Health and Wellbeing Board

Date **Wednesday 5 November 2014**
Time **9.30 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies for Absence

2. Substitute Members

3. Declarations of Interest

4. Minutes of the meeting held on 3 July 2014 (Pages 1 - 8)

5. Making Smoking History and Signing of NHS Statement of Support for Tobacco Control - Presentation of Director of Public Health County Durham, Children and Adults Services, Durham County Council

6. County Durham 'No Health without Mental Health' Local Implementation Plan - Report of Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 9 - 66)

7. Mental Health Crisis Care Concordat - Local Response and Implementation - Report of Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 67 - 74)

8. Securing Quality in Health Services - Joint Report of Chief Officer, Darlington Clinical Commissioning Group and Clinical Chair, Hartlepool and Stockton on Tees Clinical Commissioning Group (Pages 75 - 80)

9. Better Care Fund - Joint Report of Corporate Director, Children and Adults Services, Durham County Council, Chief Clinical Officer, Durham Dales Easington and Sedgefield Clinical Commissioning Group and Chief Operating Officer, North Durham and Durham Dales Easington and Sedgefield Clinical Commissioning Group (Pages 81 - 86)

10. Safeguarding Framework - Joint Report of Strategic Manager, Policy, Planning & Partnerships, Children and Adults Services, Durham County Council, Safeguarding and Practice Development Manager, Children and Adults Services, Durham County Council and Local Safeguarding Children Board Business Manager, Children and Adults Services, Durham County Council (Pages 87 - 114)

11. County Durham Drug Strategy 2014-2017 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 115 - 168)

12. Strategy for Prevention of Unintentional Injuries in Children and Young People (0-19year) - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 169 - 196)

13. Healthy Weight Strategic Framework for County Durham - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 197 - 224)

14. Children and Adolescent Mental Health Services Strategy - Report of Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 225 - 268)

15. Early Help Strategy - Report of Head of Children's Services, Children and Adults Services, Durham County Council (Pages 269 - 310)

16. Joint Health & Wellbeing Strategy - 2nd Quarter 2014/15 Performance Report - Report of Head of Planning and Service Strategy, Children and Adults Services, Durham County Council (Pages 311 - 340)

17. Update - Implementing "Fulfilling and Rewarding Lives"- the statutory guidance for local authorities and NHS bodies regarding the implementation of the Autism Act (2010) - Report of Head of Commissioning, Children and Adults Services, Durham County Council (Pages 341 - 348)

18. Integrated Personal Commissioning - Report of Corporate Director, Children and Adults Services, Durham County Council and Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 349 - 352)

19. Winterbourne View Concordat and Action Plan Implementation in County Durham - Report of Head of Commissioning, Children and Adults Services, Durham County Council (Pages 353 - 366)

20. Transfer of 0 to 5 Commissioning Responsibilities for Health Visitors and Family Nurse Partnership - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 367 - 374)

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

22. 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)

23. Pharmacy Relocation Applications - Report of Director of Public Health, County Durham, Children and Adults Services, Durham County Council (Pages 375 - 378)

24. 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
28 October 2014

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, County Durham, Durham County Council
R Shimmin	Corporate Director of Children and Adult Services, Durham County Council
N Bailey	North Durham CCG
M Barkley	Tees, Esk and Wear Valley NHS Foundation Trust

J Chandy	DDES CCG
Dr S Findlay	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
J Mashiter	Local Healthwatch
Dr D Smart	North Durham CCG

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

DURHAM COUNTY COUNCIL

At a Meeting of **Health and Wellbeing Board** held in Committee Room 1A, County Hall, Durham on **Thursday 3 July 2014 at 9.30 am**

Present:

Members of the Committee:
Councillors L Hovvels, O Johnson and M Nicholls, N Bailey, J Chandy, Dr S Findlay, A Foster, S Halpin, C Harries, S Jacques, J Mashiter, R Shimmin and L Wilson.

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 and A Lynch.

4 Substitute Members

L Wilson for A Lynch and S Halpin for M Barkley.

5 Declarations of Interest

Councillor L Hovvels declared an interest in Item No 10.

Dr Stewart Findlay and Joseph Chandy declared an interest in Item 10 Primary Care Strategy and Item No. 13 Urgent Care Strategy.

6 Minutes of the meeting held 5 March 2014

The Minutes of the meeting held on 5 March 2014 were confirmed by the Board as a correct record and signed by the Chairman.

Rachael Shimmin, Corporate Director of Children and Adults Services asked how the Mental Health Concordat was moving forward with an overview of Mental Health. Peter Appleton, the Head of Planning and Service Strategy said that a

specific Task Group had been set up, led by Michael Houghton from North Durham CCG.

The Chairman informed the Board of the retirement of Dr Kate Bidwell and placed on record her thanks for the significant contribution she had made. Dr David Smart would take up her place on the Board.

7 Housing, Health and Wellbeing

The Board received a joint presentation of the Special Projects Housing Manager, Regeneration & Economic Development, Durham County Council and the Chief Executive of Cestria Community Housing that focused on making the links between Housing and Health and Wellbeing (for copy of presentation see file of Minutes).

David Siddle, Special Projects Housing Manager highlighted the following:-

- The importance of housing to health and care
- Linking with the priorities of the Joint Health and Wellbeing Strategy
- Solution through the integration of housing with health and social care
- Available housing services
- The challenge of Housing Conditions
- The challenge of the Housing Market

Paul Fiddaman, Chief Executive of Cestria Community Housing continued the presentation and focused on the following points:-

- The challenge of housing and communities
- The National Picture
- The local picture in County Durham
- Making Strategic Connections

The Chairman thanked David Siddle and Paul Fiddaman for their very informative presentation and welcomed the joined up approach to deal with these issues.

Rachael Shimmin, Corporate Director, Children and Adults Services referred to the Care Act and how there is a wellbeing duty within it that will change the way we think about prevention. She said that it was important to capture what housing were doing. David Siddle stated that the rationale was to invest to save in the long term, and that they were looking at schemes to cater for a wider range of people, e.g. extra care. Paul Fiddaman added that the housing sector needs to act more upon the evidence that is available. Work will take place to further include housing information into the Joint Strategic Needs Assessment.

Peter Appleton, the Head of Planning and Service Strategy referred to the challenge of housing conditions and the estimate cost of £39m to the NHS over the next 10 years, and asked if this figure had been shared with Public Health. David Siddle agreed that a dialogue with Public Health was very important. The Head of Planning and Service Strategy went on to discuss the importance of housing being

involved in an Implementation Group dealing with dementia. He informed the Board that fuel poverty was a discussion topic at Area Action Partnership meetings and he felt it was important to get the message across to help people to sign up for the scheme.

Joseph Chandy, DDES CCG said that the presentation was refreshing and recognised the relationship with housing and health. He referred to a scheme by Gentoo working with DDES around fuel poverty issues whereby patients with medical issues can have improvements to their homes to help alleviate health problems.

The Board continued to discuss the challenge of fuel poverty and how best to address this issue by working together. Dr Lynn Wilson, Public Health Consultant, said that the scheme by Gentoo would be interesting to show the impact warmer homes have on reducing health inequalities and that this could be brought back to a future meeting.

8 Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 - 2018

The Board considered a report of the Chief Operating Officer, North Durham and DDES Clinical Commissioning Group, which presented the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013-2018 (for copy see file of Minutes).

The Corporate Director, Children and Adults Services said that this was an important piece of work and a commitment had been given to deliver the plan and suggested that it would be interesting to carry out an evaluation at some point. Judith Mashiter, Healthwatch County Durham, noted that Healthwatch could be involved in the evaluation of this work.

Resolved:

(i) That the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013-2018 attached at Appendix 2, be agreed.

(ii) That the direction of travel and development work required in primary care to locally take this forward, be supported.

(iii) That the continued partnership working to ensure integrated delivery of patient centred services, be supported.

9 Dementia Strategy 2014-2017

The Board considered a report of the Chief Operating Officer, North Durham and DDES Clinical Commissioning Group, which presented the 'Dementia Strategy for County Durham and Darlington; 2014 - 2017' (for copy see file of Minutes).

The Head of Planning and Service Strategy said that this was a really good document with a lot of interest in it and that there would be publicity surrounding it.

It was agreed the CCGs would invite a housing representative to join the Dementia Strategy Implementation Group. Nicola Bailey, North Durham CCG will present an

evaluation report of the dementia-friendly communities to a future Health and Wellbeing Board meeting.

