where (in the reasonable opinion of NHS England):

14.1.6 the action or offence described in Clause 14.1.1 to 14.1.4 above is an isolated infrequent or uncommon incident; and

14.1.7 the Local Authority has taken reasonable steps to avoid the commission by any of its officers, employees or anyone acting on its behalf of any such action or offence and the Local Authority has taken reasonable steps (including where appropriate the dismissal of any employee or officer) to prevent the future commission by any of its officers or employees or anyone acting on its behalf of any such action or offence; and

14.1.8 such action or offence has not been authorised endorsed or condoned by the Local Authority.

Counter fraud and security management arrangements

14.2 The Parties shall ensure that appropriate counter fraud and security management arrangements are in place.

14.3 A Party shall upon request permit a duly authorised person nominated by the other Party to review the counter fraud and security management arrangements put in

place and shall implement such modifications to those arrangements within such time periods as such a duly authorised person may reasonably require.

14.4 The Parties shall, promptly upon becoming aware of any suspected fraud or corruptions involving a service user, staff or public funds, report such matter to the local counter fraud specialist.

15 THIRD PARTY RIGHTS

15.1 No person other than a party to this Agreement shall have any right under the Contracts (Rights of Third Parties) Act 1999 to enforce any of the terms of this Agreement.

16 DISPUTES

16.1 In the event of any dispute arising under the terms of this Agreement, the Parties shall attempt in good faith to resolve such disputes.

16.2 If such dispute cannot be solved under the provisions of Clause 16.1 within 30 days, it shall be referred for review and negotiation between the Chief Executive of the Local Authority and the Area Director, NHS England, Durham, Darlington and Tees who shall attempt to resolve the dispute within 10 days of it being referred to them.

16.3 If the matter is not resolved under the provisions of Clauses 16.1 and 16.2 the dispute shall be referred to a mediator as the Parties shall jointly nominate. If the Parties shall fail to agree on the selection of a mediator within 14 days after the date of expiry of the 30 days period specified in Clause 16.2 the mediator shall be nominated at the request of either Party by the President for the time being of the CEDR (Centre for Dispute Resolution).

16.4 The result of such mediation shall, except in the case of manifest error, be final and binding upon Parties.

16.5 The Local Authority and NHS England shall use their best endeavours to ensure that the mediation starts within 20 Working Days of nomination of the mediator under Clause 16.3. The mediator's fee shall be paid in proportions as advised by the mediator.

16.6 The provisions of this Clause 16 are without prejudice to the rights of the Parties expressed elsewhere in this Agreement and the use of the dispute resolution procedures set out in this Clause 16 shall not delay or take precedence over the provisions for termination.

16.7 Notwithstanding any provision in this Agreement to the contrary, a Party may, as a course of action, at any time seek remedies of injunction, or specific performance in relation to any matter arising out of or pursuant to this Agreement.

17 FORCE MAJEURE

17.1 Each Party shall give written notice to the other Party as soon as it becomes aware of any Force Majeure event, setting out details of the Force Majeure event, its likely duration and the steps being taken and to be taken by the Parties to minimise the effect of the Force Majeure on the Parties' obligations under the Agreement.

17.2 The Parties shall use all reasonable endeavours to mitigate the effects of the Force Majeure event and take appropriate remedial action in order to meet their obligations under the Agreement.

17.3 Where an event of Force Majeure continues for a period exceeding 90 calendar days either Party may terminate this Agreement in accordance with Clause 10.1.6.

18 FREEDOM OF INFORMATION AND DATA PROTECTION

18.1 The Parties shall be entitled to publish and/or release any and all terms or conditions of this Agreement and/or the contents of any documents and/or

information relating to the formation of this Agreement under the provisions of the Freedom of Information Act 2000 (FOIA) and/or the Data Protection Act 1998 (DPA).

18.2 Each party shall:

18.2.1 Co-operate and supply to the other all necessary information and documentation required in connection with any request received by the other Party under FOIA and the DPA;

18.2.2 Supply all such information and documentation to the other Party within 7 Working Days of receipt of any request at any pre-arranged or agreed costs.

18.3 Should either Party receive a request for information, they shall not publish or otherwise disclose any information contained in this Agreement or in any negotiations leading to it without the other Party's previous written consent unless the Party wishing to disclose information is bound to publish and/or disclose such information under FOIA and/or the DPA.

18.4 The Parties shall comply with the Codes of Practice on the Discharge of Public Authorities' Functions and on the Management of Records (issued under sections 45 and 46 of the FOIA respectively), and the Environmental Information Regulations 2004 as may be amended, updated or replaced from time to time and any other applicable codes of practice and guidance applicable from time to time to the extent that they apply to the functions of the Parties under the Agreement.

19 CONFIDENTIALITY

19.1 Each Party shall subject to Clause 19.2 treat any information given to it by the other Party marked or referred to as "Commercial – in confidence" (or using such other similar words signifying that they should not be disclosed) confidential and shall not disclose such information to any third party.

19.2 Clause 19.1 shall not apply in the case of disclosures:

19.2.1 pursuant to the order of any court or where requested by any police or regulatory organisation in the United Kingdom; and

19.2.2 where disclosure is pursuant to FOIA, DPA, the Audit Commission Act 1998 or the Environmental Information Regulations 2004.

20 GENERAL

20.1 This Agreement is personal to the Local Authority and it shall not, without the previous written consent of NHS England, assign, transfer or vest, except by the operation of any statutory provision, the benefit of the Agreement to any other person.

20.2 The benefit and/or burden of this Agreement may be assigned or transferred by NHS England to any successor of all or part of their functions, property, rights and liabilities.

20.3 Any notice required to be given by each Party to the other shall be in writing and shall be served by sending the same by registered post or facsimile transmission or by delivering the same by hand (in the case of NHS England addressed to Mr Cameron Ward, Area Director, NHS England, Durham, Darlington and Tees and in the case of the Local Authority, addressed to Mrs Rachael Shimmin, Corporate Director, Children and Adults Services, Durham County Council) to the relevant party's principal address and any notice shall be deemed to have been served:

20.3.1 48 hours after posting if sent by registered post; and

20.3.2 two hours after transmission if a notice is sent by facsimile transmission save that where such deemed time of service is not during normal business hours the notice shall be deemed to have been served at the opening of business on the next Working Day; and

20.3.3 immediately on delivery if served by hand.

20.3.4 In proving service it will be sufficient to prove:

20.3.5 in the case of a delivery by hand that the notice was delivered to or left at the correct address; or

20.3.6 in the case of a notice sent by registered post that the letter was properly addressed stamped and posted; or

20.3.7 in the case of a facsimile that it was properly addressed and dispatched to the correct number.

20.4 Any complaints relating to the performance of the Services by a Qualifying Person or anyone else shall be dealt with in accordance with the Local Authority's complaints procedure, as updated from time to time. Copies of such complaints and responses shall be provided to NHS England on demand.

20.5 No failure or delay on the part of NHS England to exercise any right or remedy under this Agreement shall be construed or operate as a waiver thereof nor shall any single or partial exercise of any right or remedy as the case may be and no waiver by NHS England of any breach of this Agreement shall be effective unless agreed by NHS England and the Local Authority in writing.

20.6 The Parties agree that this Agreement shall not be interpreted as constituting a partnership between the Parties nor constitute any agency between the Parties and the Local Authority agrees that it shall not do cause or permit anything to be done which might lead any person to believe otherwise.

20.7 This Agreement shall not be construed as an endorsement by NHS England of the Local Authority, its employees, agents or sub-contractors or the Local Authority's activities and the Local Authority agrees that it shall not do cause or permit anything to be done which might lead any person to believe otherwise.

20.8 Any termination of this Agreement shall be without prejudice to any rights or remedies of either Party in respect of any antecedent breach of this Agreement.

20.9 The termination of this Agreement shall not affect the coming into force or the continuation in force of any provision of this Agreement which is expressly or by implication intended to come into or continue in force on or after such termination or expiry. For the avoidance of doubt, Clauses 8, 16, 18 and 19 shall survive expiry or termination of this Agreement.

20.10 Unless otherwise stated all sums stated in this Agreement (including but not limited to the Revenue Grant Payments) are inclusive of all applicable Value Added Tax (if any) or of any successor tax.

20.11 The Local Authority shall at all times observe and perform all Laws, court orders and bye-laws and all rules, regulations, provisions or conditions thereunder, and the Local Authority shall do and execute or cause to be done and executed all acts required to be done in respect of the project under or by virtue of such Laws, orders, bye-laws, rules, permissions or conditions.

20.12 The Local Authority shall, and shall ensure that its employees, agents and sub-contractors shall, at all times act in a way which is compatible with the convention rights within the meaning of Section 1 of the Human Rights Act 1998.

20.13 Prior to the issue of any press release about matters relating to this Agreement or making any contact with the press on any issue relating to this Agreement attracting media attention the Area Director, NHS England, Durham, Darlington and Tees and the Corporate Director, Children and Adults Services, Durham County Council (or such persons as they shall each designate) will consult with each other to agree a joint strategy for the release or handling of the issue. The provisions of this clause are subject to any alternative arrangements that the Parties may agree for press relations in particular situations.

20.14 The construction, validity and performance of this Agreement shall be governed by the laws of England.

20.15 This Agreement may be entered into in any number of counterparts and by the parties to it on separate counterparts, each of which, when so executed and delivered shall be an original.

IN WITNESS WHEREOF the Parties have executed this Agreement as a Deed the day and year first above written:

THE COMMON SEAL of **NHS ENGLAND** was hereunto affixed in the presence of:

.....
Authorised Officer

"**EXECUTED** as a **DEED** (but not delivered until the date of it) by the affixing of **THE COMMON SEAL OF THE COUNTY COUNCIL OF DURHAM** By Order:

Authorised Sealing Officer
(A permanent Officer of the County Council)"

ANNEX 1

Memorandum of Agreement
Section 256 transfer

Reference number: NHS England Gateway Reference 00186

Title of scheme: Funding Transfer from NHS England to support Adult Social Care Services that also have a Health Benefit (the "**Scheme**")

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

Detailed at appendix4

2. How will this funding make a positive difference to social care services and outcomes for service users?

Detailed in Annex 3

3. Description of scheme and relationship to Local Delivery Plan (In the case of revenue transfers, please specify the services for which money is being transferred).

Detailed in Annex 3

4. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Revenue amount	Capital amount
2013/14	£10,101,753	£0

In the case of the capital payments, should a change of use as outlined in directions at paragraph 4(1) (b) occur, both parties agree that the original sum shall be recoverable by way of a legal charge on the Land Register as outlined in directions at paragraph 4(4).

5. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

The Key Performance Indicators identified in appendix 4

Signed …… for NHS England

…… Position

…… Date

…… for Local Authority

…… Position

…… Date

ANNEX 2

SECTION 256 ANNUAL VOUCHER

……..
DURHAM COUNTY COUNCIL

PART 1 STATEMENT OF EXPENDITURE FOR THE FINANCIAL YEAR ENDED 31 MARCH 2014
(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	Revenue Expenditure £	Capital Expenditure £	Total Expenditure £

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by NHS England in accordance with Directions made by the Secretary of State under section 256 of the National Health Service Act 2006.

Signed…….
Date…….

(Local Authority Chief Financial Officer (Section 151 Appointment), other relevant chief financial officer, or Chairman of voluntary sector organisation, as appropriate (see paragraph 6(2) of Directions).

Certificate of auditor appointed by the Audit Commission
The Statement of Responsibilities of grant-paying bodies, authorities, the Audit Commission and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these parties, and the limitations of our responsibilities as appointed auditors. I/We have:

- examined the entries in this form **[which replaces or amends the original submitted to me/us by the authority dated [ ]** and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and

- carried out the tests specified in Certification Instruction HLG03 prepared by the Audit Commission for its appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.

[Except for the matters raised in the attached qualification letter dated [ ]
I/we have concluded that the entries are
- fairly stated; and

    - in accordance with the relevant terms and conditions.

Signature_____ Name (block capitals) _____

Date _____

ANNEX 3

DESCRIPTION OF THE SERVICES

SERVICE SPECIFICATION

Scheme	Specification
Eligibility	Supporting the maintenance of current substantial and critical eligibility levels
Reablement	Maintenance and expansion of current reablement provision- this services act as an extension of traditional rehabilitation services, working with individuals to build confidence and skills to ensure they reach their optimum functional potential.
Community Alarms/ Wardens	Maintenance of the current community warden service- providing monitoring and response of those in the community who are isolated or vulnerable this service provides a support system and crisis response.
Intermediate Care	This is funding identified for implementation of the new IC model
Stonham	Supports a wide range of client groups including; young people; MH; LD; substance misuse; offenders; teenage parents; single homeless. Provides practical support to help the client achieve / maintain independent living
Transformational Change	This funding will deliver initiatives that support communities to build resilience and capacity including a community chest grant and implement the transformational change of social care.
Home Equipment Loans Service	Maintenance and expansion of current service including driver fitter and clinical advisor roles- This service provides aids and equipment to allow people to remain at home. It facilitates discharge and prevents admission. The new roles assist requisitioners of equipment to select the most effective solution and enable more efficient installation .
MH Preventative Services	The remodelling of support and recovery services in line with a proposed recovery college model for County Durham. Development of additional step down accommodation to facilitate hospital discharge.
Telecare/Telehealth	Maintenance and expansion of current telecare/telehealth initiatives. These services provide assistive technology options i.e. fall detector, epilepsy sensors, gas shutoff valves which reduce risk and enable people to remain at home and independent for longer.
Tees Valley Housing	Supports teenage parents and parents with LD with practical support including parenting skills, health & wellbeing issues, training & employment, arrears, debts
Creative Support	Supports OP with MH issues with practical support. Will also help clients access social care services if eligible
BID	Supports clients who are deaf with practical support and help the client access social care services if eligible.
Hardship Fund	To support clients who are at risk of disengaging from support and to aid those clients moving on from accommodation based support. Fund can help with training / employment, setting up tenancies, debts, arrears and overcoming health issues
Foundation PPO Mentors	Supports PPO referred through IOM Team. Provides practical support to the client to address health issues, offending issues, housing, budgeting, employment & training, access to children
Richmond Fellowship	Supports clients with MH through the use of IT in the more rural areas of Durham

The Cyrenians	Supports single homeless males providing practical support to help clients achieve / maintain independence including, debt / arrears issues, housing, training & employment, offending behaviour
DISC G&T	Supports Gypsy & Traveller community on registered / unregistered sites. Provides practical support and also helps address health issues, e.g. ensures registered with GP, dentist etc.
Mental Health Matters	Support clients with MH issues, with practical support to help them achieve / maintain independent living. Support areas include MH and may also include housing, budgeting, training & employment, substance misuse, offending behaviour, arrears, income maximisation

The allocation of funds can be varied by written agreement between the Parties, such variation to be reported retrospectively to the Health and Wellbeing Board in the annual performance report.

SERVICE LEVELS

Performance Indicators – Quality & Performance

Durham County Council will be responsible for monitoring quality and performance of individual contracts with providers.

Performance against delivery of the strategy will be monitored via the nominated Officers Group meetings and an annual report produced and presented to the Health and Well Being Board. This report should include progress against plan, the reasons for non-achievement – potential risks to delivery, outcomes achieved and any future recommendations.

The Services shall be carried out by the Local Authority in accordance with:-

1) Good Industry Practice;

2) the Laws;

3) where applicable with the registration and regulatory compliance guidance of the Care Quality Commission (or its successor), and any other appropriate/relevant regulatory body;

ANNEX 4

QUALIFYING PERSONS

Persons residing within the boundaries of Durham County Council.

ANNEX 5

REVENUE GRANT PAYMENTS

The Agreed Costs are:

Eligibility	£4,000,000
Reablement	£2,500,000
Community Alarms/ Wardens	£600,000
Intermediate Care	£525,000
Stonham	£500,000
Transformational Change	£498,225
Home Equipment Loans Service	£400,000
MH Preventative Services	£385,753
Telecare / Telehealth	£200,000
Tees Valley Housing	£140,000
Creative Support	£72,088
BID	£66,850
Hardship Fund	£60,000
Foundation PPO Mentors	£48,132
Richmond Fellowship	£30,246
The Cyrenians	£30,000
DISC G&T	£28,746
Mental Health Matters	£16,712
Total Transfer	**£10,101,752**

ANNEX 6

NOMINATED OFFICERS AND PERFORMANCE MEETING SCHEDULE

Nominated Officers including representatives from each of the organisations below:
NHS England
Durham County Council
Durham, Dales, Easington and Sedgefield Clinical Commissioning Group
North Durham Clinical Commissioning Group

Meeting Schedule (Dates to be confirmed)
September 2013
December 2013
March 2014
June 2014
September 2014
December 2014

ANNEX 7

TERMS OF REFERENCE OF THE NOMINATED OFFICERS

To be developed

ANNEX 8

REPORTING AND INFORMATION REQUIREMENT OF THE NOMINATED OFFICERS

- NHS England make it a condition of the transfer that Local Authority demonstrates how the funding transfer makes a positive difference to social care service, and outcomes for service users, compared to service plans in the absence of the funding transfer.
- NHS England require that expenditure plans and monitoring reports are categorised into the following service areas:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

- NHS England make it a condition of the transfer that it has access to timely information (routine monthly performance reports within four weeks of month end plus access to ad-hoc information as requested) on how the funding is being used against the agreed programme of expenditure and the outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Appendix 4

Social Care Fund Initiatives 2013/14

The initiatives detailed below, with the exception of Transformational change, Intermediate Care and Eligibility, represent additional activity to core contracted services. This additionality has been funded via non recurrent social care funds (s.256) since 2009/10. Withdrawal of this funding would necessitate shrinking back to core contract delivery.

The Intermediate Care element represents the new funding required to facilitate the remodelling planned for short term intervention provision.

Durham currently provide services to individuals assessed to have a substantial or critical need. In light of the severe financial pressure being felt by local authorities consideration of lifting this to critical only would be required if the identified financial support was withdrawn; affecting 3200 service users.