Resolved:
That the content of the Dementia Strategy for County Durham and Darlington; 2014 – 2017, be agreed.

10 CCG Primary Care Strategy - A Discussion Document

The Board considered a joint report of the Chief Clinical Officer, DDES Clinical Commissioning Group and Chief Operating Officer, North Durham and DDES Clinical Commissioning Group, which sets out how Clinical Commissioning Groups (CCG) in County Durham are proposing to develop Primary Care in the next five years. This is particularly relevant at this moment in time when NHS England is seeking expressions of interest for the co-commissioning of Primary Care. The drivers for developing Primary Care were set out clearly in the Call to Action debate lead nationally by NHS England (for copy see file of Minutes).

Joseph Chandy, DDES CCG, stated that really useful feedback from patient groups had been received and incorporated into the strategy. He said that it had been a really useful process and affordability had been key to the plan. Nicola Bailey, North Durham CCG, echoed that statement for North Durham.

Following a question from Judith Mashiter, Healthwatch about what the consumer can see is happening, Mr Chandy explained that a patient group was established and that their comments had been carried through the core of the strategy.

Alan Foster, Chief Executive of North Tees and Hartlepool NHS Foundation Trust said that he endorsed the approach and the strategy for all CCGs and understands how enormous the challenge was. He added how important it was to work together around funding as felt it was key to the challenge of delivery.

Andrea Petty, the Strategic Manager, Policy, Planning and Partnerships, Children and Adults Services, informed the Board that she was happy to put together a response to CCGs and asked that any feedback be given to her by 16 July.

Resolved:

(i) That the report and the draft primary care strategies, be received.
(ii) That CCG's be advised whether it supports the 'direction of travel' outlined in this report and commit to provide any detailed comments into the CCGs by the 25th July 2014.
(iii) That the CCG's be informed if there any priorities not covered in this report.
(iv) That further updates as appropriate, be received.

11 County Durham Drug Strategy 2014-2017

The Board considered a report and summary document of the Director of Public Health County Durham which presented the first County Durham Drug Strategy 2014-2017 (for copy of report see file of Minutes).

Dr Lynn Wilson, Public Health Consultant, highlighted the 3 themes that the strategy focused on

- Reducing Demand;
- Restricting Supply; and
- Building Recovery in Communities.

The Chairman suggested that it would be helpful for Dr Wilson to provide a briefing on what differences there are from the previous approach to drugs compared to the new approach outlined in the Strategy. Nicola Bailey agreed and was pleased to see that the strategy would come back to the Board in its final stages in November 2014.

The Corporate Director, Children and Adults Services pointed out that it was important to remember that this was the first ever strategy for County Durham and commented that it was helpful that all strands had been brought together.

Councillor Nicholls commented how important it was to protect the young, aged and vulnerable population.

Resolved:

(i) That a copy of the Drugs Strategy (2014-2017) for comment, be received.

(ii) That the drug strategy will be presented to CMT, Children and Families Partnership and Safe Durham Partnership for comment between May and July, and presented to the Health & Wellbeing Board in November for final agreement, be noted.

12 Child and Adolescent Mental Health Services Commissioning - Outcome of Review

The Board considered a report of the Chief Operating Officer, North Durham and DDES Clinical Commissioning Group, which gave an update on the outcome of the Children and Adolescent Mental Health Services (CAMHS) commissioning review (for copy see file of Minutes).

Resolved:

(i) That the governance for CAMHS as outlined in Appendix 2, be supported.

(ii) That the Children and Young People's Mental Health and Emotional Wellbeing group will also provide updates to the Children and Families Partnership, be noted.

(iii) That an interim 1-year CAMHS/children and young people's mental health and emotional wellbeing joint commissioning strategy 2014/15 is developed by September 2014, based on available intelligence, be agreed.

(iv) That a longer term Children and Young People Mental Health and Emotional Wellbeing (including CAMHS) strategy, starting from 2015, is developed as part of the overarching Mental Health Framework - No Health without Mental Health Implementation plan, be agreed.

13 Urgent Care Working Group Update

The Board considered a report of the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that provided an overview of the collaborative approach being taken by County Durham and Darlington Urgent Care Working Group to addressing issues being experienced across the whole health and care system – from primary & community care to social care and acute hospital care, ambulance transport and police and fire services (for copy see file of Minutes).

Dr Stewart Findlay explained that in future the Urgent Care Working Group will be named the System Resilience Group and would also cover planned as well as urgent care. Dr Findlay also explained that the Urgent Care Strategy would be rewritten to be a Whole System Strategy which would be consulted upon.

Sue Jacques, County Durham and Darlington NHS Foundation Trust acknowledged the extremely difficult work carried out in trying to get all agencies to work together. She added that there would need to be a tighter role between the Clinical Programme Board, the System Resilience Group and Health and Wellbeing Board.

Dr Findlay also explained that winter pressures funding from the government had been made available to CCGs for whole system planning and response for winter 2014.

Alan Foster, North Tees and Hartlepool NHS Foundation Trust said that there was a wider role of the resilience group in terms of cancer awareness campaigns and radiology capacity.

The Corporate Director, Children and Adults Services said that it was important for the group to have sight of demand through the group, and thought it would be useful to receive regular updates, along with a programme of work.

Resolved:
That the report for information, be received.

14 Proposal for a Consultation to Make Play Parks/Area in County Durham Smoke Free

The Board considered a report from the Director of Public Health County Durham that proposed a consultation to Make Play Parks/Area in County Durham Smoke Free (for copy of report see file of Minutes). It was noted that Area Action Partnerships will be part of the consultation process.

Resolved:
That the proposal for a consultation to implement a voluntary code to make play parks/area in County Durham smokefree, be supported.

15 Joint Health and Wellbeing Strategy Annual 2013-2014 Performance Report

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services that described the progress being made against the

priorities and outcomes set within the County Durham Joint Health & Wellbeing Strategy (JHWS) 2013-17 (for copy of report see file of Minutes).

Resolved:

(i) That the performance highlights and areas for improvements identified throughout this report, be noted.

(ii) That the actions taking place to improve performance and agree any additional actions where relevant, be noted.

16 Health and Wellbeing Board Annual Report 2013-2014

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services that presented the Health and Wellbeing Board Annual Report 2013/14 for agreement (for copy of report see file of Minutes).

Resolved:

(i) That the Health and Wellbeing Board Annual Report 2013/14 which is attached at Appendix 2, be agreed.

(ii) That the work that has taken place during the first year of operation of the Health and Wellbeing Board, be noted.

17 Joint Health and Wellbeing Strategy Delivery Plan 2014-17

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services that presented the Joint Health and Wellbeing Strategy (JHWS) Delivery Plan 2014-2017 for agreement (for copy of report see file of Minutes). The report will be published following presentation to Cabinet in September 2014.

Resolved:

(i) That the JHWS delivery plan which is attached at Appendix 2, be agreed.

(ii) That performance updates will be presented to the Health and Wellbeing Board in November 2014 and July 2015, be noted.

18 Healthwatch County Durham Annual Report 2013-2014

The Board considered a report of the Joint Chair of Healthwatch County Durham that presented the Annual Report for 2013-2014 (for copy of report see file of Minutes).

The Chairman thanked Healthwatch County Durham for producing a helpful and clear report.

Resolved:

(i) That the report and the progress which Healthwatch County Durham has achieved during its first year be received and noted.

(ii) That the organisation's ongoing work as consumer champion for health and social care services, be noted.

19 Any Other Business

The Head of Planning and Service Strategy informed the Board about the funding round for the Integrated Digital Care Fund and asked for an application to be supported, as was in line with the direction of travel.

Sue Jacques, County Durham and Darlington NHS Foundation Trust added that a number of events had been held with stakeholders and approval from the board could be included in the bid.

Resolved:-
That the board fully support the bid.

20 Exclusion of the Public

Resolved:
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 Pharmacy Relocation Applications

The Board considered a report of the Director of Public Health which provided a summary of Pharmacy Relocation Applications received from NHS England in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 since the last formal meeting of the Board in March 2014 (for copy see file of Minutes).

Resolved:
That the Board note the Pharmacy Relocation Applications received.

Health and Wellbeing Board

5 November 2014

County Durham Implementation Plan of the "No Health without Mental Health" National Strategy

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

Purpose of the Report

1. Following discussion at the Health and Wellbeing Board development meeting on 3 September 2014, this report seeks agreement and ratification from the Board of the Mental Health Implementation Plan for County Durham – attached at Appendix 2

Background

2. The National Strategy "No Health without Mental Health" was introduced by the government in 2011. The County Durham Mental Health Implementation Plan aims to introduce these objectives locally to improve the mental wellbeing of people across County Durham. A joint approach was taken to develop the priorities set within the plan.

3. The publication of the No Health without Mental Health: a cross government mental health strategy for people of all ages drew together the wider principles that the government has laid down for its health reforms, including patient centred care and locally determined priorities and delivery.

4. At a national level the strategy sets out the "high level" objectives to improve the mental health and wellbeing of the population;

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

5. More recently, the Government published – Closing the Gap: Priorities for essential change in mental health. The document sets out 25 priorities for action – issues that current programmes are starting to address and where 'strategy is coming to life'.

6. County Durham Mental Health Partnership Board made the decision to develop a local implementation plan of the national strategy. A Task & Finish Group was established to lead on the development. The group has a broad membership and the draft Implementation Plan has been developed in partnership with a wide range of organisations, people that use mental health services and carers. This is the first time any North East area has developed an Implementation Plan of the National Strategy.

7. The work of the group was to first of all gather information using the knowledge we already have as well as engaging with the wider workforce along with users or past users of services and their family members or carers. This was achieved by holding community events as well as using surveys to capture experiences. A scoping document was also developed which allowed organisations to measure progress in line with the implementation framework.

8. By taking this collaborative approach it has allowed the Task & Finish Group to be well informed and equipped with the knowledge and understanding of what is working well, what needs to be improved and where the gaps are. This enabled us to develop our key priorities.

Progress to date

9. The Implementation Plan is now in its final version (Appendix 2). In order to ensure the work is coordinated and the priorities are progressed a new group has been formed – No Health without Mental Health Implementation Group. The purpose of this group is to support and drive the delivery of the Implementation Plan. This group will oversee the work and be accountable to the Mental Health Partnership Board. Each of the priorities has been aligned to one of the groups within the proposed governance structure as seen in Appendix 3, this includes:

    - Countywide Service User Forum
    - County Durham Mental Health Provider & Stakeholder Forum
    - Public Mental Health Strategy Implementation Group
    - Children and Young Peoples Mental Health & Emotional Wellbeing Group
    - Mental Health Crisis Care Concordat Task Group
    - Dual Diagnosis Strategy Implementation Group
    - Pan CCG Mental Health and Learning Disabilities Commissioning Work stream

10. The Chairs of the groups above will be required to offer the No Health without Mental Health Implementation Group an update on progress of each of their priorities they are leading on using an agreed pro forma. This will help inform the group on progress as well as highlighting issues for escalation to the Mental Health Partnership Board.

Recommendations

11. The County Durham Health and Wellbeing Board is recommended to:

    - Receive the report
    - Note the contents of this report and the Implementation Plan
    - Agree with the priorities set out in the plan and the approach for implementation

Contact: Jemma Robson, Commissioning Support Officer, North of England Commissioning Support Unit Tel: 0191 3011300

Appendix 1: Implications

The paper is being presented to the County Durham Health & Wellbeing Board to gain approval of the Mental Health implementation Plan and the priorities listed.

Resource Implications – financial/staffing
The Implementation Plan sets out a number of priorities, some of which may require funding, for example the recovery college. Once the Plan is in place it will help identify potential mental health commission intentions.

Quality, Innovation, Productivity and Prevention
The Implementation Plan aims to improve the quality of mental health provision by delivering on the six national objectives. Contained within the plan are priority areas that will focus on early intervention and prevention, particularly within children's services.

Patient, Public and Stakeholder involvement
The development of the plan has taken a collaborative approach, involving service users, carers and other stakeholders.

Clinical Engagement
The Task Group membership included each CCG GP Mental Health lead and there were also opportunities for clinical engagement at a clinicians meeting, which included secondary care clinicians.

Communications and engagement
A communication and engagement plan was developed and the NECS team have been actively involved throughout the process.

2014 - 2017

County Durham

Implementation Plan of the 'No Health without Mental Health' National Strategy

Developed on behalf of the County Durham Mental Health Partnership Board

Contents

Welcome

Acknowledgements

This plan was produced by the Mental Health Task & Finish Group which was made up of members from the County Durham Mental Health Partnership Board and the Darlington Mental Health Network.

The Task & Finish Group would like to first of all express thanks to the individuals who use or have used services, and indeed their carers for contributing to the plan by completing surveys or attending the stakeholder events.

Also thanks to the many organisations that have provided valuable support and input to the production of this plan:

Breathing Space Project

Age UK County Durham

North Durham CCG

Durham Dales, Easington & Sedgefield CCG

County Durham & Darlington NHS Foundation Trust

Tees, Esk & Wear Valleys NHS Foundation Trust

National Council of Women of Great Britain

Foundation

Blackhall & Peterlee Practice

Sovereign Care

Richmond Fellowship

St Margaret's Centre

Durham County Carers Support

Chester le Street & Durham City MIND

North East Ambulance Service

Countywide Service User & Carer Forum

Waddington Street Centre

Park House Surgery

Durham Deafened Support

DISC

Relate North East

Macmillan Information and Support Centre

Healthwatch

Community Alcohol Service

Mental Health North East

Family Action

Time to Change

Community Mental Health Team

Bridge End Surgery

Etherley Lodge

Gay Advice Darlington/Durham

Stonham

DCC Support & Recovery

Aspire

Dene Valley Partnership

North Durham Clinical Commissioning Group

Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Foreword

This document is the County Durham Mental Health Implementation Plan for the national strategy "No Health without Mental Health[1]" which sets out how, over the next 3 years, we intend to develop and improve Mental Health services covering all ages across the county. It also outlines what our local priorities will be in order to achieve positive outcomes in line with the requirements and objectives of the national strategy.

The document has been developed through the local Mental Health Partnership Board, a sub-group of the Health and Wellbeing Board, involving a wide range of stakeholders and partner agencies. Crucially, people who have "lived experience" of mental health issues have been involved throughout the process of consultation and dialogue and have made a significant contribution to this ambitious attempt to improve the mental health and emotional wellbeing of people in our area. People with "lived experience" will also feature strongly in the implementation of this plan, as the Mental Health Partnership Board is committed to such co-production throughout its work.

Central to this approach is the fact that there is a proven strong relationship between mental health and physical health and that this influence works in both directions. Poor mental health is associated with a greater risk of physical health problems and poor physical health is associated with a greater risk of mental health problems. As a result several health publications such as Whole Person Care 2013[2] and Parity of Esteem for Mental Health[3] stress the importance of giving mental health equal status with physical health.

A Public Mental Health Strategy has already been agreed by 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 Implementation Plan. In addition, a Mental Health and Emotional Wellbeing Strategy will be developed in 2015 to specifically take forward work relating to children and young people and will incorporate Children and Adolescent Mental Health Services (CAMHS).

You will see in the document that the local priorities include:

- Supporting people who are socially isolated
- Improving outcomes for people experiencing mental health crisis (Crisis Care Concordat)
- Providing support to people who self-harm or attempt suicide
- Support the armed forces community who have poor mental / physical health

These priorities are aligned to those in the County Durham Joint Health and Wellbeing Strategy 2014/17.

Successful implementation of the Plan will require close joint working between all partners across Health and Public Health, in Local Authority Children and Adults Services, as well as other key agencies including the Police, Housing, Leisure and the Voluntary and Community Sector.

Reporting progress on the implementation of this plan will be regularly provided to the Mental Health Partnership Board and the County Durham Health and Wellbeing Board.

Dr Richard Lilly
Chair of the Mental Health Partnership Board

George Blakemore
Chair of the Countywide Service User & Carer Forum

Cllr Lucy Hovvels
Cabinet Portfolio holder for Safer and Healthier Communities
Mental Health Champion, Durham County Council

Anna Lynch
Director of Public Health County Durham
Mental Health Champion, Durham County Council

Summary of the Implementation Plan

This summary provides a short overview of the County Durham Mental Health Implementation Plan 2014 - 2017. Durham County Council (DCC), North Durham Clinical Commissioning Group (NDCCG) and Durham Dales, Easington & Sedgefield Clinical Commissioning Group (DDESCCG) are committed to working in partnership to improve the mental health and emotional wellbeing of our population. This document is our local response to the National Strategy – 'No Health without Mental Health' and is aimed at a broad audience.