Initiative	Subjective Code	Short Description	Cost	KPIs	Impact on Health
Eligibility	52131018	Supporting the maintenance of current substantial and critical eligibility levels	£4,000,000	Eligibility remains at current levels	There are currently c3200 people assessed as having substantial needs. If eligibility raised a large % would experience health deterioration and require health interventions
Reablement	52131019	Maintenance and expansion of current reablement provision- this services act as an extension of traditional rehabilitation services, working with individuals to build confidence and skills to ensure they reach their optimum functional potential.	£2,500,000	Percentage of people who have no ongoing care needs following completion of provision of a reablement package; Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	These services support the intermediate care function and increase confidence and independence reducing use of health& social care services and improving wellbeing

Community Alarms/ Wardens	52131017	Maintenance of the current community warden service- providing monitoring and response of those in the community who are isolated or vulnerable this service provides a support system and crisis response.	£600,000	Number of people in receipt of community alarms	Reduction in this service will see a shunt onto health services particularly through increased GP and community services activity.
Intermediate Care	52131020/52131021	This is funding identified for implementation of the new IC model	£525,000	Emergency readmissions within 30 days of discharge from hospital; Delayed transfers of care from hospital per 100,000 population; Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	Inability to implement IC changes and continued pressure on acute services and CCG budgets
Stonham	52131023	Supports a wide range of client groups including; young people; MH; LD; substance misuse; offenders; teenage parents; single homeless. Provides practical support to help the client achieve / maintain independent living	£500,000	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services.
Transformational Change	52131023	This funding will deliver initiatives that support communities to build resilience and capacity including a community chest grant and implement the transformational change of social care.	£498,225	Reduction in social care assessments; Increased volunteering opportunities.	This asset based approach and community capacity building will not only impact on social care referrals but also the health economy

Home Equipment Loans Service	52131015	Maintenance and expansion of current service including driver fitter and clinical advisor roles- This service provides aids and equipment to allow people to remain at home. It facilitates discharge and prevents admission. The new roles assist requisitioners of equipment to select the most effective solution and enable more efficient installation .	£400,000	% of items delivered within 7 days of receipt of requisition- stock-specials. Target 97%	Reduction in the council's ability to provide equipment would see a direct impact on hospital admission rates and discharge delays., as well as long term care.
MH Preventative Services	52131022	The remodelling of support and recovery services in line with a proposed recovery college model for County Durham. Development of additional step down accommodation to facilitate hospital discharge.	£385,753	Number of referrals in the period to Support and Recovery; Number of clients in receipt of Support and Recovery services; Percentage of discharges from Support and Recovery with a positive outcome	These services impact on hospital discharge and crisis support for those people with MH problems.
Telecare/Telehealth	52131016	Maintenance and expansion of current telecare/telehealth initiatives. These services provide assistive technology options i.e. fall detector, epilepsy sensors, gas shutoff valves which reduce risk and enable people to remain at home and independent for longer.	£200,000	Number of people in receipt of telecare	Withdrawal of current equipment would put clients at risk of falls, long lie, injury or fatality from fire etc. Use of telecare also reduces carer stress.

Tees Valley Housing	52131023	Supports teenage parents and parents with LD with practical support including parenting skills, health & wellbeing issues, training & employment, arrears, debts	£140,000	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services. Reduction in this service would see increase primary & community care activity
Creative Support	52131022	Supports OP with MH issues with practical support. Will also help clients access social care services if eligible	£72,088	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Reduction in this service would result in an increase activity for primary care and community mental health services
BID	52131023	Supports clients who are deaf with practical support and help the client access social care services if eligible.	£66,850	Service reports on Every Child Matters Outcomes; Be Healthy; Stay Safe; Enjoy & Achieve; Make a Positive Contribution; Achieve Economic well-being; No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	This service supports deaf people reducing their need to access primary and community care for support

Hardship Fund	52131023	To support clients who are at risk of disengaging from support and to aid those clients moving on from accommodation based support. Fund can help with training / employment, setting up tenancies, debts, arrears and overcoming health issues	£60,000	No. of clients supported to address health issues.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services.
Foundation PPO Mentors	52131023	Supports PPO referred through IOM Team. Provides practical support to the client to address health issues, offending issues, housing, budgeting, employment & training, access to children	£48,132	Service contributes to reducing reoffending figures monitored by the IOM Team; No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services.
Richmond Fellowship	52131022	Supports clients with MH through the use of IT in the more rural areas of Durham	£30,246	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services.
The Cyrenians	52131023	Supports single homeless males providing practical support to help clients achieve / maintain independence including, debt / arrears issues, housing, training & employment, offending behaviour	£30,000	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	The support this service provides reduces risky behaviours and the associated health problems , thereby reducing the activity for primary and community care services

DISC G&T	52131023	Supports Gypsy & Traveller community on registered / unregistered sites. Provides practical support and also helps address health issues, e.g. ensures registered with GP, dentist etc.	£28,746	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Address's general and specific health issues of clients through direct support, sign posting / referring to specific services. Reduction in this service would see increased health issues and activity for primary and acute services
Mental Health Matters	52131022	Support clients with MH issues, with practical support to help them achieve / maintain independent living. Support areas include MH and may also include housing, budgeting, training & employment, substance misuse, offending behaviour, arrears, income maximisation	£16,712	No. of referrals; No. of clients with an identified need; No. of clients with their needs met.	Reduction in this service would result in increased activity for primary care and community mental health services

Health and Wellbeing Board

15th November 2013

Winterbourne View Concordat and Action Plan Implementation in County Durham

Report of Nick Whitton - Head of Commissioning, Children and Adults Services, Durham County Council

Purpose of the Report

1. To update on progress in relation to the Winterbourne View Concordat and Action Plan implementation in County Durham.

Background

2. Previous reports on Winterbourne View have been submitted to the Learning Disability Partnership Board (September 2013) and Health and Wellbeing Board (June 2013).

3. Key actions required by the Winterbourne View Concordat were as follows:

    - Register of people placed outside local area in hospital/private hospital settings by 31st March 2013 – Completed.
    - Review of those people by 31 May 2013 – Completed.
    - Development of plans to move people to appropriate local placements – On-going.
    - Transfer to community based settings by June 2014 – On-going.

4. Regionally the process is being monitored by the Health Learning Disability Clinical Leads Network and the Association of Directors of Adult Social Services (ADASS).

Update on Current Situation

5. To complete this work a project group involving Durham County Council (DCC) Commissioning, the Operations Manager for Learning Disability (LD), the Continuing Health Care (CHC) Team and the North East Commissioning Support Unit has been established.

6. The primary focus in relation to individuals centres on ten people with Learning Disability on the Winterbourne register.

7. Further work will follow subsequently in relation to children and young people and people with forensic needs, but the timescales for that are yet to be identified by the Department of Health.

8. The joint commissioning issues will be dealt with through the LD Joint Commissioning Group, chaired by the Head of Commissioning for DCC, Nick Whitton. This group will coordinate how shared resources are used more

effectively in the future, especially the possible development of pooled budget arrangements and the shifting of resources from hospital to community based settings. There may also be a need to identify capital investment to develop specialist provision. To carry out the detailed work a task group has been convened, together with Darlington Borough Council, Tees Esk & Wear Valley NHS Foundation Trust (TEWV) and North East Commissioning Service (NECS), which will link into a similar Tees-wide group to address any issues with wider service implications.

9. At the time of the previous report to the Health and Wellbeing Board in June, it was expected that significant progress would have been made on aspects of organisational change and the shifting of resources from hospital to community settings. However, the focus so far has been on the individual service users so the work on organisational change and future service design/commissioning is only now about to commence.

10. Regarding the ten individuals, initial plans are in place to either identify suitable placements locally or to develop new services where required. Detailed individual work is now being actioned.

11. The individuals, their families/carers will be involved in all aspects of the process, as it is recognised that 'co-production' is most likely to achieve successful outcomes.

12. Advocacy services will also be available to support the process.

13. Given the complex needs of the people involved significant risks of placement breakdown, delays and further hospital admissions remain, but every effort is being made to ensure a smooth and successful transition.

14. Implementing the Winterbourne Concordat also has significant implications for service design tendering and procurement, as well as for service providers and staff. Local Authority and Health Commissioners will be working closely with providers to make sure that suitable services are available in County Durham.

15. Progress will be reported back to the Department of Health via the Learning Disability Self Assessment Framework, which has to be completed by the end of November 2013.

Recommendations

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

- Receives the update and assurance that plans are in place to work collaboratively between DCC and Clinical Commissioning Groups to develop long-term solutions for the identified individuals.
- To receive further progress updates in 2014, including a detailed action plan in relation to any significant 'resource shifts' from hospital to community-based services.

Contact:	**Nick Whitton, Head of Commissioning – nick.whitton@durham.gov.uk**
Tel:	**03000 267 357**

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.

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Health and Wellbeing Board

15th November 2013

2010 Adult Autism Strategy "Fulfilling and Rewarding Lives" Evaluating Progress – the second national self assessment exercise

Report of Nick Whitton - Head of Commissioning, Children and Adults Services, Durham County Council

Purpose of the Report

1. To update on progress in relation to the Autism Strategy implementation and completion of the self assessment framework.

2. To give approval for the development of a local action plan for submission to the Health and Wellbeing Board in January 2014.

Background

3. Early in August 2013, Local Authorities were notified by Norman Lamb, Minister of State for Care and Support, that a second self assessment exercise is to be undertaken.

4. The purpose of the exercise is to:

   - Assist Local Authorities and partners in assessing progress in implementing the 2010 Adult Autism Strategy.
   - See how much progress has been made since the baseline survey of February 2012.
   - Provide evidence of examples of good progress and of remaining challenges.

5. The return date for completion of the self-assessment was Monday 30 September, however this was subsequently extended. Durham County Council's return was submitted to Public Health England via the 'Improving Health and Lives' website.

Current Situation

6. Work has been carried out with partners to complete the on-line return.

7. A 'Validation Event' with 25 stakeholders including service users and carers took place on 27 September 2013, where further evidence to populate the return was gathered. The event also assessed what

red/amber/green rating should be applied in relation to some areas of the return.

8. The on-line evaluation template consists of 37 questions, covering specific area as follows:
    - Planning
    - Training
    - Diagnosis
    - Care and Support
    - Housing and Accommodation
    - Employment
    - Criminal Justice System

Appendix 2 contains the completed 'Autism Self Evaluation'.

9. There is also an optional area for inclusion of up to 5 self advocacy stories to illustrate or support any of the questions answers/traffic light ratings. Several case studies have been submitted as evidence.

10. Norman Lamb acknowledged the short timescales for this exercise, as well as the overlap with the on-going Learning Disability self-assessment framework (SAF). Consequently, the expectation is that Directors "are aware of the content of the return when it is submitted and that it is discussed by the local Health and Wellbeing Board by the end of January 2014".

11. This two-stage process, by implication, is to allow Local Authorities further time to develop a local action plan in response to the evaluation findings.

12. As can be seen from the submitted return, the self assessment return is very positive/shows a green traffic light rating in relation to the following areas;
    - Planning
    - Training
    - Diagnosis
    - Care and Support
    - Housing and Accommodation

    This reflects progress made since the passing of the Autism Act 2009.

13. In relation to the areas of Employment and Criminal Justice the return was less positive/red or amber. This reflects the lack of progress locally and regionally in these areas. However, training has been provided by a local autism provider for Magistrates Courts, Probation and Custody Sergeants. Engagemen with Criminal Justice Service partners will be consolidated through the Health and Wellbeing Board and will be a feature of the next autism action plan for County Durham.

14. Areas to be addressed following the Self Evaluation will include the following:

- The needs of older people with autism (as was also highlighted by a recent National Autism Society policy document, “Getting On? Growing older with Autism”) So far these have not been considered in County Durham.
- Strengthening the focus on employment pathways for people with autism, to achieve higher levels of employment rather than work experience or volunteering.
- Engaging with partners in the Criminal Justice system to ensure that people with autism are dealt with effectively and fairly.

15. The local action plan will also look to consolidate progress made in relation to data and needs mapping, carer and service user engagement and the development of post diagnosis support services.

16. Alongside that, mainstream agencies need to continue to make ‘reasonable adjustments’ where possible, in order to improve service access for people with autism.

Recommendations

17. The Health and Wellbeing Board are recommended to accept this report for information and receive a detailed report and action plan in January 2014.

Contact:	**Nick Whitton, Head of Commissioning, Durham County Council, nick.whitton@durham.gov.uk**
Tel:	**03000 267 357**

Appendix 1: Implications

Finance Self-assessment may identify gaps in provision. Work to be undertaken with NHS to secure longer term funding for services.

Staffing Relevant staff are participating in a validation event.

Risk Assessment will identify risks e.g. through not meeting need etc. which will be included in the local action plan.

Equality and Diversity/Public Sector Equality Duty Assessment focuses on needs of people with autism at risk of disadvantage discrimination.

Accommodation N/A

Crime and Disorder Assessment and action plan will identify needs of people with autism in the criminal justice system.

Human Rights Assessment and action plan will identify any issues related to Human Rights Act.

Consultation Carers and service users will participate in validation event and the local action plan.

Procurement Assessment will include details of post diagnosis support service which will be procured in 2013.

Disability Issues Identified in assessment and addressed through action plan.

Legal Implications Assessment will focus on compliance with Autism Act.

Autism Self Evaluation

Local authority area

1. How many Clinical Commissioning Groups do you need to work with to implement the Adult Autism Strategy in your local authority area?

2

Comment

Durham Dales, Easington and Sedgefield CCG and North Durham CCG are both working on the implementation of the Adult Autism Strategy in County Durham.

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

- [x] Yes
- [ ] No

If yes, how are you doing this?

We work closely together with Darlington Borough Council as a shared Autism Service Development Group and we are also active members of the North East Autism Consortium, which involves partnership working with all North East authorities.

Planning

3. Do you have a named joint commissioner/senior manager of responsible for services for adults with autism?

- [x] Yes
- [ ] No

If yes, what are their responsibilities and who do they report to? Please provide their name and contact details.

The lead officer for the council is David Shipman, Strategic Commissioning Manager (david.shipman@durham.gov.uk / Tel: 03000 267 391). He reports to the Head of Commissioning and Corporate Director, Children and Adults Services. He is responsible for commissioning of learning disability, mental health and housing related support services.

The lead officer for CCGs is Donna Owens (email: Donna.Owens@nhs.net). She reports to both CCGs and the North of England Commissioning Support Unit. She is responsible for commissioning learning disability services on behalf of the CCGs.

4. Is Autism included in the local JSNA?

- [ ] Red
- [ ] Amber
- [x] Green

Comment

Autism information was included in the 2011-12 JSNA for County Durham. It is currently being reviewed and refreshed for 2012-13 and information will be updated accordingly.

5. Have you started to collect data on people with a diagnosis of autism?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment

Information is gathered by health lead officer and shared with relevant stakeholders.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

- ⊗ Yes
- ◯ No

If yes, what is

the total number of people?

268

the number who are also identified as having a learning disability?

228

the number who are identified as also having mental health problems?

34

Comment

These figures have been compiled from the local authority database (SSID) and the health trust database (PARIS) and have been cross-referenced to ensure no double counting. These figures are correct as at 30-9-2013.

7. Does your commissioning plan reflect local data and needs of people with autism?

- ⊗ Yes
- ◯ No

If yes, how is this demonstrated?

Commissioning priorities for both learning disability and mental health include service developments for people with autism.

8. What data collection sources do you use?

- ◯ Red
- ◯ Red/Amber
- ◯ Amber
- ⊗ Amber/Green
- ◯ Green

Comment

Further work is to be done in 2014 to improve links between the council and voluntary sector data sources.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Groups (including the Support Service) engaged in the planning and implementation of the strategy in your local area?

- ◯ Red
- ◯ Amber
- ⊗ Green

Comment

CCGs representatives are active participants in the LD Partnership Board, the MH Partnership Board, the LD/MH Joint Commissioning Group and the Joint Health and Wellbeing Board. Autism Act implementation is being taken forward through these channels.

10. How have you and your partners engaged people with autism and their carers in planning?

◯ *Red*
⊗ *Amber*
◯ *Green*

Please give an example to demonstrate your score.

People with Autism and their carers have helped shape a range of individual packages and the newly commissioning short break and respite service.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

◯ *Red*
⊗ *Amber*
◯ *Green*

Please give an example.

Reasonable adjustments have been made at leisure centres in Bishop Auckland and Spennymoor. Leisure Centre staff received training from the council's in-house Support and Recovery Service.

12. Do you have a Transition process in place from Children's social services to Adult social services?

⊗ *Yes*
◯ *No*

If yes, please give brief details of whether this is automatic or requires a parental request, the mechanism and any restrictions on who it applies to.

The Transition process is automatic, as outlined by the shared Transition Protocol. A Transitions Team is in place to support children with disabilities moving into Adults Services. The Transition Protocol applies to all children and young people.

13. Does your planning consider the particular needs of older people with Autism?

⊗ *Red*
◯ *Amber*
◯ *Green*

Comment

Awareness of this issue was raised at a recent validation event. Further work will be carried out as part of the local action plan.

Training

14. Have you got a multi-agency autism training plan?

⊗ *Yes*
◯ *No*

15. Is autism awareness training being/been made available to all staff working in health and social care?

◯ Red
◯ Amber
⊗ Green

Comment: Specify whether Self-Advocates with autism are included in the design of training and/or whether they have a role as trainers. If the latter specify whether face-to-face or on video/other recorded media.

Self-advocates are included in the design of training and have a role as trainers, both face-to-face and on video/other recorded media.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

◯ Red
◯ Amber
⊗ Green

Comments

All mental health and learning disability teams have received autism training to enhance their approach and communication during assessments.

17. Have Clinical Commissioning Group(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged included in the training agenda?

⊗ Yes
◯ No

Please comment further on any developments and challenges.

The Health Facilitation Team deliver training to individual GP and primary care practitioners. Further work is required to ensure comprehensive engagement in this training.

18. Have local Criminal Justice services engaged in the training agenda?

⊗ Yes
◯ No

Please comment further on any developments and challenges.

Criminal Justive Service staff have been involved in multi-agency training programmes delivered by the specialist autism provider, ESPA. Training has also been provided to the British Transport Police. A programme which has been delivered via Northumbria Police and Probation is to be considered for suitability in County Durham.

Diagnosis led by the local NHS Commissioner

19. Have you got an established local diagnostic pathway?

◯ Red
◯ Amber
⊗ Green

Please provide further comment.

The Local Diagnostic Pathway is established and is funded within core budgets.

20. If you have got an established local diagnostic pathway, when was the pathway put in place?

Month (Numerical, e.g. January 01)

10

Year (Four figures, e.g. 2013)

2011

Comment

21. How long is the average wait for referral to diagnostic services?

Please report the total number of weeks

6

Comment

First appointments in secondary care are within the Trust directive timescales of 6 weeks, and within the tertiary service of 6 weeks from referral.

22. How many people have completed the pathway in the last year?

Comment

There is no completion of the pathway other than discharge. Assessments take several months depending on the need of the individual, but support and intervention is initiated at first contact where required.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?

- [x] Yes
- [ ] No

Comment

The Pathway was initially established on a temporary basis by the outgoing PCT, following a pilot in 2008. This has now been consilidated by the CCGs.

24. How would you describe the local diagnostic pathway, ie Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis or a specialist autism specific service?

- [ ] a. Integrated with mainstream statutory services with a specialist awareness of autism for diagnosis
- [x] b. Specialist autism specific service

Please comment further

A specialist disagnostic and assessment service, led by a Psychiatrist, is in place.

25. In your local diagnostic path does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

- [x] Yes
- [ ] No

Please comment, i.e. if not who receives notification from diagnosticians when someone has received a diagnosis?

Anybody receiving a diagnosis of autism receives a letter informing them that they are entitled to a Community Care Assessment.

26. What post-diagnostic support (in a wider personalisation perspective, not just assuming statutory services), is available to people diagnosed?

One to one support in the community is available through a range of voluntary sector providers for mental health and learning disability.

Post-diagnosis workshops for carers and service users are provided by a local autism service (ESPA).

In 2014 the council will be commissioning a multi-agency post-diagnosis support service.

Care and support

27. Of those adults who were assessed as being eligible for adult social care services and are in receipt of a personal care budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a. Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget

182

b. Number of those reported in 27a. who have a diagnosis of Autism but not learning disability

4

c. Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability

178

Comment

Data has been collected from the local authority database (SSID) and the health trust (PARIS) and cross-referenced to ensure accuracy. Data is correct as at 30-9-2013.

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?

- ⊗ *Yes*
- ○ *No*

If yes, please give details

Social Care Direct is the single point of contact for social care and the Durham Information Guide (DIG) is an online directory of services across County Durham and the North East. The council's front of house customer service points also offer a wide advice and information service and have received autism awareness training.

29. Do you have a recognised pathway for people with autism but without a learning disability to access a community care assessment and other support?

- ⊗ *Yes*
- ○ *No*

If yes, please give details

Community Care Assessments for people without a learning disability is provided by the integrated mental health teams.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Autism training requirements are built into contract specifications for advocates.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Advocacy services can provide advocates who have received specialist training. There have been no instances where the service has been unable to meet need.

32. Can people with autism access support if they are non Fair Access Criteria eligible or not eligible for statutory services?

- ⊗ *Yes*
- ◯ *No*

Provide an example of the type of support that is available in your area.

Individual support in the community for people with non-FACS eligible autism is provided by the council's in-house Support & Recovery Service and a local voluntary sector provider (Stonham). They offer practical advice and support for up to 2 years and will network with other services for additional specialist input.

33. How would you assess the level of information about local support in your area being accessible to people with autism?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Accessible information is available via the Durham Information Guide (DIG) on a wide range of services.

Housing & Accommodation

34. Does your local housing strategy specifically identify Autism?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Detailed work on specialist autism provision is done through a Housing Strategy Sub-group linked to the LD and MH Partnership Boards. Development of accomodation options for people with autism has been a priority in County Durham and has involved partnership working between DCC and a number of registered social landlords.

Employment

35. How have you promoted in your area the employment of people on the Autistic Spectrum?

- ◯ *Red*
- ⊗ *Amber*
- ◯ *Green*

Comment

Specialist support to employers is delivered through two local providers (Mental Health Matters and Shaw Trust). Job Centre Plus staff have been provided with specialist autism training. A numbers of autism providers have worked with individual service users to make them work-ready via work experience, placements and volunteering, however a co-herent employment pathway is still to be achieved which reflects the challenges of autism and the current employment climate in the North East.

The DCC in-house supported employment service, WorkAble Solutions, unfortunately was terminated due to financial pressures.

36. Do transition processes to adult services have an employment focus?

- ◯ *Red*
- ◯ *Amber*
- ⊗ *Green*

Comment

Transition Plans require a focus on the development of independence and work related skills wherever possible. A wide range of day care providers and local colleges offer skills training in areas such as gardening, woodwork and catering. Currently these lead to volunteering and work placement opportunities but actual employment has only been achieved by a small number of individuals.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults with autism?

- ⊗ *Red*
- ◯ *Amber*
- ◯ *Green*

Comment

Training has been provided for Magistrates Courts, Probation and Custody Sergeants delivered by a local autism provider (ESPA). Engagement with CJS partners will be consolidated through the new Joint Health and Wellbeing Board and will be a feature of the next autism action plan for County Durham.

Optional Self-advocate stories

Self-advocate stories.

Up to 5 stories may be added. These need to be less than 2000 characters. In the first box, indicate the Question Number(s) of the points they illustrate (may be more than one. In the comment box provide the story.

Self-advocate story one

Question number

12

Comment

PLEASE NOTE THAT PERMISSION WILL BE REQUIRED TO PUBLISH OR SHARE WIDER THESE STORIES

A is a young man who has ASC and this results in him displaying severe challenging behaviour. When he was approaching the age of 18 he needed to move on from a children's service. His school placement was in jeopardy as a result of his behaviour and the children's provider was supporting him in the classroom to minimise the impact of this on others. The Children's social worker, transitions worker and the Service Improvement Team worked to develop a new service for A that would meet his needs. A suitable property was found and the Commissioning Department tendered for an appropriate support provider to work with A. Two compatible service users were identified to move with A - they both lived with him in the children's service and both needed to move on to adult services. A was gradually introduced to staff over a period of months as part of his transitional plan. He was supported to become a tenant within the property and staff worked with him to choose his own furniture for his bedroom. His bedroom was decorated to suit his taste.

Since his move, staff report that he has decreased his dependence on staff and increased his independence. He has developed his life and social skills. He now willingly completes domestic duties such as cleaning his own dishes and vacuuming. He puts his own laundry into the washing machine and switches it on. He loves to be in the kitchen and has begun to bake cookies, which staff report has been a great start to developing his cooking skills and confidence further. He goes shopping to Aldi on a Thursday and is now able to access the cinema, which staff describe as a fantastic achievement, and something he really enjoys.

Self-advocate story two

Question number

11

Comment

P is a young man with ASC and challenging behaviour who lived in a children's service with AW. He also needed to move into an adult service and a bespoke service was developed for him and AW. P had a past history of placement breakdowns due to his challenging behaviour and his aggression was so severe he required 5 staff to manage this at one point. The Children's social worker, transitions worker and the Service Improvement Team worked, together with P's family, to develop a new service for P that would meet his needs. A suitable property was found and the Commissioning Department tendered for an appropriate support provider to work with P.

P moved 12 months ago into his new home in the centre of the local community. He had a long transition to ensure new staff got to know him well and he settled quickly with very few problems. Since his move, staff report that P has developed his life and social skills. His parents regularly comment to them about his willingness to partake in domestic duties such as cleaning his own dishes and vacuuming. He now puts his own laundry into the washing machine and switches it on. P loves to be in the kitchen on a Thursday night and has made a corned beef pie from scratch. Staff report that he really enjoys this structured activity and gains a lot of confidence and a great sense of achievement from this. He goes shopping to Tesco every Monday and, like A, has become well known in the local community through visiting the corner shop most days. Staff report that people ask after him if they go into the shop when they are not at work and they say that they feel both young men have a real presence in the community and are well liked. Like A, P goes to the cinema and this is a great achievement for him.

Finally, staff have made very good links with a local optician who is working flexibly with both P and A to familiarise them with the service to ensure that they can cope when they visit for appointments.

Self-advocate story three

Question number

34

Comment

D moved from a residential learning disability hospital into the community ten years ago as part of the reprovision of the local learning disabilities hospital. His family were included throughout the reprovision process. He has ASC and challenging behaviour which includes self-harm and high pitched screeching. Whilst in hospital his self-harming behaviour was so severe that he damaged the sight in one of his eyes and required an operation to prevent blindness. His screeching and extremely unpredictable behaviour made it difficult for him to access ordinary everyday facilities. His distress on a day to day basis was quite severe and made it difficult for him to reach his full potential. Attempts to take him out were largely unsuccessful as he would drop to the floor and refuse to move, putting himself and staff at risk from traffic.

D now lives in his own bungalow in a residential area of the county. Since moving into a bespoke service in the community D has made excellent progress. He has not needed staff to use physical interventions to prevent him harming himself or others. He rarely self-harms (occasionally tapping his head); and staff described him as happy and settled. He no longer makes noises indicating distress and now accesses the community on a frequent basis. He enjoys going to the cinema and bowling. His physical health has improved as he will now go for long walks, something he would not do when he was in hospital. He can now use public transport and enjoys going to social events. He goes shopping to Tesco and can now sit in a pub and enjoy a meal. He now involves himself in small domestic task such as setting the table and carrying his dirty clothes to the laundry and putting them in the washing machine. His personal skills have also developed and he now dresses himself. Staff describe him as a different man to the one they knew when he was in hospital.

Self-advocate story four

Question number

25

Comment

The following is an extract from information provided by the mother of a service user with severe ASC and challenging behaviour. The names have been changed to respect confidentiality.

S's needs were met well in Durham until his teenage years, when unfortunately he developed epilepsy, which greatly impacted on his mental health. Consequentially, he was admitted to XXX Hospital (L D Residential Hospital) and needed an Educational Tribunal for Specialist Autistic Residential Services in Sunderland.

His adult transition assessment included assessment by the 'Coming Home Team' for a placement in Durham; after some intial scepticism by ourselves the following months led to an extensive assessment of S's very complex needs by the team, who worked in partnership with XXX (Independent Sector Specialist Autism Provider) to develop a placement which addressed and supported him to have his needs met; thus the team supported and helped him to successfully achieve his goals happily, and extend his enjoyment of the world around him safely.

S is extremely sensory-sensitive, thus his placement is within a rural environment, and he has his own flat, which also provides him with security due to having tenancy rights. S's care team have extensive understanding of his complex needs and how to support him to have a happy supportive environment; he is very challenging but also can be very happy, cheeky and full of fun!

The joy and sense of achievement as parents is seeing S happily enjoying activities and a life-style which was previously so difficult for him; examples of the activities he can now enjoy include the following:

Sharing visits with his family in his cosy home, and seeing him safe and happy.
Sharing birthday BBQ's with S in his garden.
Sharing a Christmas meal out with all the young people from the house and their parents.
Sharing part of Christmas day with him, with his flat festively-decorated, and seeing S enjoying himself.
Knowing he can go along to a disco and enjoy having a dance with his carers as mates, not just carers.
Seeing him cope with holidays away with his carers, again as more than just carers.

We feel the above was only achievable with the initial and extremely detailed assessment of S's needs from the 'Coming Home Team', then setting up a placement from there to meet those needs with an organization which has the expertise and skills to address them.

Yours sincerely,

Mr X. and Mrs Y.

Self-advocate story five

Question number

Comment

This marks the end of principal data collection.

Can you confirm that the two requirements for the process to be complete have been met?

a. Have you inspected the pdf output to ensure that the answers recorded on the system match what you intended to enter?

☒ *Yes*

b. Has the response for your Local Authority area been agreed by the Autism Partnership Board or equivalent group, and the ratings validated by people who have autism, as requested in the ministerial letter of 5th August 2013?

☒ *Yes*

The data set used for report-writing purposes will be taken from the system on 30th September 2013.

The data fill will remain open after that for two reasons:

1. to allow entry of the dates on which Health and Well Being Boards discuss the submission and
2. to allow modifications arising from this discussion to be made to RAG rated or yes/no questions.

Please note modifications to comment text or additional stories entered after this point will not be used in the final report.

What was the date of the meeting of the Health and Well Being Board that this was discussed?

Please enter in the following format: 01/01/2014 for the 1st January 2014.

Day

Month

Year

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Health and Wellbeing Board

15th November 2013

Joint Health & Wellbeing Strategy 2nd Quarter 2013/14 Performance Report

Report of Peter Appleton, Head of Planning & Service Strategy, Children & Adults Services

Purpose of the Report

1. To present the first performance report to the Board to describe the progress being made against the priorities and outcomes set within the County Durham Joint Health & Wellbeing Strategy (JHWS) 2013-17.

Background

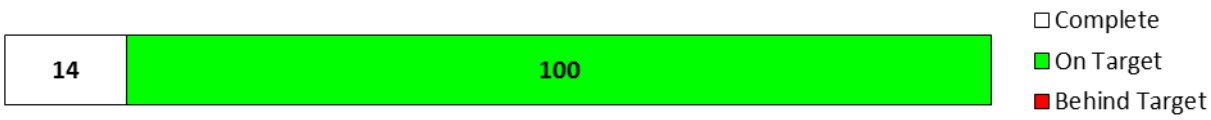
2. The Health & Wellbeing Board Performance Report is structured around the six strategic objectives of the JHWS and reports progress being made against the strategic actions and performance outcomes identified.

3. The Performance Scorecard, which includes all of the performance indicators within the JHWS, is attached at **Appendix A**.

4. Due to the nature of the performance data being reported, there is significant variation in the time periods associated with each indicator. For example, several indicators have a time lag of over 12 months. The information in this report includes the latest performance information available nationally, regionally and locally.

Overview of Progress Against Actions in Delivery Plan

5. There are 114 actions within the JHWS 2013-17 Delivery Plan. Progress in Quarter 2 is as follows:



The 14 completed actions are identified in **Appendix B**

6. The Board is asked to note that the following action, which relates to Strategic Objective 2: Reduce health inequalities and early deaths, is being reviewed:

   - **Work with Clinical Commissioning Groups to ensure universal access to the Health Check Programme in County Durham by increasing the uptake of Health Checks from community providers**
     - See paragraph 35 for changes being considered to Health Checks.

Overview of Delivery Plan Performance Indicators

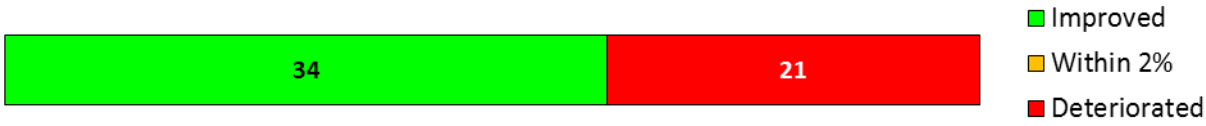
7. The following rating system is used to illustrate performance levels and is consistent with performance reporting to the County Durham Partnership:

Performance Against Target	Direction of Travel	Performance Against Comparators	Banding
Target achieved or exceeded	Improved/Same	Better than comparator	
Performance within 2% of target	Within 2% of previous performance	Within 2% of comparator	
Performance more than 2% away from target	Deteriorated by more than 2%	More than 2% worse than comparator	

8. There are 26 indicators with targets for which data is reported. **Performance against target** is as follows:

The six indicators which have not achieved target are included in the narrative below and are identified with (*).

9. There are 55 indicators where it is possible to track **Direction of Travel.** Performance is as follows:



10. The following pages of this report identify the performance highlights and areas for improvement which are for the attention of the Board.

Performance Highlights (paragraphs 11 to 23)

11. The following section identifies key achievements based on the latest performance data available.

Objective 1: Children and young people make healthy choices and have the best start in life

12. Percentage of exits from young person's treatment for alcohol and substance misuse that are planned discharges is better than target and is above national performance.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
88% (2012/13)	Percentage of exits from young person's treatment that are planned discharges	**89%** (Apr-Jun 2013)	**79%**	**80%** (Apr-Jun 2013)	Not available	⇧

13. Under 18 conception rate in County Durham has continued the downward trend and is better than the North East region, though it is still worse than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
37.4 (Jan-Dec 2011)	Under 18 conception rate per 1,000 15-17 year old women	**34.3** (Apr-Jun 2012)	Tracker (no target required)	**28.4** (Apr-Jun 2012)	**35.6** (Apr-Jun 2012)	⇩

14. The latest full year under 18 conception data relates to 2011 and shows that the rate in County Durham decreased from 54.4 (1998 baseline) to 37.4 in 2011. Over the same time period the national rate decreased from 47.1 to 30.9, whilst the North East average fell from 56.5 to 38.4.

15. The latest provisional quarterly data (April to June 2012) shows 74 conceptions, which equates to a conception rate of 34.3 per 1,000 girls aged 15-17 years. The quarterly rate in County Durham is better than the North East (35.6) and Statistical Neighbours (39.1) but is worse than the National rate of 28.4.

16. Actions being taken to reduce teenage conceptions include:
    - A social norms project commenced in the 2012/13 Academic Year in all secondary schools. It aims to gather views and perceptions of children and then use these to positively influence the culture in schools through enabling staff to have appropriate conversations about sexual health and wellbeing with young people and also signposting to appropriate services.
    - Public Health is currently developing a Resilience Strategy and delivery plan to reduce teenage conceptions and improve sexual health.
    - Sex & Relationship Education (SRE) Framework is to be finalised in November 2013. Delivery of the SRE Framework will include guidance for professionals and school staff to support parents and carers to discuss sex and relationship and provide effective messages to young people.
    - A Communication & Engagement Strategy is to be developed and Public Health will engage with young people in order to assess their preferred methods of communication (e.g. the types of media to utilise) for messages relating to the SRE Framework, the social norms work, and the sexual health and wellbeing agenda as a whole.

<u>Objective 2: Reduce health inequalities and early deaths</u>

17. Excess winter deaths have decreased in County Durham and are lower than the national rate.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
19.8% (2007-10)	Excess Winter Deaths – the excess of deaths in winter compared with non-winter months (August to July) expressed as a percentage	**18.1%** (2008-11)	Tracker (no target required)	**19.1%** (2008-11)	**16.7%** (2008-11)	⇩

Objective 3: Improve the quality of life, independence and care and support for people with long term conditions

18. Proportion of people who use services who have control over their daily life is well above target (based on local data).

Previous Data	Indicator	Latest Data*	Target	National Average	North East Average	Direction of Travel
84.4% (2012/13)	Proportion of people who use services who have control over their daily life	**95%** (Apr-Aug 2013)	**80.1%**	**75.9%** (2012/13)	**75.7%** (2012/13)	⇧

PLEASE NOTE: Latest data is taken from the local survey of adult social care users. 2012/13 performance for County Durham and comparators is sourced from the National Adult Social Care Survey and is used for banding Durham's performance against national/regional averages.

19. Admissions to residential or nursing care have decreased and exceeded targets.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
13.4 (2012/13)	Adults aged 18-64 per 100,000 population admitted on a permanent basis in the year	**5.4** (Apr-Sep 2013)	**8.8**	**14.9** (2012/13)	**15.3** (2012/13)	⇩
840.7 (2012/13)	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year	**340.6** (Apr-Sep 2013)	**472.0**	**708** (2012/13)	**861** (2012/13)	⇩

20. Percentage of people with no ongoing care needs following completion of provision of a reablement package has increased and exceeded the target.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
60.3% (2012/13)	Percentage of people who have no ongoing care needs following completion of provision of a reablement package	**62.0%** (Apr-Sep 2013)	**55%**	Not available	Not available	⇧

Objective 5: Protect vulnerable people from harm

21. Repeat incidents of domestic violence have decreased and are well within target.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
13% (2012/13)	Percentage of repeat incidents of domestic violence	**7.8%** (Apr-Sep 2013)	**Less than 25%**	**24.3%** (Jul 12 - Jun 13)	Not available	⇩

22. The proportion of people who use services who say that those services have made them feel safe and secure is well above target (based on local data).