This Implementation Plan has been developed in partnership with a wide range of organisations, people that use mental health services and carers. Working in partnership in this way has put the community and people that use services at the heart of the design of this plan ensuring their experience, insight and expertise shape our priorities.

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%)

We are committed to developing a detailed action plan to deliver the improvements in mental health services that we have outlined as priorities. This will explain how we plan to achieve change, with specific actions and timescales.

This will require the hard work and collaboration of local organisations, individuals, carers, families, employers, educators, voluntary groups and communities. A Steering Group will lead on the implementation and will report progress to the Mental Health Partnership Board.

Introduction

A Collaborative Approach

A Task & Finish Group was established to lead on the development of this plan. This had representation from the following organisations:

- NHS North of England Commissioning Support
- Durham County Council
- Darlington Borough Council
- North Durham Clinical Commissioning Group
- Durham Dales Easington & Sedgefield Clinical Commissioning Group
- Darlington Clinical Commissioning Group
- Provider & Stakeholder Forum
- Countywide Service User & Carer Forum
- Tees, Esk & Wear Valleys NHS Foundation Trust
- NHS County Durham & Darlington Foundation Trust
- Healthwatch
- NHS England

The Task & Finish Group will become the Strategy Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The membership of the group will include key agencies, service user and carer representatives as well as a wide range of stakeholders. The group will produce and be responsible for the delivery of the detailed action plan and will report directly to the County Durham Mental Health Partnership Board.

FACT

People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases.

If you have a mental health problem you are four times more likely to die of a respiratory disease

Smoking Cessation is a real problem for our patients as the programmes only seem to have an impact on people without mental health problems

Gastrointestinal disease is raised at least four times and most of that are liver issues to do with alcohol

Co-Production

The term “co-production” is increasingly being applied to new types of public service delivery in the UK. It refers to active input by the people who use all services, as well as, or instead of, those who have traditionally provided them. It emphasises that the people who use services have assets which can help to improve those services, rather than simply needs which must be met. These assets are not usually financial, but rather are the skills, expertise and mutual support that service users can contribute to effective public services.[1]

The work of the Task & Finish group was to first of all gather information using the knowledge we already have as well as engaging with the wider workforce, users or past users of services and their family members or carers. This was achieved by holding community events and using surveys to capture experiences. A scoping

[1] Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence

document was also developed which allowed organisations to measure progress in line with the implementation framework.

This collaborative approach has allowed the Task & Finish Group to be well informed and equipped with the knowledge and understanding of what is working well, what needs to be improved and where the gaps are. This has enabled us to develop our key priorities.

The Implementation Plan covers 'all ages', is far reaching and aims to cover services for individuals with mild to moderate mental wellbeing needs as well as those with severe and enduring mental health conditions.

There are a number of facts[2] throughout the document along with extracts from people's personal stories and some of the responses to the survey questions. We received an overwhelming amount of personal stories and unfortunately were unable to include them all but a selection can be found in Appendix 1. The priorities feature throughout the document and are linked to relevant areas; these are also listed in full in Table 1. Thanks go to all those individuals and organisations who contributed.

Priority

Explore opportunities to embed co-production and peer support models within contracts

National Directives

There are a number of national directives and strategies that are relevant to the development of this implementation plan.

No Health without Mental Health[3]

FACT

No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact.

The publication of No Health without Mental Health: A cross government mental health strategy for people of all ages published in February 2011 drew together the wider principles that the government has laid down for its health reforms, including patient-centred care and locally determined priorities and delivery. At a national level, the strategy sets out the 'high level' objectives to improve the mental health and wellbeing of the population. These are:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

[2] No Health without Public Mental Health, (2010) Royal College of Psychiatrists
[3] No Health without Mental Health(2011) HM Government

Resulting from this an implementation framework has been developed and sets out how progress will be monitored through the outcomes frameworks and made a series of recommendations for local and regional organisations to take forward.

These included providers and commissioners of mental health services, primary, acute and community health providers, the new health and wellbeing boards, social services, children`s services, public health services, housing organisations, schools and colleges.

The position statement of the Royal College of Psychiatrists states:

- No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact
- Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour
- Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year

Mental health practice should aim to put the person's needs at the centre of care planning and service delivery. No Health without Mental Health encourages recovery based approaches; this is further reinforced in the NHS Outcomes Framework as well as the Social Care Outcomes Framework.

No Health without Mental Health states that a good start in life and positive parenting promotes good mental health, wellbeing, self-esteem and resilience to adversity throughout life. Parental mental health is an important factor in determining the child's mental health and secure attachments with parent or care-givers are associated with better outcomes for the child, including improved learning and academic achievement. As adults, those who are securely attached tend to have trusting, long-term relationships, higher self-esteem and supportive social networks.

FACT

Circulatory, respiratory & digestive diseases are all raised in our population.

Then we've got diseases of the nervous system then mental & behavioural disorders

We have potentially got a minimum of 700 un-necessary deaths per year, that's 700 more deaths than to be expected on top of the poor lifestyle mortality

One in six of all deaths is attributed to smoking

On average mental health patients have twice the rate of smoking and this is not changing

A mental health dashboard[4] was then developed which brings together relevant measures from a wide range of sources to show us the progress being made against these objectives and to give a clear, concise picture of mental health outcomes as a whole. The dashboard draws only on existing, publicly available sources of information and is not intended to hold individual organisations to account.

[4] No Health without Mental Health, mental health dashboard, (2013) HM Government

The dashboard covers the full, wide scope of the strategy and aims to provide a balanced picture across all six of the strategy's objectives. It therefore focuses not only on mental health services, but also on the mental wellbeing of the whole population, the physical health of people with mental health problems, people's experience of care and experience of stigma and discrimination.

The measures which make up the dashboard have been chosen for their relevance to these objectives and include those measures which are most relevant or important for mental health outcomes as a whole, not necessarily those which will be easiest, or even possible, for specific organisations (public services or other organisations) to affect. It focuses primarily on the outcomes we want to achieve, rather than how they will be achieved, or by whom.

The main purpose of the dashboard is to bring the best information we have about mental health outcomes together in one place, as a resource for everyone with an interest in improving these outcomes.

The Care Act 2014[5]

The new Care Act consolidates much of existing social care law along with best practise and creates a new obligation on local authorities to deliver the personalised agenda.

Many duties and requirements will be introduced particularly around assessments for carers and self-funders which will require a full care and support plan with Independent Personal Budgets for all adults who have eligible social care needs irrespective of whether they choose to have these met by the local authority.

The Act will also for the first time set out a clear legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect.

Priority

Work together to give people greater choice and control over the services they purchase and the care that they receive

Children & Families Act 2014[6]

The Children & Families Act will mean changes in law to give greater protection to vulnerable children and young people, a new system for under 25s who have special education needs and disabilities to provide great choice and control and help for parents to balance work and family life. It underpins wider reforms to ensure that all children and young people can succeed, no matter what their background.

[5] The Care Act (2014) HM Government

[6] Children & Families Act (2014) HM Government

Closing the Gap: Priorities for essential change in mental health[7]

"Her journey had seen her, through support, become able to socialise and enjoy a fuller life, attending a number of trips out and organised holidays. Her family also benefitted from her more positive outlook and that she was no longer isolated".

Closing the Gap supports the measures in the national mental health strategy No Health without Mental Health, the Mental Health Implementation Framework and the Suicide Prevention Strategy. It is intended to bridge the gap between long term strategic ambitions and short term actions through the 25 priorities for action – issues that current programmes are starting to address and where 'strategy is coming to life'. The government will report on progress on these priorities next year.

The document is a useful update on significant developments such as the Crisis Care Concordat[8], which is a commitment from organisations to prevent crises through prevention and early intervention, and is a mechanism to promote partnership working. It emphasises the government's intention for parity between mental and physical healthcare as set out in the NHS Mandate.

Achieving parity of esteem between mental and physical health

In our society mental health does not receive the same attention as physical health. People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

There is an ambition for the NHS to put mental health on a par with physical health. However, the concept of parity in this context is not always well understood. In this report[9] an expert working group defines 'parity of esteem' in detail and examines why parity between mental and physical health does not currently exist and how it might be achieved in practice.