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
86.8% (2012/13)	The proportion of people who use services who say that those services have made them feel safe and secure	**93.4%** (Apr-Aug 2013)	**75%**	**77.9%** (2012/13)	**79.4%** (2012/13)	⇧

PLEASE NOTE: Latest data is taken from the local survey of adult social care users. 2012/13 performance for County Durham and comparators is sourced from the National Adult Social Care Survey and is used for banding Durham's performance against national/regional averages.

23. Children becoming the subject of a Child Protection (CP) Plan for a second or subsequent time has reduced and is better than national.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
16.9% (2012/13)	Children becoming the subject of a CP Plan for a second or subsequent time	**13.6%** (Apr-Sep 2013)	**15.0%**	**13.8%** (2011/12)	**12.4%** (2011/12)	⇩

Areas for Improvement (paragraphs 24 to 66)

24. The following section identifies areas for improvement based on the latest performance data available. Areas for further attention have been identified when performance in County Durham is below target, displays a deteriorating trend, or is significantly worse than the national average.

Objective 1: Children and young people make healthy choices and have the best start in life

25. Breastfeeding Initiation and Prevalence rates in County Durham are significantly lower than the national rate and also below regional levels.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
58.8 (2012/13)	Breastfeeding Initiation - percentage of new mothers known to have put the baby to the breast or given the baby breast milk within 48 hours of birth	**56.9%** (Jul-Sep 2013)	Tracker (no target required)	**73.9%** (2012/13)	**59.3%** (2012/13)	⇩
28.1 (2012/13)	Breastfeeding Prevalence - the percentage of infants due for 6-8 weeks check recorded as totally or partially breastfed	**26.4%** (Jul-Sep 2013)	Tracker (no target required)	**47.2%** (2012/13)	**31.2%** (2012/13)	⇩

26. Actions to increase breastfeeding include:
    - Completion of the UNICEF action plan by March 2014 by County Durham & Darlington Foundation Trust (CDDFT). This underpins CDDFT's work towards UNICEF's Baby Friendly Initiative and to achieve accreditation of maternity and community facilities that adopt internationally recognised standards of best practice in the care of mothers and babies.
    - Rolling out telecontact in the One Point Service – a daily telephone call to mothers, up to and including 10 days following birth, to support breastfeeding on days when there is no other planned contact with Health Visitors.
    - Public Health has commissioned the National Childbirth Trust to train mothers who have previously breastfed to support new mothers.
    - A website (www.breastmilk.co.uk) and Facebook page have been developed by County Durham & Darlington Foundation Trust to provide information.
    - A radio campaign was launched in County Durham during national breastfeeding week in June 2013.

27. Alcohol specific hospital admissions for under 18's per 100,000 population in County Durham are higher than the North East and more than double the national rate.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
122 (2007/8-2009/10)	Alcohol specific hospital admissions for under 18's (rate per 100,000)	**116** (2008/9-2010/11)	Tracker (no target required)	**55.8 (2008/9-2010/11)**	**96.5 (2008/9-2010/11)**	⇩

28. Actions being taken to reduce admissions include:
    - All secondary schools across County Durham are taking part in the social norms work commissioned by Durham County Council. This project aims to gather the views of young people (including alcohol-related issues) and then compares their perceptions against actual behaviours. This information is then feedback to them to positively impact on their behaviour and perceptions.
    - Targeted schools are accessing alcohol education through the 4Real Alcohol Education Worker.
    - Pathways for referrals to 4Real Brief Intervention workers have been developed through the Alcohol Seizure Policy across County Durham.
    - Children and Young People's Overview and Scrutiny Committee are to undertake a review of Alcohol and Substance Misuse by Young People.

29. Percentage of mothers smoking at time of delivery has reduced but is significantly higher than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
21.3% (2011/12)	Percentage of mothers smoking at time of delivery	**19.9%** (2012/13)	Not set for 2012/13	**12.7%** (2012/13)	**19.7%** (2012/13)	⇩

30. Work continues between maternity services and stop smoking services to increase referrals and uptake of the stop smoking service by pregnant women. County Durham and Darlington are in the first phase of services (maternity and stop smoking services) to be involved in the regional babyClear project; the North East's approach to reducing maternal smoking rates.

31. The September 2013 Progress Report from the babyClear steering group detailed that for County Durham and Darlington:
    - A total of 101 midwives, Maternity Care Assistants and Health Care Assistants have been trained to facilitate delivery of a 3-minute intervention at first contact with maternity services (first booking appointment).
    - Ten administrative staff have been trained on how to convert pregnancy leads of mothers who smoke into appointments attended with the Stop Smoking Service.
    - Eight midwives have completed Risk Perception Masterclass training, with two more to be trained. This cohort of midwives will deliver more intensive "risk perception" interventions to pregnant women who continue to smoke at time of scan appointment. To date, 27 women have received the "risk perception" intervention; 24 of whom went on to engage with the stop smoking service.

Objective 2: Reduce health inequalities and early deaths

32. Take up of the NHS Health Check programme increased during Quarter 1 in comparison to the same period of last year but the uptake of Health Checks is below target and is not expected to exceed the 2012/13 total. (*)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
14.2% (2012/13)	Percentage of eligible people (aged 40-74) who receive a NHS Health Check	**2.4%** (Apr-Jun 2013)	**5%**	**1.9%** (Apr-Jun 2013)	**2.3%** (Apr-Jun 2013)	⇧

33. Between April and June 2013 there were 3,936 Health Checks undertaken, which equates to 2.4% of eligible people. Performance is below the target of 5% but was an improvement from 0.8% (1,336 Health Checks) during the same period of the previous year.

34. Developments for 2013/14 to increase the number of Health Checks include:
    - A new IT system that will transfer data on all Check4Life Health Checks in community settings to the person's GP practice. Approximately 70% of GP practices are now using this system with work ongoing to roll this out across the county. Public Health has commissioned the North of England Commissioning Support Unit (NECS) to carry out a Health Equity Audit of Health Check data on GP practice systems.
    - Expansion of the community Check4Life programme, with Health Checks now offered in 30 pharmacies and a range of community settings across the county.
    - The Check4Life bus will be visiting various locations across the county from October 2013 to March 2014 and will enable people to attend on the day for

their Health Check and to discuss the results with a Check4Life Health Advisor afterwards.

35. Public Health is considering changing the focus of Health Checks from a universal to a targeted approach. This would involve expanding the community based Check4Life programme in areas with a high prevalence of Cardiovascular Disease (CVD) risk factors and GP Practices targeting those eligible people with an estimated high risk of CVD.

36. The main advantages of changing from a universal to a targeted approach are: the identification and management of more people at a high risk of CVD; promoting lifestyle interventions where it is most needed; and having a greater impact on health inequalities. However, the requirement to secure continuous improvement in the percentage of eligible people participating in health checks will not be met.

37. The CVD Prevention Framework will be presented to the Health & Wellbeing Board for approval in March 2014.

38. Mortality rates (deaths per 100,000 population) in County Durham are significantly higher than those nationally.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
71.6 (2010)	Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population	**70.6** (2011)	Not set for 2011	**58** (2011)	**68.6** (2011)	⇩
115.6 (2010)	Mortality from cancer for persons aged under 75 years per 100,000 population	**120.7** (2011)	Not set for 2011	**107** (2011)	**125.7** (2011)	⇧
Not available	Mortality from liver disease for persons aged under 75 years per 100,000 population	**17.9** (2009-11)	Not set for 2009-11	**14.4** (2009-11)	**18.3** (2009-11)	N/A
Not available	Mortality from respiratory disease for persons aged under 75 years per 100,000 population	**28.5** (2009-11)	Not set for 2009-11	**23.4** (2009-11)	**28.8** (2009-11)	N/A

Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population

39. Annual premature cardiovascular disease (CVD) mortality rates in County Durham have reduced by 47.1% from 133.4 per 100,000 in 2001. This decrease is better than national (46.3%) and the North East (46.5%) reductions. The gap to the national rate has narrowed from 25.5 per 100,000 in 2001 to 12.7 in 2011.

40. 3-year pooled data for County Durham shows a decreasing trend, from 125.8 in 2001-03 to 72.7 in 2009-11 (42% reduction). The England rate is 62.9 for 2009-11.

41. Actions to reduce the mortality rate from CVD include:
    - Consideration of targeting Health Checks at areas/people with an estimated high risk of CVD
    - The Smokefree Tobacco Control Alliance's five-year plan to reduce smoking prevalence was approved by the Health Improvement Partnership in July 2013.
    - The CVD Prevention Framework will be presented to the Health & Wellbeing Board for approval in March 2013.

Mortality from cancer for persons aged under 75 years per 100,000 population

42. Whilst there can be a degree of fluctuation in year-on-year rates, from 2001 to 2011 annual premature cancer mortality rates fell by over 16% in County Durham (compared to 15% nationally). The gender breakdown shows that male rates fell by 20% (17% nationally) and female rates fell by 11% (14% nationally).

43. The 3-year pooled data (2009-11) for County Durham shows a rate of 120.0 per 100,000. This has decreased from 140.4 in 2001-03. England rate is 108.4 in 2009-11.

44. A health equity audit is being undertaken by Public Health and CCGs to identify variances in cancer detection and diagnosis rates across the county. The focus of this is upon increasing earlier diagnosis as this is expected to have the most impact upon the under 75 mortality rate. The first health equity audit meeting was held in June 2013 and the audit is due to be completed by autumn 2013.

45. Successful completions as a percentage of total number in drug treatment for opiates and non-opiates are well below target. (*)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
8% (2012/13)	Successful completions as a percentage of total number in drug treatment - Opiates	**7%** (Apr-Jun 2013)	**11%**	**8%**	Not available	⇩
33% (2012/13)	Successful completions as a percentage of total number in drug treatment - Non Opiates	**36%** (Apr-Jun 2013)	**48%**	**40%**	Not available	⇧

46. The provision of treatment through the Recovery Academy Durham (RAD) has temporarily reduced due to a lack of availability of appropriate supported housing, which is a requirement of access to treatment. The RAD usually contributes to a large proportion of successful completions in County Durham and so the reduction of this resource can have a significant impact on this indicator. Three new properties have been identified and will be available for use from November 2013.

47. Four week smoking quitters is below target and has decreased from the same period of the previous year. (*)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
1,165 [4,949 quitters] (2012/13)	Four week smoking quitters per 100,000 population	**257 [1,092 quitters]** (Apr-Jun 2013)	**286 [1,215 quitters] (Apr-Jun 2013)**	**944** (2011/12)	**1,318** (2011/12)	⇩

48. All North East services have seen a decrease in the number of 'Quit Dates Set' by smokers compared to last year. This continues a trend seen over the last year of sharply declining throughput. When comparing 2013/14 Quit Dates Set against the peak year of 2011/12, throughput in Quarter 1 has fallen by more than 3,300 clients (or 21%) over the last 2 years. Regionally in Quarter 1 this year there were approximately 1,900 (13.6%) clients fewer than Quarter 1 2012/13. County Durham is 9.3% down on quarter one last year.

49. The number of quitters has also reduced due to the fact that from April 2013 the stop smoking figures for the Local Authority area no longer take into account those quitters who reside in the prison community. This change in the national definition of the indicator will impact more on County Durham than other local authorities due to the presence of three prisons within the county.

50. 'Stoptober' was officially launched on Monday 9th September. Smokers will be able to take advantage of free support including a Stoptober support pack, a daily messaging service and Stoptober mobile app. As a result, it is expected that the number of quitters will increase in Quarter 3.

Objective 3: Improve the quality of life, independence and care and support for people with long term conditions

51. The proportion of people using social care who receive direct payments is lower in County Durham is below national and regional rates. (*)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
9.1% (2012/13)	Proportion of people using social care who receive direct payments	**8.5% (Oct-Sep)**	**9%**	**16.4% (2012/13)**	**12.5% (2012/13)**	⇩

52. Direct Payments are a cash budget provided to service users to facilitate the purchase of their own care. Performance in Durham is below national and regional averages, has not achieved target, and shows a decline in performance in the most recent 12 month period

53. External consultants People Too are currently undertaking a fundamental review of direct payments and will report to Children & Adult Services Management Team in November.

Objective 4: Improve mental health and wellbeing of the population

54. Self-harm and Suicides rates in County Durham are significantly higher than the national rates.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
354.6 (2010/11)	Hospital admissions as a result of self-harm (all ages)	**343.1** (2011/12)	Tracker (no target required)	**207.9** (2011/12)	Not available	⇩
Not available	Suicide rate per 100,000 population	**11.5** (2009-11)	Tracker (no target required)	**7.9** (2009-11)	**9.3** (2009-11)	N/A

55. For children and young people aged 0-17 years, the rate in County Durham of hospital admissions as a result of self-harm was 228 per 100,000 population. This was almost double the national rate of 116 per 100,000 population.

56. Self-harm can be a risk factor for subsequent suicide. It occurs in all sections of the population but is more common among those who are socio-economically disadvantaged or those who are single or divorced, live alone, are single parents or have a severe lack of social support.

57. Analysis from the County Durham Suicide Audit shows:
    - 81% of suicides from 2005 to 2012 were male, with a peak age of 40-49;
    - 62% were divorced;
    - 32% lived alone;
    - Hanging was identified as the most common method used;
    - 58.9% were found to have diagnosed mental health problems;
    - 30% were recorded as alcohol dependent;
    - 13% were recorded as users of illicit drugs;
    - 39.2% had a history of self-harm;
    - 26% had experienced a relationship or family breakdown;
    - 17% were recently bereaved;
    - 12% were in financial difficulty.

58. The Public Mental Health Strategy, which has the objective to reduce the suicide and self-harm rate in County Durham, is being presented to the Board on the 15th November 2013 for approval.

59. Excess under 75 mortality rate in adults with serious mental illness has decreased in County Durham but is significantly higher than the national rate.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
1241.3 (2009/10)	Excess under 75 mortality rate in adults with serious mental illness per 100,000 population	**1064** (2010/11)	Tracker (no target required)	**921** (2010/11)	Not available	⇩

60. Life expectancy is on average 10 years lower for people with mental health problems due to poor physical health. The Public Mental Health Strategy therefore includes the objectives:
    - Improve physical health of people with poor mental health through integration of mental health into existing programmes and targeted approach to those experiencing mental ill-health
    - Improve early detection and intervention for mental ill-health across lifespan

61. Actions within the Strategy include:
    - Improve access to lifestyle advice including stop smoking and weight management services within community venues.
    - Co-ordinate services to promote healthy lifestyles and reduce health risk behaviours.
    - Promote the delivery of physical health checks.

62. The Strategy is being presented to the Board on the 15th November 2013 for approval.

Objective 5: Protect vulnerable people from harm

63. Percentage of Children in Need (CIN) referrals occurring within 12 months of previous referral has increased significantly and is above the national average. (*)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
16.8% (2012/13)	Percentage of CIN referrals occurring within 12 months of previous referral	**30.6%** (Apr-Sep 2013)	**21.0%**	**26.1%** (2011/12)	**23.8%** (2011/12)	⇧

64. The restructuring of services as part of the Children's Care Transformation Project, including the introduction of a structured front of house service between Children's Care and the One Point Service, is to ensure more effective and earlier interventions and therefore reduce the re-referral rate.

65. The Strategic Manager Safeguarding Children has undertaken a mini-audit of re-referrals (10 cases) which demonstrated that cases which were closed were being re-referred for similar issues within 12 months. Findings of this audit will be focused on at the next round of Children's Care Practitioner Briefings in December 2013.

Objective 6: Support people to die in the place of their choice with the care and support that they need

66. No performance issues have been identified in relation to objective 6.

Recommendations

67. The Health and Wellbeing Board is recommended to:

a. Note the performance highlights and areas for improvements identified throughout this report.
b. Note the actions taking place to improve performance and agree any additional actions where relevant.

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Joint Health and Wellbeing Board Performance Scorecard: 2nd Quarter 2013/14

Key - Direction of Travel: Improvement Deterioration No change

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
Strategic Objective 1: Children and young people make healthy choices and have the best start in life									
58.3% (2011/12)	58.8% 2012/13)	Breastfeeding initiation	56.9% (Jul-Sep 2013)	Tracker	⇩	Qtr 3 (Apr-Dec 2013)	73.9% (2012/13)	59.3% (2012/13)	57.1% (2012/13)
27.7% (2011/12)	28.1% (2012/13)	Prevalence of breastfeeding at 6-8 weeks from birth	26.4% (Jul-Sep 2013)	Tracker	⇩	Qtr 3 (Apr-Dec 2013)	47.2% (2012/13)	31.2% (2012/13)	29.2% (2012/13)
22.55 (2009/10)	22.9% (2010/11)	Percentage of children in reception with height and weight recorded who have excess weight	23.6% (2011/12)	Tracker	⇧	Qtr 4 (2012/13)	22.6% (2011/12)	24.5% (2011/12)	22.9% (2011/12)
34.7% (2009/10)	36.0% (2011/12)	Percentage of children in year 6 with height and weight recorded who have excess weight	38.4% (2011/12)	Tracker	⇧	Qtr 4 (2012/13)	33.9% (2011/12)	37.0% (2011/12)	35.2% (2011/12)
Not available	Not available	Children and young people's participation in out of school sport (year 6)	89.4% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Children and young people's participation in out of school sport (year 9)	78.4% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they are happy (year 6)	97.7% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they are happy (year 9)	96.1% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they feel lonely (year 6)	26.1% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they feel lonely (year 9)	22.6% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
1594 (2011/12)	2150 (2012/13)	Number of new referrals to Child and Adolescent Mental Health Services (CAMHS)	1213 (Apr-Sep 2013)	1183	⇧	Qtr 3 (Apr-Dec 2013)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they drink alcohol (year 9)	33.9% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people who report that they take drugs (year 9)	3.0% (2011/12)	Tracker	N / A	Qtr 4 (2013/14)	Not available	Not available	Not available