A Call to Action: Achieving Parity of Esteem

In July 2013, NHS England launched A Call to Action, which began a programme of engagement and evidence collection that encourages everyone to contribute to the debate about the future of health and care provision in England. It also signalled the beginning of a process to develop a new strategy for the health service.

[7] Closing the Gap: Priorities for essential change in mental health (2014) HM Government
[8] Mental Health Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis (2014) HM Government
[9] Whole person care: from rhetoric to reality (Achieving parity of esteem between mental and physical health) (2013) RCP

A discussion paper was developed[10] which focuses on valuing mental and physical health equally. This resource focuses on one of the outcome ambitions set out in the strategic planning framework: to achieve 'parity of esteem' and is intended to stimulate debate between Clinical Commissioning Groups and local partners to think about changes that can be made.

What do we mean by parity of esteem? It's about equality in how we think about mental health and physical health care – it's about how they're valued. We need to 'close the gap' between mental and physical health services – whether that's a gap in access, in quality, in research, or even in the aspirations we have for people. As the report makes clear so powerfully, the current state of disparity is obvious.

It is astonishing that in the 21st Century NHS, 3 in 4 people with common mental health problems receive no treatment, and even for psychotic disorders this figure is nearly 1 in 3. It is equally astonishing that people with severe mental illness are, in some cases 3 or 4 times more likely to die prematurely from the 'big killer' diseases, when compared to the population as a whole. This says something, of course, not only about mental health services, but also how we treat people with mental illness, something which must change (Norman Lamb MP, 2013).

Priority *Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles*
Priority *Develop a more integrated response for people with both mental and physical health conditions*
Priority *Undertake local campaigns to raise awareness as well as taking an active part in any regional or national campaigns*
Priority *Ensure that people with mental health conditions have their physical health needs actively addressed*

The following 10 Facts are taken directly from A Call to Action: Achieving Parity of Esteem and are reasons why we should strive to achieve parity between physical and mental health.

1. Mental health problems develop at a young age. I in 5 children have a mental health problem in any given year. First experience of mental health in those suffering lifetime mental health problems: 50% by 14 years old and 75% by 25 years old

2. Mental health is widespread and common. Every year 1 in 4 adults experience at least one mental disorder

3. Mental health is a significant burden. Mental illness is the single largest cause of disability in the UK

[10] A Call to Action: Achieving parity of Esteem; Transformative ideas for commissioners (2013) NHS England

4. Mental health impacts on life expectancy. Average life expectancy in England and Wales for people with mental health problems is behind the national average. 68 years for males and 73 years for females for people with mental health problems. 79 years for males and 83 years for females for everyone else.

5. People with mental health problems have worse physical outcomes. People with mental illness are at increased risk of the top five health killers, including heart disease, stroke, liver and respiratory diseases and some cancers. People with Schizophrenia are twice more likely to die from cardiovascular disease and three times more likely to die from respiratory disease.

6. When people with long term conditions also have mental health issues the cost of treatment can rise significantly. 1/3 of people with long term conditions also experience mental health problems increasing treatment costs by around £8–13 billion a year.

7. The mental health of people with serious physical health problems is often overlooked. ½ of terminally ill or advanced cancer patients suffer from depression, anxiety and/or an adjustment disorder, yet less than half receive treatment for their mental health

8. Mental health problems affect the likelihood that people will be compliant with their treatment. Depression co-morbid patients are three times more likely to be non-compliant with treatment recommendations than non-depressed patients.

9. There are often long walls for mental health services. 1 in 10 people wait over a year for access to talking therapies.

10. There is a wider economic impact of mental health. The full costs of mental illness in England have been estimated to be £105.2 billion a year

FACTS

Annual homicides in England and Wales: 550.

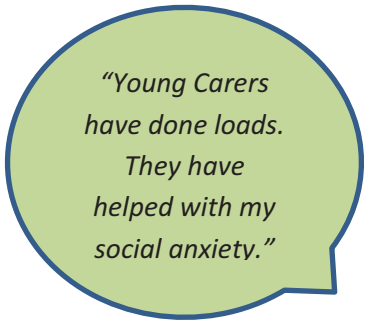
Annual fatal road traffic accidents: 1850.

Total military casualties that have occurred in Afghanistan from the very beginning of the conflict to the present day: 446. (www.bbc.co.uk/news/uk-10629358)

How many people with a mental health condition die early every year of preventable conditions? 18,000 - and that is only ages 19–74.

Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis

The Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur. The Concordat is arranged around:



- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat.

Priority *To develop a more extensive, accessible crisis team*
Priority *To co-ordinate a local response of the Crisis Care Concordat*

Transforming Rehabilitation

The Ministry of Justice 'Transforming Rehabilitation' programme of Probation reforms sets out proposals for reforming the delivery of offender services. On the 1st of June 2014 the Government split probation services into two new organisations: A new public sector National Probation Service (NPS) dealing with all those who pose the highest risk of serious harm to the public and twenty one regional Community Rehabilitation Companies (CRCs) managing all other offenders.

Recognised, valued & supported: next steps for the Carers Strategy[11]

It is important that the role of unpaid carers of those with mental health problems is recognised. We know that caring for someone with a mental health problem can be emotionally and often financially draining. In 2014, National Institute for Health and Care Excellence (NICE) issued clinical guidelines for 'Psychosis and Schizophrenia in adults: treatment and management'.

These introduced new requirements in respect of identifying and supporting carers, including the following:

- Mental health services to offer and provide carers with an assessment of their own needs; develop a care plan to address any needs identified; review this annually and advise carers of their statutory right to a formal carer's assessment by social care services
- Give carers written and verbal information about diagnosis and management of psychosis and schizophrenia; positive outcomes and recovery; types of support for carers; role of teams and services; getting help in a crisis
- Negotiate with service users and carers about how information will be shared and review regularly
- Involve carers in decision making if the service user agrees

[11] Recognised, valued & supported: next steps for the Carers Strategy (2010) HM Government

- Offer a carer focused education and support programme

There are a number of services commissioned to provide a free high quality service to support unpaid carers, this includes Young Carers, Adult Carers and Parent Carers who care for someone living within County Durham. These services provide confidential, non-judgmental and impartial one to one support, advice and information.

Priority
Ensure service users and their carers have access to NICE recommended guidance and evidence based interventions

Better Care Fund

In June 2013, the government announced that it would be allocating £3.8 billion to a pooled budget called the Better Care Fund. In County Durham, joint plans have been developed between the Local Authority and Clinical Commissioning Groups and £43.735m has been allocated locally on health and social care initiatives through pooled budget arrangements from 2015/16.

The aim for the Better Care Fund is to improve the health and wellbeing of the people of County Durham by innovating and transforming services, with a focus on reducing reliance on long term health and social care, providing more preventative services, helping people to stay independent in their own homes, and improving care in community settings.

Priority
Develop an integrated Primary Care Model for access to talking therapies.

Transforming Care: A national response to Winterbourne View Hospital Department of Health Review*:* Final Report[12]

Following the BBC Panorama Programme on the abuse at Winterbourne View Hospital, The Department of Health set out a transformation programme that looks to ensure people with complex support needs due to a learning disability, mental health problem and/or autism are supported closer to home and where possible within their local communities. Each area is required to develop a local plan that sets out how people with complex needs will be supported in the future.

Welfare Reform

The Welfare Reform Act[13] legislates for a range of changes to the welfare system some of which will have a direct effect on people with mental health problems. It introduces a wide range of reforms including the introduction of Universal Credit and

[12] Transforming care: A national response to Winterbourne View Hospital (2012) HM Government
[13] Welfare Reform Act 2012

changes to housing benefit. There has been concern amongst a range of mental health stakeholders nationally about the impact of welfare reform on people with mental health problems.

Priority

Ongoing monitoring and awareness of the financial challenges and how the welfare reforms impact on the ability to access services

Employment

Many people who experience mental health problems face difficulties in gaining and maintaining employment. They often face stigma and discrimination that sometimes results in losing their job or cause challenges in getting a job. People who experience severe and enduring mental health problems have one of the lowest employment rates. Only one user in five of specialist mental health services either has paid work or is in full-time education[14]

FACT

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

Lesbian, Gay, Bisexual & Transgender

Lesbian, Gay, Bisexual and Transgender (LGBT) people are a minority community who often suffer from widespread harassment, discrimination and at times violence. The high levels of stigmatisation often lead to higher rates of mental health issues within the community with much higher instances of self-harm and attempted suicide.

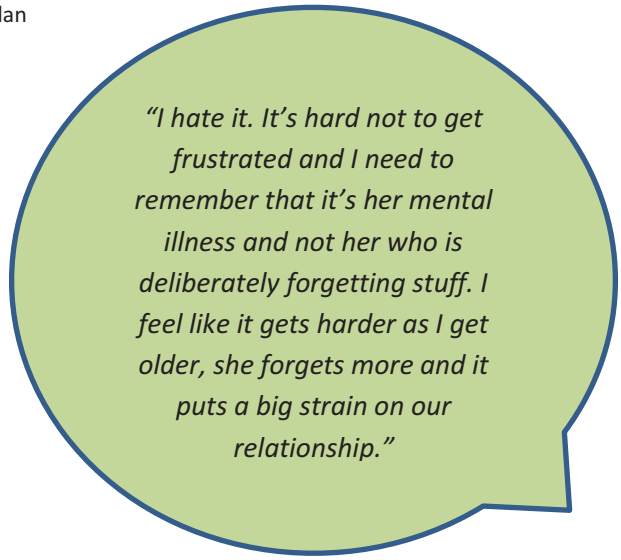
The problems of discrimination are especially prevalent in the case of transgender individuals who have very little in the way of support and are often isolated within their communities.

53% of transgender individuals have carried out some form of self-harm in their lives, while 48% have attempted suicide at some point in their lives, with 33% more than once.[15] These statistics seem alarming, however when put into context of a small isolated community with little or no support and a lack of community understanding they begin to make more sense.

Homelessness

Homelessness easily descends into a destructive cycle of hopelessness and mental distress. It has been described as “a dire condition and if protracted highly damaging to an individual’s identity, self-worth, morale and physical and mental health”[16].

[14] Removing barriers: the facts about mental health and employment Centre for Mental Health (2009)
[15] Trans Mental Health Study (2012)
[16] Building Homelessness Prevention Practice: Combining Research Evidence and Professional Knowledge, University of Sheffield



There is a strong body of evidence[17] that points to markedly higher rates of mental health problems in populations of homeless adults than among the securely domiciled.

Most studies support the finding that unusually high rates of psychosis and substance misuse are a common feature of homeless populations. The difficulties of addressing combined substance misuse and mental illness (dual diagnosis), which exists in this group, has long been acknowledged. Nationally, the prevalence of substance misuse dependency among the homeless mentally ill can be as high as 50-60 percent and is up to five times higher than that for the general population.

Homeless people experience twice the rate of neurotic disorder than that of the general population, including anxiety, depression and mental distress. They are also more likely to become hospital in-patients than to be treated on an out-patient basis for their mental health problems.

Transition[18]

The ages 16–18 are a particularly vulnerable time when there is increased susceptibility to mental illness, as well as major physiological, emotional, educational and social change. It is also the age at which the young person already in contact with mental health services will move from child and adolescent services (CAMHS) to adult services (AMHS).

Transitions can be problematic if there are gaps in service provision and different structures and systems to navigate.

Local Context

In order to be able to plan effective mental health services it is important that we understand the mental and emotional wellbeing needs of the population. 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%)

[17] Melvin P (2004) A Nursing Service for homeless people with Mental Health Problems. Mental Health Practice, vol 7 no 8
[18] Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services (2012)

The collation of current information in relation to mental wellbeing needs to be co-ordinated better. 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 and 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 the greatest. County Durham has some of the most deprived areas in the country.

There are many factors that may increase the likelihood of becoming unwell, such as:

- poor housing
- homelessness
- financial poverty
- unemployment
- drug and/or alcohol dependency
- being a carer
- poor physical health
- having a learning disability
- lesbian, gay, bisexual and transgendered people
- people that have committed criminal offences
- black, minority & ethnic people
- gypsies, roma & travellers

FACT

Women are more likely to have been treated for a mental health problem than men.

The North East Public Health Observatory published a Community Mental Health Profile for County Durham[19] which is designed to give an overview of mental health risks, prevalence and services at a local level.

In County Durham there are already a number of plans and strategies which contribute to the implementation of the National Directives to improve the mental health and wellbeing of the people of County Durham. The section sets the key local documents which have helped the development of this implementation plan and will support work required to meet the agreed priorities.

County Durham Joint Health and Wellbeing Strategy[20]

The Health and Social Care Act 2012 places clear duties on Local Authorities and Clinical Commissioning Group's to prepare a Joint Strategic Needs Assessment (JSNA)[21] and Joint Health & Wellbeing Strategy which will influence commissioning

[19] Community Mental Health Profile for County Durham (2013)
[20] Co Durham Joint Health & Wellbeing Strategy
[21] Co Durham Joint Strategic Needs Assessment

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.

Strategic Objective 4 of this strategy is to improve the mental and physical wellbeing of the population through:

- Maximised independence
- Increased social inclusion
- Reduced suicides
- Increased physical activity and participation in sport and leisure

County Durham Public Mental Health Strategy[22]

County Durham have a Public Mental Health Strategy in place, 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.

'Starting well' is a priority in the national and local public mental health strategies, recognising that 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 and emphasising the crucial importance of early intervention in emerging emotional and mental health problems for children and young people.

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 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.

Priority

Undertake an assessment of the mental health needs of the population of County Durham

[22] Co Durham Public Mental Health Strategy

Priority *Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles*
Priority *Implement the multi-agency Public Mental Health and Suicide Prevention Strategy for County Durham*

County Durham & Darlington Dual Diagnosis Strategy[23]

People with concurrent learning disabilities, mental behavioural diagnosis and substance misuse problems have reported difficulty in accessing services able to address their complex needs. Although guidance refers to 'diagnosis' it is vital that our focus is on the needs of people with dual problems. People with dual needs experience problems in many diverse ways with varying degrees of severity and may require different services to help them. The County Durham & Darlington Dual Diagnosis strategy sets out ways to help individuals, families, providers and commissioners to work together to respond to the complex and changing needs of individuals living with dual diagnosis.

The aim of this strategy is to identify people with a dual diagnosis and to ensure they have access to co-ordinated and responsive services to meet their complex and changing needs. This strategy is to be presented for agreement at the November 2014 Health & Wellbeing Board.

Children, Young People and Families Plan 2014 - 2017

The Children, Young People and Families Plan 2014-2017 is the single overarching, multi-agency plan for the delivery of priorities for children and young people in County Durham. The plan draws on a vast range of evidence including the Joint Strategic Needs Assessment, performance data, policy drivers, legislation and the ongoing engagement with children, young people, parents, carers and partner agencies.

The Children, Young People and Families Plan will focus on the following three outcomes:

1. Children and young people realise and maximise their potential
2. Children and young people make healthy choices and have the best start in life
3. A Think Family Approach is embedded in our support for families

The plan details a number of priority areas to deliver the above outcomes; including a specific priority on making children and young people more resilient. One of the key actions identified in this regard is to develop and deliver a children and young people mental health and emotional wellbeing plan.

[23] Co Durham & Darlington Dual Diagnosis Strategy

The resilience strategic framework[24] identifies the need to build the strengths and resilience of all children and young people. Resilience can be increased through the enhancement of protective factors which help children successfully adapt and cope with life's challenges. This framework aims to demonstrate the links to resilience within current Durham County Council strategies and plans, rather than develop a separate strategy. It should be read in conjunction with the Children, Young People's and Family Plan 2014-2017[25].

Priority

Continue to improve the emotional wellbeing of children & young people and provide effective, high quality mental health services to those who need it

County Durham Interim Children and Adolescent Mental Health Strategy 2014- 2016

The Interim Children and Adolescent Mental Health Services (CAMHS) Joint Strategy for County Durham is currently being developed by local Clinical Commissioning Groups and Durham County Council as an short-term measure whilst a more detailed piece of work is undertaken to develop a three year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan commencing in 2015.

This interim strategy has been developed to:

- Provide strategic direction in the interim whilst further work is undertaken on longer-term priorities, based on the needs of the local population.
- Provide a cohesive approach across the partner agencies, in regard to improving the mental health and wellbeing of children and young people in County Durham.
- Ensure any work taken forward is centred on the child and family and is outcome focused.

The action plan within the document captures priority areas of focus related to children and young people's mental health and emotional wellbeing for 2014/15 as detailed within the Children and Families Plan 2014-17.