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
303 (2011/12)	232 (2012/13)	Number of young people in Tier 3 treatment for drugs and alcohol with 4Real	110 (Apr-Jun 2013)	74	⇩	Qtr 3 (Apr-Sep 2013)	Not available	Not available	Not available
126.2 (2006/7-2008/09)	122 (2007/8-2009/10)	Alcohol specific hospital admissions for under 18's (rate per 100,000)	116 (2008/9-2010/11)	Tracker	⇩	Qtr 3 (2009/10-2011/12)	55.8 (2008/9-20010/11)	96.5 (2008/9-20010/11)	94.2 (2008/9-20010/11)
77% (2011/12)	88% (2012/13)	Percentage of exits from young person's treatment that are planned discharges	89% (Apr-Jun 2013)	79%	⇧	Qtr 3 (Apr-Sep 2013)	80% (Q1 2013/14)	Not available	Not available
9.4 (2009)	10.8 (2010)	Under 16 conception rate	7.7 (2011)	Tracker	⇩	Qtr 4 (2012)	6.1 (2011)	8.6 (2011)	8.7 (2011)
43.2 (Jan-Dec 2010)	37.4 (Jan-Dec 2011)	Under 18 conception rate	34.3 (Apr-Jun 2012)	Tracker	⇩	Qtr 3 (Jul-Sep 2012)	28.4 Apr-Jun 2012)	35.6 Apr-Jun 2012)	39.1 Apr-Jun 2012)
22.9% (2010/11)	21.3% (2011/12)	Percentage of mothers smoking at time of delivery	19.9% (2012/13)	Target not set for 2012/13	⇩	Qtr 3 (Apr-Sep 2013)	12.7% (2012/13)	19.7% (2012/13)	19.8% (2012/13)
3.7 (2007-09)	3.9 (2008-10)	Infant mortality rate, per 1,000 live births and stillbirths	4.0 (2009-11)	Tracker	⇧	Qtr 4 (2010-12)	4.3 (2009-11)	3.7 (2009-11)	Not available
9.4 (2008)	6.6 (2009)	Stillbirth and neonatal mortality rate, per 1,000 live births and stillbirths	6.5 (2010)	Tracker	⇩	Qtr 3 (2011)	8.0 (2010)	7.4 (2010)	Not available
15.2 (2010/11)	15.9 (2011/12)	Emotional and behavioural health of Looked After Children	16.1 (2012/13)	Tracker	⇧	Qtr 4 (2013/14)	13.8 (2011/12)	13.8 (2011/12)	13.5 (2011/12)
Not available	566.7 (2010/12)	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) - DDES CCG	603.3 (2011/12)	Tracker	⇧	Qtr 4 (2012/13)	366.5 (2011/12)	Not available	Not available
Not available	439.0 (2010/12)	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) - North Durham CCG	461.0 (2011/12)	Tracker	⇧	Qtr 4 (2012/13)	366.5 (2011/12)	Not available	Not available

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
Strategic Objective 2: Reduce health inequalities and early deaths									
79.0 (2009)	71.6 (2010)	Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population	70.6 (2011)	Target not set for 2011	⇩	Qtr 4 (2012)	58 (2011)	68.6 (2011)	Not available
123.6 (2009)	115.6 (2010)	Mortality from cancer for persons aged under 75 years per 100,000 population	120.7 (2011)	Target not set for 2011	⇧	Qtr 4 (2012)	107.0 (2011)	125.7 (2011)	Not available
7.9 (2004-08)	8.4 (2005-09)	Slope Index of Inequality (Males)	8.2 (2006-10)	Tracker	⇩	Data release date TBC	8.9 (2006-10) *not a valid comparator	Not available	Not available
6.3 (2004-08)	6.5 (2005-09)	Slope Index of Inequality (Females)	6.7 (2006-10)	Tracker	⇧	Data release date TBC	5.9 (2006-10) *not a valid comparator	Not available	Not available
15.5% (2011/12)	14.2% (2012/13)	Percentage take up of the NHS Health Check programme – by those eligible (percentage of eligible people who receive a NHS Health Check)	2.4% (Apr-June 2013)	5% (Apr-June 2013)	⇧	Qtr 3 (Apr-Sep 2013)	1.9% (Apr-Jun 2013)	2.3% (Apr-Jun 2013)	Not available
Not available	Not available	Mortality from liver disease for persons aged under 75 years per 100,000 population	17.9 (2009-11)	Target not set for 2009-11	N/A	Qtr 4 (2010-12)	14.4 (2009-11)	18.3 (2009-11)	Not available
Not available	Not available	Mortality from respiratory disease for persons aged under 75 years per 100,000 population	28.5 (2009-11)	Target not set for 2009-11	N/A	Qtr 4 (2010-12)	23.4 (2009-11)	28.8 (2009-11)	Not available
Not available	Not available	Mortality for persons aged under 75 years per 100,000 population	302 (2010)	296.8 (2011)	N/A	Data will not be refreshed	272.8 (2010)	Not available	Not available
99.9% (Oct-Dec 2012)	98.7% (Jan-Mar 2013)	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date)	98.6% (Apr-Jun 2013)	96%	⇩	Qtr 3 (Jul-Sep 2013)	98.3% (Apr-Jun 2013)	98.5% Durham, Darlington & Tees Area Team (Apr-Jun 2013)	Not available
87.1% (Oct-Dec 2012)	86.7% (Jan-Mar 2013)	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	89.0% (Apr-Jun 2013)	85%	⇧	Qtr 3 (Jul-Sep 2013)	86.8% (Apr-Jun 2013)	87.4% Durham, Darlington & Tees Area Team (Apr-Jun 2013)	Not available

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
76.9 (2007-09)	77 (2008-10)	Male life expectancy at birth (years)	77.5 (2009-11)	Tracker	⇧	Qtr2 2014/15 (2010-12)	78.9 (2009-11)	77.5 (2009-11)	Not available
80.7 (2007-09)	81 (2008-10)	Female life expectancy at birth (years)	81.4 (2009-11)	Tracker	⇧	Qtr2 2014/15 (2010-12)	82.9 (2009-11)	81.5 (2009-11)	Not available
Not reported	8% (2012/13)	Successful completions as a percentage of total number in drug treatment - Opiates	7% (Apr-June	11%	⇩	Qtr 3 (Apr -Sep 2013)	0	Not available	Not available
Not reported	33% (2012/13)	Successful completions as a percentage of total number in drug treatment - Non Opiates	36% (Apr-June 2013)	48%	⇧	Qtr 3 (Apr -Sep 2013)	0	Not available	Not available
		National alcohol-related admissions to hospital indicator (exact definition to be agreed by the Department of Health)	Indicator removed from PHOF	Tracker					
Not reported	42 (2012/13)	Successful completions as a percentage of total number in treatment – Alcohol	38 (Apr-Jun 2013)	36	N/A	Qtr 3 (Apr -Sep 2013)	36	Not available	Not available
1,308 per 100,000 (5,523 quitters) (2011/12)	1,165 per 100,000 (4,949 quitters) (2012/13)	Four week smoking quitters per 100,000 population	257 per 100,000 (1,092) (Apr-Jun 2013)	286 per 100,000 (1,215) (Apr-Jun 2013)	⇩	Qtr 3 (Apr -Sep 2013)	944 per 100,000 (2011/12)	1318 per 100,000 (2011/12)	Not available
26.2 (2009/10)	22.3 (2010/11)	Estimated smoking prevalence of persons aged 18 and over	20.9 (2011/12)	Tracker	⇩	Qtr 3 (2012/13)	20.0 (2011/12)	21.2 (2011/12)	Not available
Previous data not comparable		Proportion of physically active adults	52.2 (2012)	Tracker	N/A	Qtr 3 (2012/13)	56 (2012)	53.9 (2012)	Not available
Previous data not comparable		Proportion of physically inactive adults	29.3 (2012)	Tracker	N/A	Qtr 3 (2012/13)	28.5 (2012)	30.1 (2012)	Not available
Not available		Excess weight in adults (Proportion of adults classified as overweight or obese)	PHOF indicator under development	Tracker	N/A	Data release data unknown	Not available		
80.0% (2010)	79.75 (2011)	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	79.3% (2012)	Target not set for 2012	⇩	Qtr 3 (Jan-Jun 2013)	76.8% (2012)	78.6% (2012)	Not available

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
78.1% (2011)	78.8% (2012)	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	81.1% (Jan-Mar 2013)	80%	⇧	Qtr 3 (Apr-Jun 2013)	75.3% (2012)	79.5% (Jan-Mar 2013)	Not available
N/A		The percentage of people eligible for bowel screening who were screened adequately within a specified period	Indicator under development	60%	N/A	Data release data unknown	Not available		
21.8 (2006/09)	19.8 (2007/10)	Reduce excess winter deaths (Ratio)	18.1 (2008/11)	Tracker	⇩	Qtr 4 (2009/12)	19.1 (2008/11)	16.7 (2008/11)	Not reported
Strategic Objective 3: Improve the quality of life, independence and care and support for people with long term conditions									
Not reported	36.2% (Apr-Jun 2013)	Percentage of carers assessments as a proportion of all social care assessments	37.9% (Apr-Sep 2013	37	⇧	Qtr 3 (Apr-Dec 2013)	Not available		
Not reported		Carer reported quality of life	8.7 (2012/13)	Tracker	N/A	Qtr 4 (2013/14)	8.1 (2012/13)	8.6 (2012/13)	Not reported
Not reported		Overall satisfaction of carers with social services	47.9 (2012/13)	Target not set for 2012/13	N/A	Qtr 4 (2013/14)	42.7 (2012/13)	48.9 (2012/13)	Not reported
Not reported		Estimated diagnosis rate for people with dementia	50.7 (2011/12)	Tracker	N/A	Data release date TBC	46 (2011/12)	51.2 Durham, Darlington & Tees Area Team (2011/12)	Not reported
Not reported	94.9% (2012/13)	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	95.2% (Apr-Sep 2013)	92%	N/A	Qtr 3 (Apr-Dec 2013)	Not reported		
Not reported	84.4% (2012/13)	Proportion of people who use services who have control over their daily life	95.0% (Apr-Sep 2013)	80%	⇧	Qtr 3 (Apr-Dec 2013)	75.9% (2012/13)	75.7% (2012/13)	Not reported
53.5% (2011/12)	60.0% (2012/13)	Social care service users offered self-directed support (direct payments and individual budgets)	59.5% (Apr-Sep 2013)	55%	⇧	Qtr 3 (Apr-Dec 2013)	55.6% (2012/13)	51.9% (2012/13)	52.9% (2012/13)
8.65 (2011/12)	9.1% (2012/13)	Proportion of people using social care who receive direct payments	8.5% (Apr-Sep 2013)	9%	⇩	Qtr 3 (Apr-Dec 2013)	16.4% (2012/13)	12.5% (2012/13)	12.7% (2012/13)

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
11.0 (2011/12)	13.4 (2012/13)	Adults aged 18-64 per 100,000 population admitted on a permanent basis in the year to residential or nursing care	5.4 per 100,000 (Apr-Sep 2013)	8.8 per 100,000 (Apr-Sep 2013)	⇩	Qtr 3 (Apr-Dec 2013)	14.9 (2012/13)	15.3 (2012/13)	15.0 (2012/13)
907.0 (2011/12)	840.7 (2012/13)	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	340.6 per 100,000 (Apr-Sep 2013)	472 per 100,000 (Apr-Sep 2013)	⇩	Qtr 3 (Apr-Dec 2013)	708 (2012/13)	861 (2012/13)	758.6 (2012/13)
86.0% (2011/12)	85.2% (2012/13)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	88.5% (Apr-Sep 2013)	85%	⇧	Qtr 3 (Apr-Dec 2013)	81.5% (2012/13)	84.9% (2012/13)	84.8% (2012/13)
54.3% (2011/12)	60.3% (2012/13)	Percentage of people who have no on going care needs following completion of provision of a reablement package	62.0% (Apr-Sep 2013)	55%	⇧	Qtr 3 (Apr-Dec 2013)	Not available	Not available	Not available
11.8 (2008/09)	11.1 (2009/10)	Emergency readmissions within 30 days of discharge from hospital (NB this is broader than long term conditions)	12.1 (2010/11)	Tracker	⇧	Data release date TBC	11.8 (2010/11)	12.6 (2010/11)	Not available
4.9 per 100,000 (2011/12)	10.7 per 100,000 (2012/13)	Delayed transfers of care from hospital per 100,000 population	10.3 per 100,000 (Apr-Aug 2013)	Tracker	⇩	Qtr 3 (Apr-Dec 2013)	9.5 (2012/13)	9.3 (2012/13)	7.6 (2012/13)
1.0 per 100,000 (2011/12)	1.76 per 100,000 (2012/13)	Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	0.92 per 100,000 (Apr-Aug 2013)	Tracker	⇩	Qtr 3 (Apr-Dec 2013)	3.3 (2012/13)	3.2 (2012/13)	2.2 (2012/13)
Not reported	1673 (2010/11)	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)	1701 (2011/12)	Tracker	⇧	Qtr4 (2012/13)	1665 (2011/12)	1885 (2011/12)	Not reported
483.5 (2009/10)	512.5 (2010/11)	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)	470.7 (2011/12)	Tracker	⇩	Qtr4 (2012/13)	457.2 (2011/12)	499.6 (2011/12)	Not reported
Strategic Objective 4: Improve mental health and wellbeing of the population									
Not reported		Self-reported well-being - people with a low satisfaction score	26.1 (2011/12)	Tracker	N/A	Qtr 3 (2012/13)	24.3 (2011/12)	24.6 (2011/12)	Not reported

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
Not reported		Self-reported well-being - people with a low worthwhile score	21.6 (2011/12)	Tracker	N/A	Qtr 3 (2012/13)	20.1 (2011/12)	21.2 (2011/12)	Not reported
Not reported		Self-reported well-being - people with a low happiness score	34.7 (2011/12)	Tracker	N/A	Qtr 3 (2012/13)	29.0 (2011/12)	30.9 (2011/12)	Not reported
Not reported		Self-reported well-being - people with a high anxiety score	43.3 (2011/12)	Tracker	N/A	Qtr 3 (2012/13)	40.1 (2011/12)	41.8 (2011/12)	Not reported
Not reported		Gap between the employment rate for those with a long term health conditions and the overall employment rate	8.2 (2012)	Tracker	N/A	Qtr 2 2014/15 (2013)	7.1 (2012)	9.7 (2012)	Not reported
9.8% (2011/12)	11% (2012/13)	Proportion of adults in contact with secondary mental health services in paid employment	9.8% (Apr-Sep 2013)	9%	⇩	Qtr 3 (Apr-Dec 2013)	Not reported	Not reported	Not reported
		Patient experience of community mental health services	Data only available by provider NHS Trust e.g. TEWV	87					
Not reported	Not reported	Number of suicides	11.5 per 100,000 (2009-11)	Tracker	N/A	Qtr 4 (2010-12)	7.9 per 100,000 (2009-11)	9.3 per 100,000 (2009-11)	Not reported
339.0 (2009/10)	354.6 (2010/11)	Hospital admissions as a result of self-harm. (Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population)	343.1 (2011/12)	Tracker	⇩	Qtr 1 2014/15 (2012/13)	207.9 (2011/12)	Not reported	Not reported
78.4% (2011/12)	89.2% (2012/13)	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	88.6% (Apr-Sep 2013)	85%	⇩	Qtr 3 (Apr-Dec 2013)	Not reported	Not reported	Not reported
877.9 (2008/09)	1241.3 (2009/10)	Excess under 75 mortality rate in adults with serious mental illness per 100,000 population	1064 (2010/11)	Tracker	⇩	Data release date TBC	921.2 (2010/11)	Not reported	Not reported
Strategic Objective 5: Protect vulnerable people from harm									
12% (2011/12)	13% (2012/13)	Percentage of repeat incidents of domestic violence	7.8% (Apr-Sep 2013)	Less than 25	⇩	Qtr 3 (Apr-Dec 2013)	24.3% (Jul 12-Jul 13)	Not reported	Not reported
81.4% (2011/12)	86.8% (2012/13)	The proportion of people who use services who say that those services have made them feel safe and secure	93.4% (Apr-Sep 2013)	75%	⇧	Qtr 3 (Apr-Dec 2013)	77.9% (2012/13)	79.4% (2012/13)	Not reported

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
Not available	Not available	Percentage of children and young people reporting that they are bullied when they are at school and when not at school (year 6)	16.6% (at school) 16.3% (Not at school)	Tracker	N/A	Qtr 4 (2013/14)	Not available	Not available	Not available
Not available	Not available	Percentage of children and young people reporting that they are bullied when they are at school and when not at school (year 9)	14.6% (at school) 5.7% (Not at school)	Tracker	N/A	Qtr 4 (2013/14)	Not available	Not available	Not available
11.2% (2011/12)	16.9% (2012/13)	Percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time	13.6% (Apr-Sep 2013)	15%	⇩	Qtr 3 (Apr-Dec 2013)	13.8% (2011/12)	12.4% (2011/12)	13.2% (2011/12)
89 (2011/12)	67 (2012/13)	Number of Initial Child Protection Conferences relating to children becoming the subject of a Child Protection Plan where parental substance misuse has been identified as a risk factor	Awaiting Q2 data	Tracker	N/A	Qtr 3 (Apr-Dec 2013)	Not available	Not available	Not available
100 (2011/12)	95 (2012/13	Number of Initial Child Protection Conferences relating to children becoming the subject of a Child Protection Plan where parental alcohol misuse has been identified as a risk factor	Awaiting Q2 data	Tracker	N/A	Qtr 3 (Apr-Dec 2013)	Not available	Not available	Not available
Awaiting data	Awaiting data	Number of Initial Child Protection Conferences relating to children becoming the subject of a Child Protection Plan where domestic abuse has been identified as a risk factor	Awaiting Q2 data	Tracker	N/A	Qtr 3 (Apr-Dec 2013)	Not available	Not available	Not available
45.4 (2011/12)	40.9 (2012/13)	Number of children with a Child Protection Plan per 10,000 population	42.4 (Apr-Sep 2013)	Tracker	⇩	Qtr3 (Apr-Dec 2013)	37.8 (31/03/2012)	53.6 (31/03/2012)	49.9 (31/03/2012)
54.0% (2011/12)	51.1% (2012/13)	Percentage of adult safeguarding referrals substantiated or partially substantiated	47.4% (Apr-Sep 2013)	Tracker	N/A (No polarity)	Qtr3 (Apr-Dec 2013)	Not available	Not available	Not available
65.2 (2011/12)	63.4 (2012/13)	Number of Looked After Children per 10,000 population	61.9 (Apr-Sep 2013)	Tracker	⇩	Qtr3 (Apr-Dec 2013)	60 (31/03/2013)	80 (31/03/2013)	81 (31/03/2013)

Previous Data		Indicator	Latest Data	2013/14 Target	Direction of Travel	Next Data Refresh	National	North East	Similar Councils
27.5% (2011/12)	16.8% (2012/13)	Percentage of Children in Need (CIN) referrals occurring within 12 months of previous referral	30.6% (Apr-Sep 2013)	21%	⇧	Qtr3 (Apr-Dec 2013)	26.1% (2011/12)	23.8% (2011/12)	21.6% (2011/12)
Strategic Objective 6: Support people to die in the place of their choice with the care and support that they need									
Not reported	Not reported	Percentage of all deaths that occur in hospital	53.4% (2008-10)	Tracker	N/A	Data release date unknown	54.5% (2008-10)	Not available	Not available
Not reported	Not reported	Percentage of all deaths that occur in own home	22.1% (2008-10)	Tracker	N/A	Data release date unknown	20.3% (2008-10)	Not available	Not available
Not reported	Not reported	Percentage of all deaths that occur in hospice	3.0% (2008-10)	Tracker	N/A	Data release date unknown	5.2% (2008-10)	Not available	Not available
Not reported	Not reported	Percentage of all deaths that occur in care home	18.8% (2008-10)	Tracker	N/A	Data release date unknown	17.8% (2008-10)	Not available	Not available
Not reported	Not reported	Percentage of hospital admissions ending in death (terminal admissions) that are emergencies	91.0% (2010/11)	Tracker	N/A	Data release date unknown	89.7 (2010/11)	Not available	Not available

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Joint Health and Wellbeing Strategy: Completed Actions

Action	Target End Date	Completion Date
Continue the development of emotional wellbeing provision with secondary schools (Year 10 – age 14/15)	Mar-14	**Sep-13**
Decommission and re-commission redesigned children's community nursing service	Mar-14	**Sep-13**
Increase targeted Child and Adolescent Mental Health (CAMHs) service provision for North Durham	Mar-14	**Sep-13**
Ensure intelligence and data is shared to enable an integrated model for a programme of enforcement	Mar-14	**Sep-13**
Undertake a tobacco control alliance plan self-assessment exercise	Jul-13	**Jul-13**
Review Exercise Referral Pathway and implement recommendations	Mar-14	**Sep-13**
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	Aug-13	**Aug 13**
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	Jun-13	**Jun-13**
In response to the Winterbourne Review Inquiry, Health and Care Commissioners will: * Complete DoH 'Stocktake' to outline local progress against national Winterbourne commitments.	Jul-13	**Jul-13**
In response to the Winterbourne Review Inquiry, Health and Care Commissioners will: * Put personal care plans into action so that all individuals receive personalised care and support in appropriate community settings	Jun-14	**Sep-13**
Improve access to psychological therapies	Mar-14	**Sep-13**
Commission a countywide specialist domestic abuse Outreach Service	Jul-13	**Jul-13**
All partner agencies to have a strategic role in relation to safeguarding and promoting the welfare of adults within their organisation	Mar-14	**Sep-13**
Ensure all partners are aware of overarching safeguarding procedures by ensuring they are represented on the Safeguarding Adults Board	Mar-14	**Sep-13**

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Health and Wellbeing Board

15th November 2013

North Durham CCG (NDCCG) and Durham Dales, Easington and Sedgefield CCG (DDESCCG) Planning Process Update for 2014/15

Joint Report of Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group

Purpose of Report

1. The purpose of this report is to outline the planning process which feeds into the 2014/15 planning round for both North Durham Clinical Commissioning Group (ND CCG) and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG).

2. This report will articulate how this activity fits into the North Durham Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group 'Clear and Credible Plan' development and the strategic challenges faced by both organisations. It will include activity that has been undertaken to date and forthcoming work that will be required.

Background – Clear and Credible Plan

3. ND CCG and DDES CCG were both formed in the autumn of 2011. During the back end of the following year both CCGs were authorised by the National Commissioning Board and assumed responsibilities for the commissioning of health services from 1st April 2013.

4. During this process each CCG had to publish its five year strategic plan. The Clear & Credible Plan 2012/13 – 2016/17. The CCGs are now looking to build on and consolidate their commissioning activity already taking place during the first two years of the plan 2012/13 – 2013/14 and are now looking to develop work programmes and commissioning activities for 2014/15 onwards.

Overarching Planning Process

5. In order to successfully undergo a planning process a number of key activities are required, an outline of these activities are summarised in the table overleaf:

	Month	Activity	Reporting to
July - September	June/July	Agree Engagement Plan to include: • Providers • Patients and the public • Member practices • Local Authority • Other commissioners • Health Networks	CCG / NHS England Area Team
	July /Aug	• Review CCG information (Joint Strategic Needs Assessment), performance against key indicators, Health and Wellbeing Board strategic aims, 2013/14 priorities (Outcome Framework and Quality Premiums and QIPP etc.) to produce long list of 'could /should do's' • Draft 'Commissioning for Quality and Innovation' (CQUIN) programme and timetable • Contract negotiation process starts	CCG / NHS England Area Team
	Aug/Sept	• Asset / Gap analysis to produce list of existing and emerging priorities and high level commissioning intentions	CCG
	Sept/Oct	• Public meetings • Feed into the 'A call to action' engagement process • CQUIN negotiations • Initial discussion with Durham County Council (DCC) partners regarding Integration Transformation Funding (ITF) allocation	CCG
October - December	October	• QIPP review • Public feedback report • Agree draft commissioning intentions and priorities for member practice approval, communication to providers • Revised NHS Mandate published • Big Tent Event	CCG / NHS England Area Team / NHS England
	November	• Draft Operating Plan (or equivalent) published • Allocations published • Detailed officer discussions between DCC and CCG relating to ITF allocation (Oct '13 – Jan '14)	NHS England / DCC
	December	• Plan refreshed in line with national planning guidance • QIPP review • National (PbR) Tariff published • 2014/15 contract issued	CCG / NHS England Area Team

January – March	January	• Final commissioning intentions and activity plans given to providers • Draft CCG Plan on a Page & Operating Plan submitted to AT • 1st draft CCG Finance & QIPP Plans submitted • Health and Wellbeing Board (HWB) to review initial ITF plans and make recommendations	CCG / NHS England Area Team / DCC / HWB
	February	• AT reviews of plans and feedback to CCGs (triangulation of activity, finance and reform programmes) • Commence weekly updates on contract negotiations (via AT template) • Second draft plan • CCGs submit proposals for 3 local priorities	CCG / NHS England Area Team
	March	• Final Finance & QIPP Plans submitted • Final activity & delivery indicators documented • CCGs and AT review provider CIPs • AT sign-off of local priorities • Final submission CCG plans-on-a-page and Assurance Plan	CCG / NHS England Area Team
	Mar/April	• CCG and NHS England contracts signed • CCG draft annual accounts (pre-audit) • CCG Boards sign-off final plans • Health and Wellbeing Board to formally agree ITF spending plans for 201/15 and 2015/16, and agreed relevant local performance indicators to be used in conjunction with nationally required indicators.	CCG / NHS England Area Team / HWB

Engagement Activity

6. During July 2013 NHS England published ‘A call to action – the NHS belongs to the people’. The Call to Action process should feed into the development of the CCG’s five-year commissioning plans. The Call to Action will also shape the national vision, identifying what NHS England should consider to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels. This ‘Call to Action’ is the opportunity for everyone who uses or works in the NHS to have their say on its future.

7. As a part of ‘Call to Action’ programme each of the Clinical Commissioning Groups within the Durham, Darlington and Tees area have agreed to work jointly with the Local NHS England Area Team utilising the North of England Commissioning Support (NECS) communication and engagement teams. This engagement activity has begun and where possible will utilise existing engagement opportunities, this will includes a session at the Big Tent event. Through this engagement process, both NDCCG and DDESCCG will feed in the views gathered from these events into their commissioning plans and will

share draft of these commissioning plans (interim commissioning intentions) with the engagement groups to seek the views of the patients and public.

8. To supplement the 'Call to Action' engagement process and ensure full engagement with other stakeholders such as providers, member practices and clinical networks, both NDCCG and DDESCCG have both written to key stakeholders to obtain their views on what the CCG and other health commissioners should consider in the development of their commissioning plans. To enable focussed feedback a context pack was included with the letter and feedback template which highlight some of the key issues faced by the CCG. An example of the letter, context pack and feedback template is included in **Appendix 2.**

Developing the Commissioning Plan

9. Once feedback has been received from stakeholders, they will be summarised, analysed and prioritised, considering: contribution towards the delivery of better outcome for patients, meeting the needs of patients, strategic fit, affordability (alignment with mid-term financial plan) and impact across the health economy. Other activities such as: detailed discussion with Durham County Council (DCC) regarding development of ITF allocations; development of business cases and face-to-face meetings with providers will support the impact assessment process. This activity will occur throughout October 2013.

10. Once a draft commissioning plan has been developed it will be shared with stakeholders for feedback. This document should be available by mid-November 2013.

11. This commissioning plan will be further refined with full consideration given to the feedback and account for any national directives and further information received throughout November and December, including: operating framework (or equivalent) requirements, Integrated Transformation Funding arrangements and budget allocations.

12. Throughout this period a number of additional reporting requirements will be required by NHS England and the Health and Wellbeing board, these are likely to include: refreshing the Clear and Credible Plan, development of an Assurance triangulation plan, submission of various activities/performance trajectories and selection of local quality premium areas.

13. The Commissioning Plan will be finalised by the end of April 2014.

Formulating contracts

14. Running in parallel and interacting with the development of the commissioning plan is the NHS contracting process. The overarching aim of this process is to secure the services from providers that meet the needs of the CCGs (and other commissioners) in terms of activity levels, quality and affordability. To facilitate the contracting round a regional group has been re-affirmed to cover the North East and Cumbria CCGs. The level of contracts will take into account: historical activity levels, impact of in-year reforms (both commissioner and provider led), population need changes and changes in technological and clinical guidance (e.g. NICE guidance). The delivery of associated outputs will be facilitated by NECS.

15. There are a number of outputs that are required throughout this process, which include: approach to contracting (lead/associate arrangements), agreement on type of contract (activity or risk share), activity and funding trajectories by provider, formulated CQUIN schedules, clearly defined quality requirements, agreed service delivery improvement plan and review schedule, devised data quality improvement plan and other items required by the commissioning organisation.

16. The contract should be signed off before the 31st March 2014 by the commissioner and provider.

Recommendations

17. It is recommended that the Health and Wellbeing Board note the contents of this report.

Contact: Jon Wrann, Commissioning Manager, North of England Commissioning Support, jonathan.wrann@nhs.net

Background papers: None

Appendix 1: Implications

Finance This process has a significant financial impact on the local health economy.

Staffing N/A

Risk CCGs will need a complete suite of provider contracts in place to ensure that the CCGs achieve the levels of efficiencies and service improvement necessary to deliver their strategic aims and contribute towards a safe and stable health economy.

Equality and Diversity / Public Sector Equality Duty An Equality and Diversity Impact Assessment will be carried out, as appropriate throughout the planning process.

Accommodation N/A

Crime and Disorder N/A

Human Rights N/A

Consultation Extensive consultation will take place through: the 'a call to action' process; communications with key stakeholders as described in the appendices of this report.

Procurement The delivery of the DDES and North Durham CCG plans are likely to involve procurement activity

Disability Issues N/A

Legal Implications N/A

NHS
North Durham
Clinical Commissioning Group

Appendix 2

North Durham Clinical Commissioning Group
Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

www.northdurhamccg.nhs.uk

Our Reference 130909 Commissioning Intentions
Your Reference

Main number
E-mail

17th September 2013

Dear Colleague

As a part of developing our commissioning plan for 2014/15 and beyond North Durham Clinical Commissioning Group (CCG) are undertaking an exercise to seek ideas, issues and potential solutions from our stakeholders.

This information gathering process will provide an essential resource to support the conversations with our partners and providers planned later in this financial year, as we will be able to share information and views from a broad range of stakeholders. Our aim is to have this information received by the end of September.

North Durham CCG would request that County Durham Local Authority consider proposals that would maximise the benefits of the health and social care integration. This process is an important catalyst for change, moving more towards preventative, community-based care that will help to keep people out of hospital and in community settings for longer.

When considering these proposals we would request that you consider some of the challenges that we face:

- One quarter of the population has a long term condition such as diabetes, depression, dementia and high blood pressure – and they account for fifty per cent of all GP appointments and seventy per cent of days in a hospital bed

- Hospital treatment for over 75s has increased by 65 per cent over the past decade and someone over 85 is now 25 times for likely to spend a day in hospital that those under 65

- The number of older people likely to require care is predicted to rise by over 60 per cent by 2030

- Modelling shows that continuing with the current model of care will lead to a national funding gap of around thirty billion between 2013/14 and 2020/21

These issues and others will be discussed further throughout this year's planning process through the '*A Call to Action'* engagement programme. Information from this process will be fed back to our stakeholders.

We enclose a pack that provides further context and illustrates to you some of the challenges facing us and some of the current work programme being worked through. We will use the themes within the pack to prioritise proposals and you might wish to refer to that as you think through your suggestions.

Please submit your suggestions using the template attached by 5pm on 30th of September 2013 to necsu.planning@nhs.net.

North Durham CCG will shortly be contacting you to arrange a face-to-face meeting in October to discuss our commissioning priorities for 2014/15 and beyond.

We would like to take the opportunity to thank you for your input into this process.

Yours sincerely

Dr Neil O'Brien
Chief Clinical Officer

Enc

North Durham CCG Context Pack for 2014/15 planning round

Overview

North Durham CCG has developed a 5 year strategic plan - The Clear & Credible Plan 2012/13 – 2016/17. North Durham CCG with support from North of England Commissioning Support is currently in the process of delivering year two of the clear and credible plan. We are now looking to build on and consolidate our commissioning activity which has taken place during the first two years of our plan and develop and refine the work programme for 2014/15 and beyond.

We believe it is essential that the CCG engages as widely as possible to ensure that the views of patients, the public, partner organisations and other key stakeholders are taken into account and used to inform commissioning decisions. This strategic context pack is being shared with our stakeholders to provide context and supporting information. This will ensure that the CCG is best placed to align any commissioning proposals to the fundamental challenges facing the CCG.

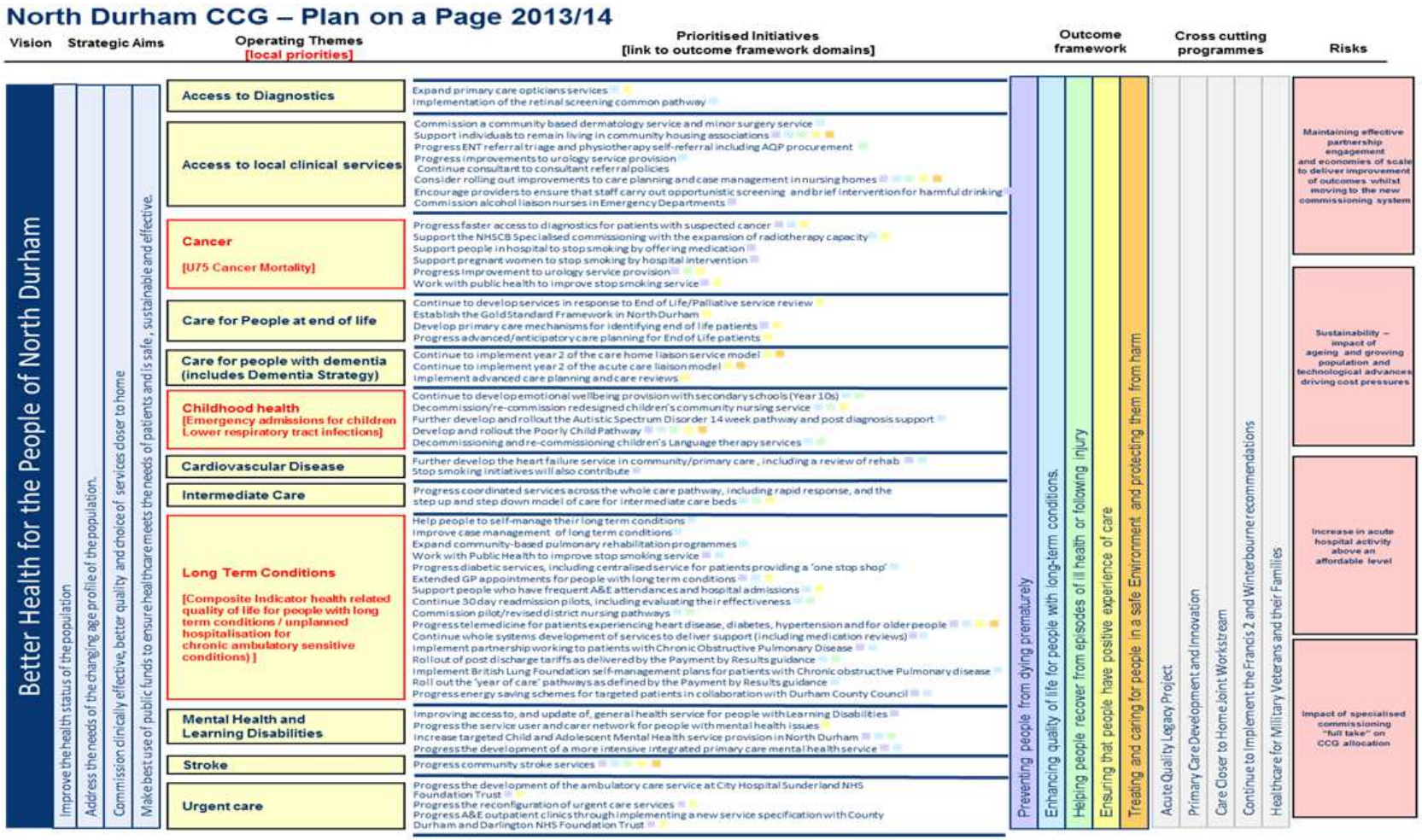
The pack contains the following information:

1. Existing delivery plan for 2013/14
2. North Durham CCG Strategic aims
3. NHS England Outcome Framework Domains
4. A Call to Action
5. NHS England Outcome profile for North Durham CCG
6. North Durham CCG Quality Premiums
7. County Durham Joint Strategic Needs Assessment key messages
8. County Durham Health and Wellbeing Board (CDHWB) strategic aims
9. CDHWB Clinical Programme Board areas
10. Quality, Innovation, Productivity and Prevention (QIPP) objectives

For a full version of our Clear and Credible Plan please go to:
http://www.northdurhamccg.nhs.uk/wp-content/uploads/2012/11/North-Durham-CCG-Clear-and-Credible-Plan-2012-17-FINAL.pdf

Delivery Plan for 2013/14

The delivery plan below includes the commissioning work streams that are currently being delivered by North Durham CCG with the support of North of England Commissioning Support (NECS)



If a proposal is on the plan and you wish to be involved please state this on the template (within the "follow up" box)

North Durham CCG Strategic Aims

We have four strategic aims in order to help us achieve our vision of “Better Health for the People of North Durham”.

1. To improve the health status of the population,
2. To address the holistic needs of the changing age profile of the population,
3. To commission clinically effective, better quality and choice of services closer to home,
4. To make best use of public funds to ensure healthcare meets the needs of patients and is safe, sustainable and effective.