Priority

Ratify and implement the County Durham Interim CAMHS Strategy 2014-16, whilst more detailed work is undertaken to develop a three year Children & Young People's Mental Health, Emotional Wellbeing & Resilience Plan 2016-18. This will incorporate CAMHS

[24] Resilience strategic framework for children and young people (2014-2017) Durham County Council
[25] Children, Young People and Families Plan (2014-2017) Durham County Council

County Durham & Darlington Dementia Strategy[26]

The future needs of people with dementia and their carers need to be planned. A dementia strategy task group was set up to plan the future needs. The group took a stocktake of services, spoke to people with dementia and their carers, as well as people looking after them to identify the gaps and priorities along with what new things we need to do differently.

"Involve the carer from the start and ask if the carer can cope with the patient and listen to the carer. The service should demonstrate and show respect, care, consideration and understanding of carer and what they have to cope with".

In the early stages of developing the strategy Healthwatch County Durham and Healthwatch Darlington engaged with various people with dementia and their carers. The draft strategy was then subjected to a public consultation.

The first Dementia Health Needs Assessment for County Durham and Darlington also commenced in April 2014 and will inform and influence the strategy as it is refreshed annually. Our aim is to ensure that the population in County Durham and Darlington have the best possible services in place for those who have dementia, their carers and families, as well as those who have not yet been diagnosed with dementia along with a focus on prevention.

County Durham Carers

There are approximately 10,400 adult carers registered within County Durham and of these 20% are caring for someone with a mental health condition. Of these, 10% are caring for an adult with a mental health condition and 10% are caring for an older person with a mental health condition. During the period from April 2013 to mid-March 2014 a total of 393 carers of people with mental ill health have accessed the NHS Carer Breaks & Opportunities funding.

Young people undertake inappropriate levels of care due to a variety of reasons and complex circumstances. Resolving some of these issues requires a partnership approach, which is delivered through a Think Family model.

The Young Carer Provider supports to up to 500 young carers living in County Durham and promotes identification, recognition and early help for many more through a 'Strengthening Bridges in the Community' programme. Of these 500 young carers approximately 80% of young carers live with a parent with mild to moderate mental health needs and an increasing number care for a parent or adult with a diagnosis of moderate to severe mental health illness.

Carer awareness training sessions are delivered to a range of professionals including trainee social workers and medical students. These sessions are broad and cover mental health awareness. Progress has been made to have carers of

[26] Co Durham & Darlington Dementia Strategy (2014)

those with a mental health problem recognised by professionals as important partners in care but there is still a lot more that can be done as carers tell us that they still don't feel valued.

One way in which we are overcoming these issues is to encourage mental health carers to become involved in local groups including the Triangle of Care and the Older Persons Involvement both in West Park Hospital and Lanchester Road Hospital. These groups give mental health carers the opportunity to put their views and concerns across, be listened to and to be involved in changes.

We would like to see more of these groups being established to enable carers to work with professionals in developing and improving mental health services.

Priority

Through co-production involve individuals and carers more closely in decisions about the shape of future service provision

Veterans[27]

A Veteran is defined as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.8 million veterans in the UK (just under 4 million in England). All should be registered with a NHS GP Practice.

The Department of Health (DoH) and the Ministry of Defence (MOD) have launched the first of a number of pilots designed to ensure that NHS health professionals have appropriate support and available expertise they may need to treat veterans with mental health problems. The four UK health departments, the Ministry of Defence, and the charity Combat Stress, have been working together closely to develop and pilot a new model of community based mental health care.

Centred on the client and GP, these arrangements will make it easier for veterans with concerns about their mental health to seek and access help. The pilot will provide veterans with a service, led by a Community Veterans' Mental Health Therapist that will offer understanding of the particular issues for those who have served in the Armed Forces.

Priority

Work together to find ways that will support the armed services community who have poor mental or physical health

Learning Disabilities

It is estimated that there are approximately 1.2 million people in England who have some form of learning disability. It is well documented that for many people with a learning disability this means significantly poorer health and the risk of dying younger. Access to healthcare through the use of reasonable adjustments and the delivery of annual health checks can identify early indications of illness, many of

[27] Veterans UK, Ministry of Defence Announcement

which risk going undetected, often due to the lack of understanding of many of the issues faced by people with a learning disability.

In County Durham people are working together to improve access to healthcare, this includes; accessing the annual health check, hospitals, and other community services such as opticians, dentists and pharmacies.

FACT

Self-harm statistics for the UK show one of the highest rates in Europe: 400 per 100,000 population.

Tees Esk & Wear Valley NHS Foundation Trust (TEWV) provide community and inpatient specialist assessment and treatment services to people with learning disabilities and mental health problems, autism, epilepsy and challenging behaviour. Tees Esk & Wear Valley NHS Foundation Trust, in partnership with Durham County Council provides integrated social care and health teams. These teams offer care co-ordination for people with Mental Health and/or Learning Disability needs

People with learning disabilities demonstrate the complete spectrum of mental health problems, with higher prevalence found in those without learning disabilities. The 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.

Perinatal Mental Health[28]

To ensure the best start in life for children maternal mental health is a key priority in County Durham. Developments in this area will be explored with stakeholders as part of the tier one emotional wellbeing work for children and young people, being taken forward by Public Health.

Perinatal Mental Health Services are concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. These include both new onset and recurrences of previous problems in women who have been well for some time, and those with mental health problems before they became pregnant. Promoting emotional and physical

[28] Joint Commissioning Panel for Mental Health: Guidance for Commissioners of Perinatal Mental Health Services (2012)

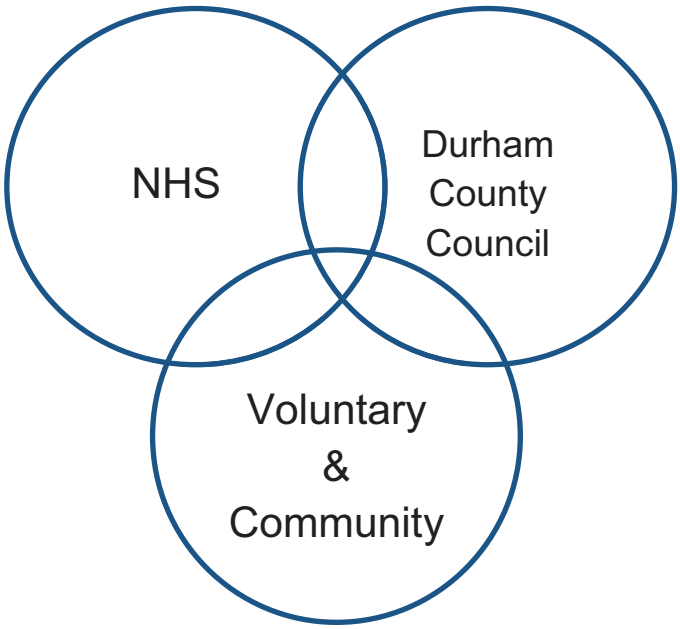
wellbeing and development of the infant is central to perinatal mental health services.

Perinatal mental health problems include a range of disorders and severities which present in a variety of health settings and are currently managed by many different services. Some of these services are specifically designed to meet the needs of pregnant and postpartum women and their infants.

The current range of Service Provision

This section explains the range of services commissioned and provided by NHS England, Clinical Commissioning Groups and Durham County Council.

Although the NHS has traditionally been the predominant provider of local mental health services, a number of independent and voluntary sector organisations have played a key part in delivering specific services to complement those in the statutory sector. This was highlighted in the scoping exercise the Task & Finish Group undertook and demonstrated that there is a range of services currently available from numerous service providers.



Local Authority

Durham County Council has developed a number of Mental Health services in the community. Some of these are delivered through the in-house 'County Durham Care & Support'. Others are provided by a number of Voluntary Community Sector services and Independent Sector Organisations across the county, who may be funded by both the Local Authority and the NHS.

The types of service provided include the following;

- Integrated mental health Social Work/Care Co-ordination teams covering each locality area
- Specialist residential care
- Supported living
- Outreach and Community-based floating support
- Domiciliary Care
- Post Diagnosis support for people with autism
- Services for Older People with mental health/Dementia issues
- Service-user led groups including Cree or Men's Sheds/Dementia Cafes & My Space
- Day care & drop in/Social access groups
- Volunteering and peer support
- Education/Employment/Training Support
- Specialist Advocacy
- Community Wellbeing Support Service
- Social Prescribing
- Looked after children service including Full Circle

In addition the council is promoting the development of an increasing number of personalised, individual service options which are funded thought Direct Payments.