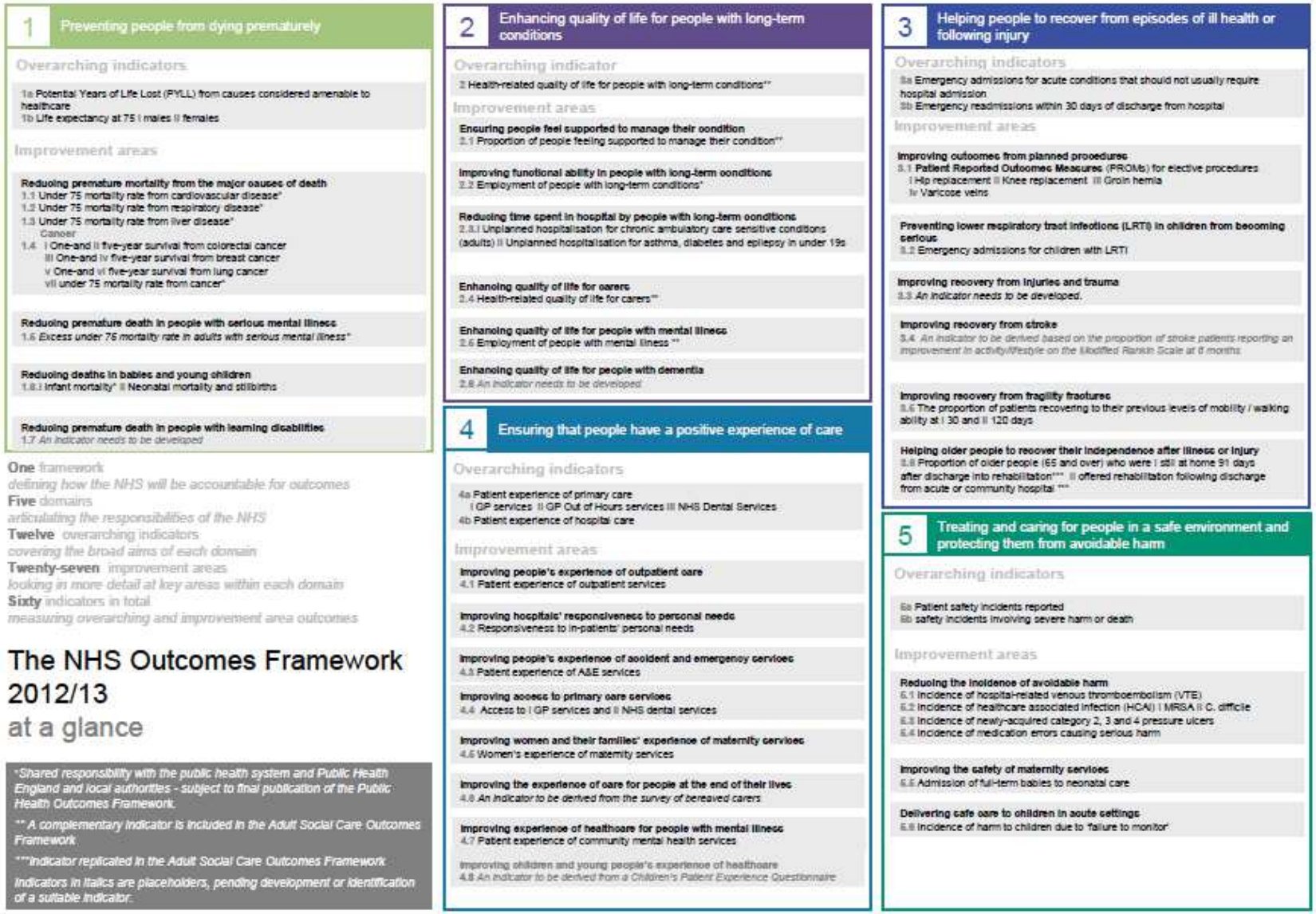
NHS England Outcome Domains

North Durham CCG as a commissioning organisation will have its success measured against the NHS Outcomes Framework. The framework acts as a catalyst for driving improvements in quality and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes. ‘Liberating the NHS’ set out a vision of an NHS that achieves health outcomes that are among the best in the world. To achieve this, it outlined two major shifts:

- a move away from centrally driven process targets,
- a relentless focus on delivering the outcomes that matter most to patients.

The main elements of the Outcome Framework are identified over the page.

The NHS Outcome Framework



A Call to Action

Under a national campaign called “A Call to Action” all CCGs have been challenged to try and address issues within the following themes:

- prevention & early diagnosis,
- valuing physical health & mental health equally,
- putting patients in control of their health needs,
- well co-ordinated care – integration/ collaboration,
- learning from success – identifying and spreading best practice & innovation.

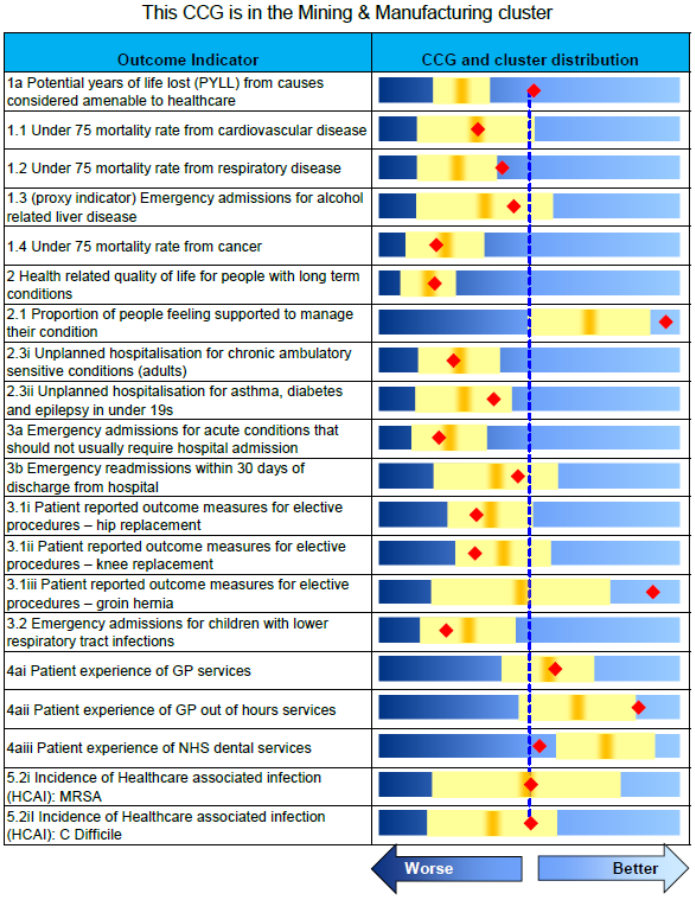
For further information on “A Call to Action” please go to the following website:

http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

Additional information on the “A Call to Action” campaign will be shared throughout various stakeholder events.

NHS England Outcome profile for North Durham CCG

Annually NHS England publishes the performance of CCGs against some of the key measurable indicators within the outcomes framework. Included below is the most recent spine chart that summarises this for North Durham CCG.



The report is available here: http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-pack-00j.pdf and is due to be refreshed and republished during late autumn of this year.

We would be particularly keen to see ideas on how to improve our position in our more poorly performing areas.

North Durham CCG Quality Premium Areas

NHS England has identified some key areas where if the CCG achieve targets, additional funding will be made available to spend on the local health economy. These included a combination of nationally derived target and locally agree targets:

The national quality premium areas are 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:

- reducing under 75 mortality rate from cancer (12.5%),
- North Durham CCG Composite Indicator (Improving health related quality of life for people with long term conditions and reducing unplanned hospitalisation for chronic ambulatory sensitive conditions) (12.5%),
- reduce the number of children developing lower respiratory tract conditions (12.5%).

Joint Strategic Needs Assessment (JSNA)

The most recent version of County Durham JSNA (2012) is available on the County Durham Local Authority website:

http://content.durham.gov.uk/PDFRepository/JSNA-2012-Key-Messages.pdf ; http://content.durham.gov.uk/PDFRepository/JSNA-2012-Interactive-Version.pdf ; http://www.durham.gov.uk/pages/JSNADocuments.aspx?JSNASubCatId=9

High level summary messages to share are:

- the overall population of County Durham is predicted to increase between 2009 and 2031 from 495,764 to 511,045,
- the population in County Durham is becoming older with a predicted increase of 61.6% in older people aged 65 years and over and a 157.3% increase in older people aged 85 years and over by 2031,
- life expectancy has improved but remains below the England average. (County Durham 77.0 for males and 81.0 for females – England 78.6 and 82.6 respectively based on 2008-10 figures),
- early death rates from heart disease/stroke continue to fall however are still significantly worse than the England average. Cardiovascular disease (CVD) is the main cause of death and premature death in County Durham and is strongly associated with inequalities in health,
- smoking is the biggest single contributor to the shorter life expectancy experienced locally and contributes substantially to the cancer burden,
- it has been estimated that over 160 deaths a year might be avoided across County Durham if more cancers were diagnosed early,
- there are particular challenges for certain conditions due to increasing age (e.g. dementia) or change in projected prevalence (e.g. diabetes),
- adult and childhood obesity levels in County Durham are worse than the England average,
- although breastfeeding initiation is increasing in County Durham it remains lower than the England average,
- teenage conception rates are lower in County Durham than the North East region but still higher than the national average,
- alcohol-related admission rates for under 18s in County Durham are higher than the regional average and hospital stays for alcohol related harm remain significantly higher than the England average,
- steady increase in the number of carer assessments carried out jointly with the service user from 3,614 in 2008/09 to 5,327 in 2011/12 (47.4%),
- nationally life expectancy is on average 10 years lower for people with mental health problems due to poor physical health,
- suicide rates in County Durham for men were significantly higher than the England average in 2008-10.

These messages are available on a summary page on the local authority website: http://www.durham.gov.uk/pages/JSNADocument.aspx?JSNASubCatId=9&JSNADocId=272

The County Durham JSNA is currently being refreshed for 2013.

Health & Wellbeing Strategic Objectives

The CCG is a member of the County Durham Health & Wellbeing Board which is responsible for the development of the County Durham Health & Wellbeing Strategy. The strategy has also been widely consulted upon and sets out six strategic objectives which are overleaf:

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

Sitting underneath these strategic objectives will be a number of strategic actions and responsibility for some of these actions will lie with the clinical commissioning group. To deliver some of these actions three Clinical Programme Boards have been established.

Clinical Programme Board areas

North Durham CCG is working collaboratively across County Durham and Darlington with neighbouring CCGs and the local authority in three areas:

1. Urgent Care,
2. Planned Care,
3. Community Care.

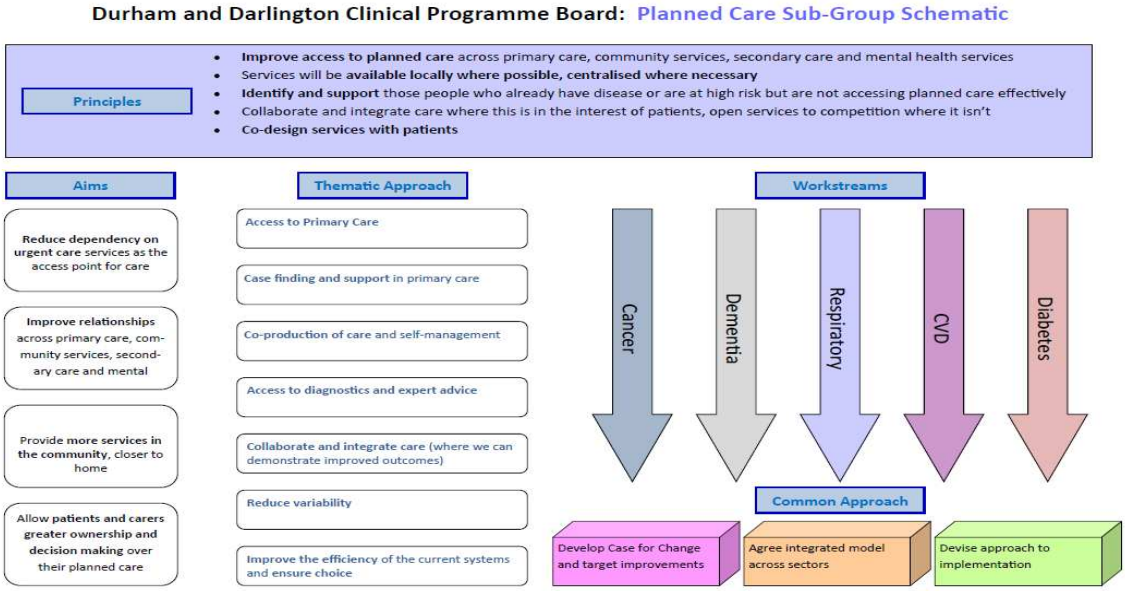
Each of these clinical programme areas has work programmes within them:

Urgent Care (Board)

- Primary Care / Prevention / Care Home,
- Urgent Care Centres,
- Front of House / Handover,
- Alternative Disposition (patient pathways other that going the the emergency department, for example, paramedics that see and treat),
- Patient and public education,
- Winter planning / Escalation Planning.

Planned Care Clinical Programme Group

The planned care workstreams are represented within the schedule overleaf:



Community Services and Care Closer to Home

- Community Nursing (including District Nursing and Community Matrons),
- Intermediate Care,
- Home Equipment Loans,
- End of Life/Palliative Care.

Financial Challenges

- One quarter of the population has a long term condition such as diabetes, depression, dementia and high blood pressure – and they account for fifty per cent of all GP appointments and seventy per cent of days in a hospital bed
- Hospital treatment for over 75s has increased by 65 per cent over the past decade and someone over 85 is now 25 times more likely to spend a day in hospital that those under 65
- The number of older people likely to require care is predicted to rise by over 60 per cent by 2030
- Around 800,000 people nationally are now living with dementia and this is expected to rise to one million by 2021
- Modelling shows that continuing with the current model of care will lead to a national funding gap of around thirty billion between 2013/14 and 2020/21
- The system needs to account for the demographic and health related issues within the back drop of no increase of funding

The only way that we can meet these challenges is to do things differently, doing nothing is not an option – North Durham CCG cannot meet future challenges without change.

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Our Reference 130909 Commissioning Intentions
Your Reference

Main number 0191-3713220
E-mail stewartfindlay.ddes@nhs.net

Sedgefield Community Hospital
Salters Lane
Sedgefield
TS21 3EE

Tel: 0191 3713222
Fax: 0191 3713223
www.durhamdaleseasingtonsedgefieldccg.nhs.uk

9 September 2013

Dear Colleague

As we move into the autumn, DDES CCG is beginning the process of collecting commissioning proposals for next year.

Our aim is to develop a long list of proposals by the end of September and then to prioritise those intentions with our colleagues in the Local Authority before the end of December 2013.

Although, we are in a healthy financial position this year and have financial stability as a result of the block contracts in place with all our providers, we know this position is likely to change over the coming two years. There is also the need to develop our Quality, Innovation, Productivity and Prevention (QIPP) Plan to support our allocated funding through efficiencies and savings.

Two specific financial challenges we need to address are:

1. In 2015/16 we have to pass in the region of 3% of our budget to the Local Authority to fund Integrated Care and this is likely to put increased pressure on the funding available for our Acute Services.

2. The Department of Health has also published a new funding formula and although it is not known how long it will take them to move us to this fair shares formula, the likely loss for DDES amounts to approximately £18 million per year.

Continued…

As we think through our Commissioning Intentions we therefore need to think of services that are cost effective and help us to continue to deliver the efficiencies we will have to generate over the coming years.

In support of this we are particularly keen to work with our partners and to move as many services as possible from Secondary Care out into Community Services closer to our patients.

I enclose the pack that will provide some context and illustrate to you some of the challenges facing us, we will use the themes within the pack to prioritise proposals and you might wish to refer to that as you think through your suggestions.

Please submit your suggestions using the template attached by 5pm on 30th of September 2013 to necsu.planning@nhs.net.

We would like to take the opportunity to thank you for your input into this process.

Yours sincerely

Dr Stewart Findlay
Chief Clinical Officer

Enc

DDES CCG Context Pack For 2014/15 planning round

North of England
Commissioning Support Unit

Overview

DDES CCG has developed a 5 year strategic plan - The Clear & Credible Plan 2012/13 – 2016/17. DDES CCG with support from North of England Commissioning Support are currently in the process of delivering year two of the clear and credible plan. We are now looking to build on and consolidate our commissioning activity which has taken place during the first two years of our plan and develop and refine the work programme for 2014/15 and beyond.

We believe it is essential that the CCG engages as widely as possible to ensure that the views of patients, the public, partner organisations and other key stakeholders are taken into account and used to inform commissioning decisions. This strategic context pack is being shared with our stakeholders to provide context and supporting information. This will ensure that the CCG is best placed to align any commissioning proposals to the fundamental challenges facing the CCG.

The pack contains the following information:

1. Prioritisation process
2. Existing delivery plan for 2013/14
3. DDES CCG Strategic aims
4. NHS England Outcome Framework Domains
5. A Call to Action
6. NHS England Outcome profile for DDES CCG
7. DDES CCG Quality Premiums
8. County Durham Joint Strategic Needs Assessment key messages
9. County Durham Health and Wellbeing Board (CDHWB) strategic aims
10. CDHWB Clinical Programme Board areas
11. Quality, Innovation, Productivity and Prevention (QIPP) objectives

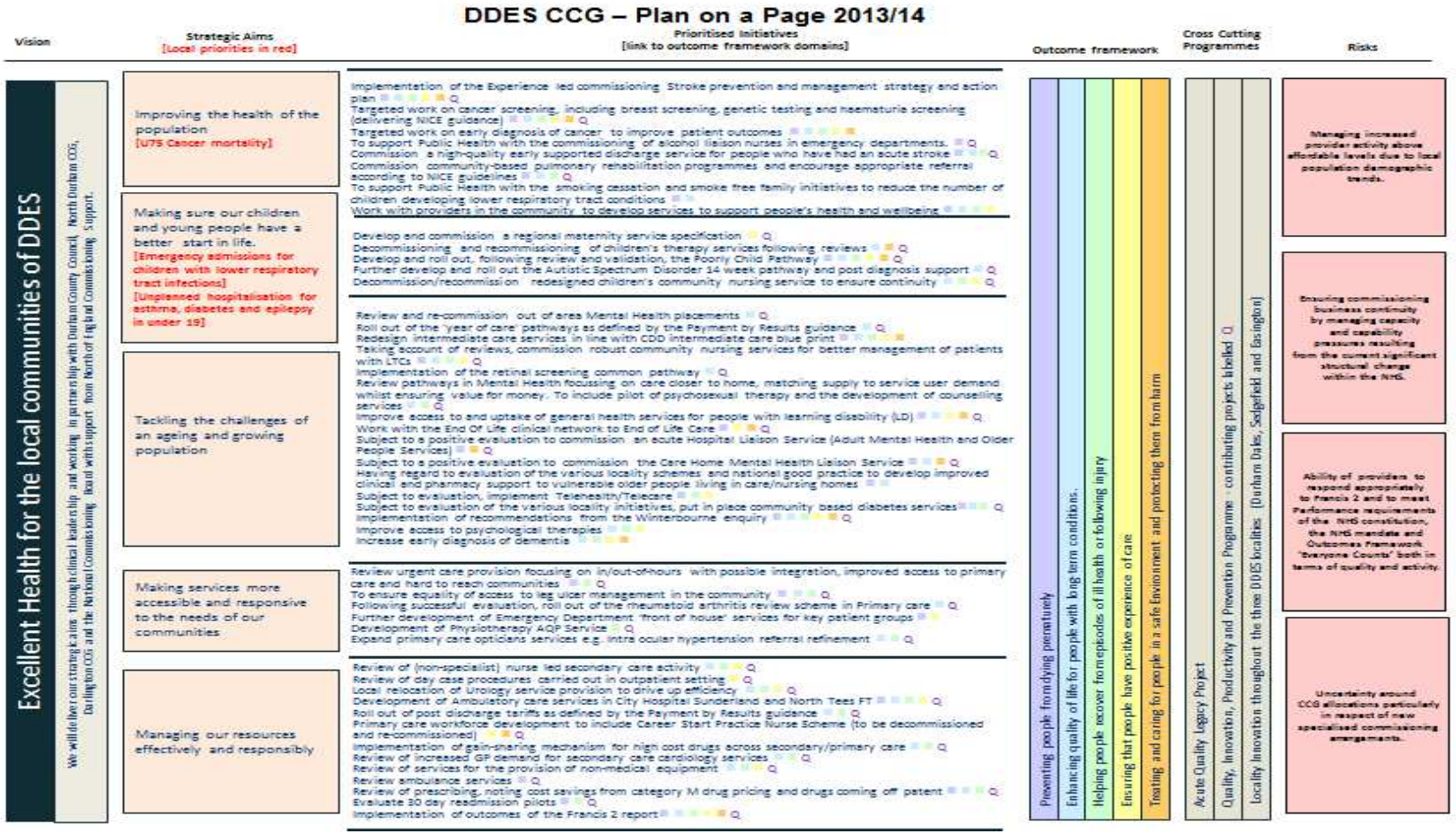
For a full version of our Clear and Credible Plan please go to:
http://www.durhamdaleseasingtonsedgefieldccg.nhs.uk/wp-content/uploads/2012/09/DdesClearCrediblePlan.pdf

Prioritisation Process

DDES CCG will use a two stage prioritisation process: An initial process will identify those proposals that will help address the challenges that face the CCG and our patients. This will be achieved by analysing how they fit with the contextual information available form this pack.

Delivery Plan for 2013/14

The delivery plan below includes the commissioning work streams that are currently being delivered by DDES CCG with the support of North of England Commissioning Support (NECS)



If a proposal is on plan and you wish to involved please state this on the template

DDES CCG Strategic Aims

We have 5 strategic aims in order to help us achieve our vision of “Excellent Health for the local communities of DDES”:

1. Improving the health of the population
2. Making sure our children and young people have a better start in life
3. Tackling the challenges of an ageing and growing population
4. Making services more accessible and responsive to the needs of our communities
5. Managing our resources effectively and responsibly

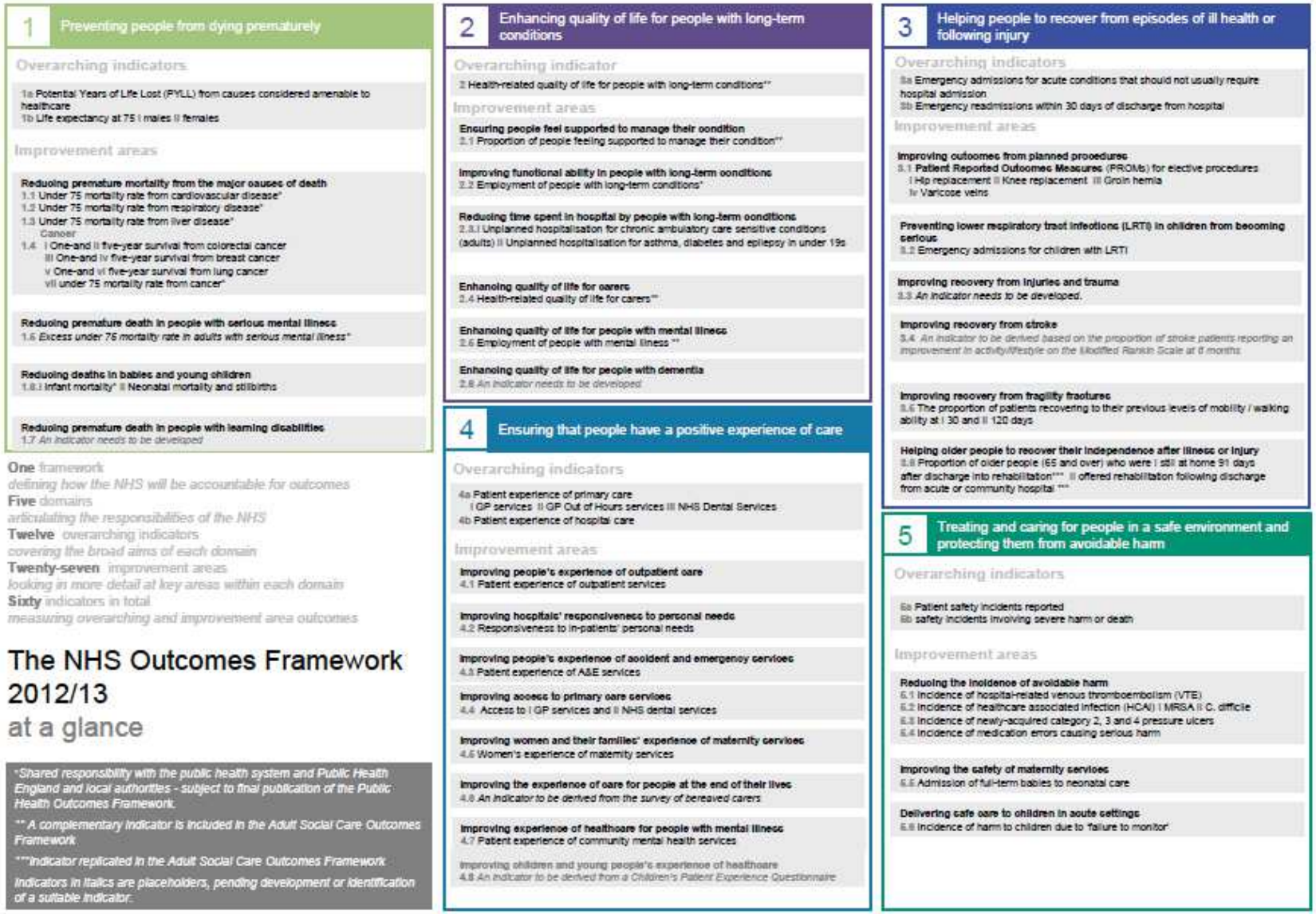
NHS England Outcome Domains

DDES CCG as a commissioning organisation will have its success measured against the NHS Outcome Framework. The NHS Outcomes Framework acts as a catalyst for driving improvements in quality and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a renewed focus on tackling inequalities in outcomes. ‘Liberating the NHS’ set out a vision of an NHS that achieves health outcomes that are among the best in the world. To achieve this, it outlined two major shifts:

- a move away from centrally driven process targets
- a relentless focus on delivering the outcomes that matter most to patients.

The main elements of the Outcome Framework are identified over the page.

The NHS Outcome Framework



A Call to Action

Under a national campaign called “A Call to Action” All CCGs have been challenged to try and address issue within the following themes:

- Prevention & early diagnosis
- Valuing physical health & mental health equally
- Putting patients in control of their health needs
- Well co-ordinated care – integration/ collaboration
- Learning from success – identifying and spreading best practice & innovation

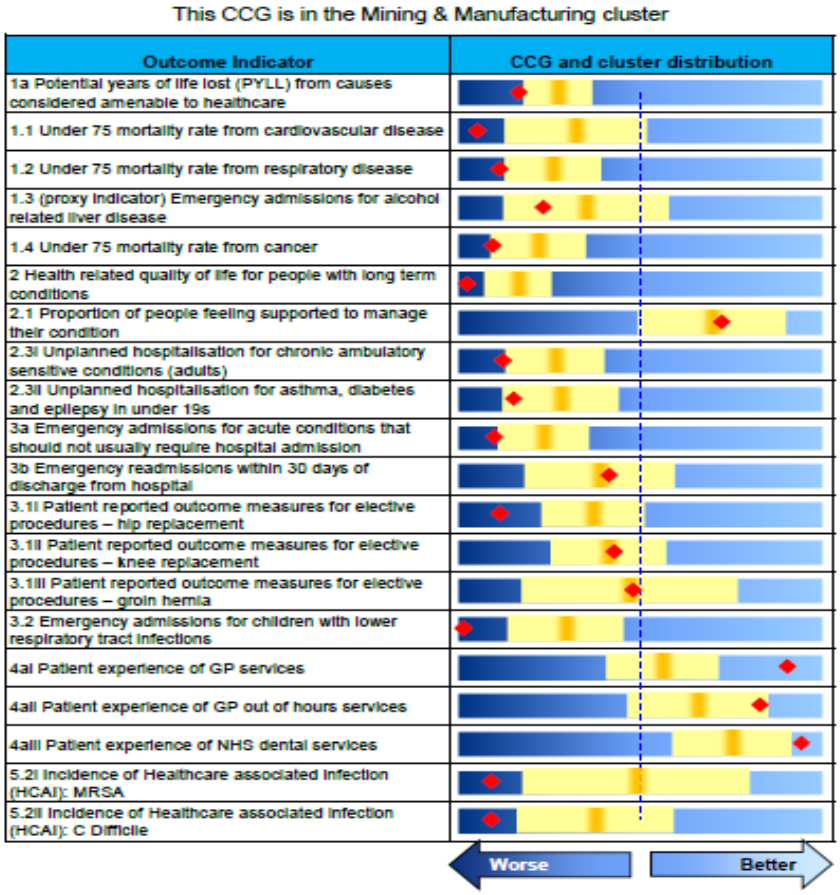
For further information on “A Call to Action” please go to the following website:

http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf

Additional information on the “A Call to Action” campaign will be shared throughout various stakeholder events.

NHS England Outcome profile for DDES CCG

Annually NHS England publish the performance of CCGs against some of the key measureables within the outcome framework, included below is the most recent spine chart that summarises this for DDES CCG.



The report is available here: http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-pack-00d.pdf and is due to be refreshed and republished during late autumn of this year.

DDES CCG Quality Premium Areas

NHS England have identified some key areas where if the CCG achieve targets, additional funding will be made available to spend on the local health economy. These included a combination of nationally derived target and locally agree targets:

The national quality premium areas are aligned to the NHS outcome domains. The percentages 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:

- Under 75 mortality rate from cancer
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- Emergency admissions for children with a lower respiratory tract infection

Joint Strategic Needs Assessment (JSNA)

The most recent version of County Durham JSNA (2012) is available on the County Durham Local Authority websites

http://content.durham.gov.uk/PDFRepository/JSNA-2012-Key-Messages.pdf ;
http://content.durham.gov.uk/PDFRepository/JSNA-2012-Interactive-Version.pdf ;
http://www.durham.gov.uk/pages/JSNADocuments.aspx?JSNASubCatId=9;

High level summary messages to share are:

- The overall population of County Durham is predicted to increase between 2009 and 2031 from 495,764 to 511,045
- The population in County Durham is becoming older with a predicted increase of 61.6% in older people aged 65 years and over and a 157.3% increase in older people aged 85 years and over by 2031
- Life expectancy has improved but remains below the England average. (County Durham 77.0 for males and 81.0 for females – England 78.6 and 82.6 respectively based on 2008-10 figures)
- Early death rates from heart disease/stroke continue to fall however are still significantly worse than the England average. Cardiovascular disease (CVD) is the main cause of death and premature death in County Durham and is strongly associated with inequalities in health

- Smoking is the biggest single contributor to the shorter life expectancy experienced locally and contributes substantially to the cancer burden
- It has been estimated that over 160 deaths a year might be avoided across County Durham if more cancers were diagnosed early
- There are particular challenges for certain conditions due to increasing age (e.g. dementia) or change in projected prevalence (e.g. diabetes)
- Adult and childhood obesity levels in County Durham are worse than the England average
- Although breastfeeding initiation is increasing in County Durham it remains lower than the England average
- Teenage conception rates are lower in County Durham than the North East region but still higher than the national average
- Alcohol-related admission rates for under 18s in County Durham are higher than the regional average and hospital stays for alcohol related harm remain significantly higher than the England average
- Steady increase in the number of carer assessments carried out jointly with the service user from 3,614 in 2008/09 to 5,327 in 2011/12 (47.4%)
- Nationally life expectancy is on average 10 years lower for people with mental health problems due to poor physical health
- Suicide rates in County Durham for men were significantly higher than the England average in 2008-10

These messages are available on a summary page on the local authority website: http://www.durham.gov.uk/pages/JSNADocument.aspx?JSNASubCatId=9&JSNADocId=272

The County Durham JSNA is currently being refreshed for 2013.

Health & Wellbeing Strategic Objectives

The CCG is a member of the County Durham Health & Wellbeing Board which is responsible for the development of the County Durham Health & Wellbeing Strategy. The strategy has also been widely consulted upon and sets out six strategic objectives which are:

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

Sitting underneath these strategic objectives will be a number of strategic actions and responsibility for some of these actions will lie with the clinical commissioning group. To deliver some of these actions three Clinical Programme Boards have been established.

Clinical Programme Board areas (Big Ticket Items)

DDES CCG is working collaboratively across County Durham and Darlington with neighbouring CCGs and the local authority in three areas:

1. Urgent Care
2. Planned Care
3. Community Care

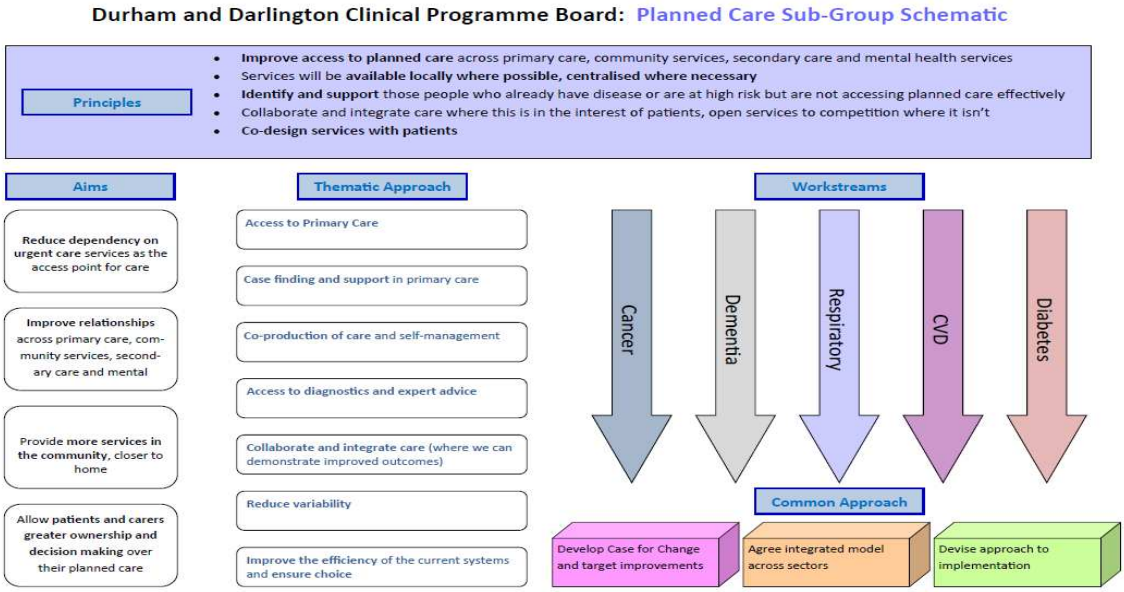
Each of these clinical programme areas has work programmes within them:

Urgent Care (Board)

- Primary Care / Prevention / Care Home
- Urgent Care Centres
- Front of House / Handover
- Alternative Disposition (patient pathways other that going the the emergency department, for example, paramedics that see and treat)
- Patient and public education
- Winter planning / Escalation Planning

Planned Care Clinical Programme Group

The planned care workstreams are represented within the schedule below:



Community Services and Care Closer to Home

- Community Nursing (including District Nursing and Community Matrons)
- Intermediate Care
- Home Equipment Loans
- End of Life/Palliative Care

QIPP (Quality, Innovation, Prevention and Productivity)

QIPP continues to be challenge that our CCG must deliver against.

NHS England has recommended to CCGs that at least 50% of QIPP savings should be delivered via transformational change, rather than continuing with a heavy reliance upon transactional change. Therefore, there is still further work to do to reconfigure the mix between these two categories for the current and future years.

Whilst it is positive that the CCG is able to demonstrate delivery against the QIPP target for 2013/14, it is vital that transformational work continues to enable on-going delivery for future financial years as the financial context becomes even more challenging.

Commissioning Feedback template

Author details	
Name	
Position	
Organisation / Group	
Address	
Contact telephone number	
Email address	

Description

Please describe in detail any issue / idea / solution that you would like the commissioning organisation to consider as a part of the 2013/14 commissioning intention development process. Please identify the scope of the issue (geography, patient demographics etc.)

Impact

What will be the impact of the issue / idea / solution on the health economy? For example: Will it prevent unnecessary hospital admissions ; Will it improve access for patients; Will it result in the delivery of NICE guidance; or, if it is an issue does it result in poor patient experience. Please consider how this will impact on the issues, challenges and objectives that are articulated within the context pack.

Evidence

Can you please provide some evidence that the issue exists or evidence that the idea is effective (e.g. NICE guidance). Please provide hyperlinks to published sources if appropriate

Cost

What are the financial implications of the issue / idea / solution?

Follow up

Who should we contact if we require further information (is it the author or another individual / team)

Which Commissioner?

Please identify which commissioning organisation you wish to consider this feedback

Name	*Yes/No*
Cumbria CCG	
Darlington CCG	
Durham Dales, Easington and Sedgefield CCG	
Gateshead CCG	
Hartlepool and Stockton CCG	
Newcastle North East CCG	
Newcastle West CCG	
North Durham CCG	
North Tyneside CCG	
Northumberland CCG	
South of Tees CCG	
South Tyneside CCG	
Sunderland CCG	
NHS England Durham, Darlington and Tees Area Team	
NHS England Cumbria, Northumberland, Tyne and Wear Area Team	
Unknown	

Other: please identify (for example Redcar and Cleveland Local Authority public health)

Please return to: necsu.planning@nhs.net

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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