Priority
To ensure close working with all County Durham partnership groups that have an impact on Mental Health issues

Clinical Commissioning Groups & NHS Foundation Trust

The Clinical Commissioning Group's commission the majority of mental health services from Tees, Esk & Wear Valleys NHS Foundation Trust.

The Trust provide community and inpatient mental health services for adults of working age in partnership with social care and a wide range of voluntary and independent service providers. The Trust treats patients with psychotic illnesses and also those with affective illnesses, such as depression, anxiety and compulsive disorders.

Primary and secondary care is often referred to within mental health services. Below is a brief explanation of what is meant by each term:

- Primary mental health services mainly provide support for people with mild to moderate mental health conditions, such as depression and anxiety. However, these services can also support people with some of the more severe mental health conditions if they are not at risk of harming themselves or others. GPs are usually the first point of contact for people with mild to moderate mental health conditions.

- Secondary (or specialist) mental health services provide support for people with severe and complex mental health conditions, such as schizophrenia and bi-polar. They also support people with other mental health conditions if they are at risk of harming themselves or others.

There are two main hospitals within County Durham & Darlington; Lanchester Road Hospital in Durham and West Park Hospital in Darlington.

Services include:

- A wide range of community based assessment and treatment services including primary care, liaison, crisis intervention, assertive outreach, community affective disorders and psychosis teams and eating disorders; mental health services for people with a sensory impairment (deafness) and Attention Deficit Hyperactivity Disorder (ADHD) are also provided

"The service from the team is great, however getting the service took several years".

- Inpatient assessment and treatment services, including acute, intensive care, challenging behaviour and rehabilitation services

- Primary care psychological therapies (working with partners)

- The specialist regional North East and North Cumbria eating disorder inpatient services for adults, with "step up" and "step down" day hospital services for County Durham and Darlington patients

- Inpatient services as part of a national consortium and community based services to military veterans

- Tees, Esk and Wear Valleys NHS Foundation Trust is committed to delivering recovery orientated services and has developed a three years strategy aimed at embedding recovery principles into their policy and practice

- The Children and Young People's Improving Access to Psychological Therapies programme (CYP IAPT) is a service transformation programme that aims to improve existing services working in the community. CYP IAPT will benefit CAMHS services, in terms of capacity building. It is different to adult IAPT as it does not create standalone services.

Priority   *Improve the awareness of the range of service provision available to General Practices and improve the accessibility and uptake to these services*
`Priority   *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*
Priority   *Continue to improve access to psychological therapies and other interventions*

Priority
Improve experience of hospital discharge processes

Voluntary and Community Sector

There are many voluntary and community organisations within County Durham providing treatment and support for people with mental health issues. Some people prefer to seek help from an organisation separate from the NHS and the voluntary sector provides many alternative options. Most, but not all, voluntary sector services work on a self-referral basis, so that individuals can approach the organisation themselves without the need for a referral from a GP or other worker.

Voluntary and Community Sector organisations operate in diverse and wide-ranging fields including many that work in health and social care, community leisure and recreation activities, environmental work, arts, sport, education, campaigning and advocacy and many are faith based organisations.

Many voluntary sector organisations are more specialised in what they provide, such as advocacy and supported accommodation, as well as help for carers, minority ethnic communities and women. Others are focused around a particular activity, such as gardening or employment.

Some community led organisations have a good understanding of local need and as a result they are better placed or more able than the larger statutory agencies to engage with communities. Many organisations have developed innovative ways of working to help people, such as through peer support or providing wellbeing activities within the community.

Priority
Work with the voluntary and community sector to develop opportunities for early identification of those people at risk of social isolation

Recovery

Recovery in this instance equates to personal recovery and is a different concept to clinical recovery, which is focused on the absence of symptoms and 'returning to normal'. Personal recovery is considered to be individually defined and is about living a satisfying and meaningful life, with or without symptoms.

A recent review of the recovery literature identified five components that have a significant role in most people's recovery, namely:

- Connectedness (relationships)
- Hope
- Identity (beyond a diagnosis or service user)
- Meaning and purpose to life
- Empowerment

FACT

1 in 4 people will experience some kind of mental health problem in the course of a year.

These five factors are known collectively as the CHIME framework.

Services that are recovery orientated focus on the individual goals of individuals, recognising and building on their personal strengths, foster self-management and offer a range of opportunities for individuals to find meaning in their lives. Co-production, learning from and working with people with lived experience of mental health to develop and deliver services should be at the heart of genuine recovery focused approach.

Priority

Ensure that all services adopt a recovery orientated approach and use validated recovery measures to evaluate outcomes

Recovery has been described as:

"...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond catastrophic effects of mental illness". [29]

Recovery challenges conventional approaches to treating mental ill health. It is consistent with the government's vision and takes a more holistic approach to mental wellbeing and health improvement, rather than addressing mental illness in isolation from other important factors in people's lives.

"So what does recovery mean to me? It means I have found answers and finding fragments of my jigsaw put the pieces together and made a whole person. It's a story of hope not fear and I have not settled for just managing and coping or using avoidance I have worked at havina a future".

We know that current and former service users can help to support people who experience problems with their mental health. Peer Support is one way of helping people recover from mental distress and its impact on their lives. It enables people to provide knowledge, experience, and emotional, social or practical help to each other. Peer support relies on the assets, skills and knowledge in the community, and the recognition that local people can offer help in ways that are sometimes more effective than professional help.

As part of the Recovery Principles Strategy the Trust is working in partnership with service users, Durham County Council and a number of Voluntary and Community sector organisations to set up a Recovery College in County Durham. This college will be co-produced with those with lived experience of mental health, offering training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing

[29] Anthony WA (1993). *Recovery from mental illness: the guiding vision of the mental health service system in the 1990s*. Psychosocial Rehabilitation Journal 16(4): 11-23.

opportunities to learn from others with similar experiences to develop a meaningful and fulfilling life beyond mental illness.

Priority
Implement the Recovery College to offer training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing opportunities to learn from others with similar experiences

Child & Adolescent Mental Health Service (CAMHS)

The term CAMHS is used as a broad concept embracing all services that contribute to the mental health and emotional wellbeing and care of children and young people, whether provided by health, education, social services or other agencies. The structure of CAMHS is often explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision.

Tier 1 Universal Services

Universal services are accessible by all children and young people; and include general practitioners, primary care services, health visitors, schools and early years provision. The mental health role of universal services is to promote positive mental health and wellbeing and to help identify, refer on and support those children who may require input from targeted or specialist services.

Tier 2 Targeted Services

Targeted services are for children and young people who may be considered to have specific identified mental health needs and/or to be vulnerable, where some low intensity monitoring/interventions may be required. Service settings include universal settings, but the provision is aimed at identified groups, not the whole population.

FACT

About 10% of children have a mental health problem at any one time.

Within County Durham, primary mental health workers (as outreach from Tier 3 CAMHS) work with the child or young person directly or indirectly by supporting professionals working in universal services.

Tier 2 services include an emotional health and wellbeing service, which includes specialist educational psychologists, specialist mental health advisory teachers and counsellors. The service promotes the emotional health and wellbeing of young people in schools; improves access to psychological therapies through the delivery of evidence based interventions across universal, targeted and specialist settings and develops capacity of staff within schools to identify and meet the needs of vulnerable young people.

In addition, community paediatrics and child health services may see children with developmental disorders and attention deficit hyperactivity disorder (ADHD), with

children and young people with more complex problems being referred into Tier 3 services.

Tier 3 - Specialist Services

Specialist CAMHS services are for children and young people with identified complex and/or high levels of need or mental health problems. These services are provided by multi-disciplinary teams of child and adolescent mental health professionals providing a range of interventions.

FACT

There is a wider economic impact of mental health; full costs in England have been estimated to be £105.2 billion a year.

In County Durham specialist CAMHS includes teams with specific remits to provide for children and young people including learning disability.

Other areas of provision include: community forensic CAMHS and paediatric liaison providing CAMHS input to children and young people in acute care settings.

Tier 4 – Highly Specialist Services

Tier 4 services are the most specialised elements of CAMHS provision and are commissioned by NHS England. Services are part of a highly specialist pathway and provide for a level of complexity that cannot be provided for by comprehensive secondary, Tier 3 community services. It is generally the complexity and severity rather than the nature of the disorder that determines the need for specialist care.

Tier 4 services include inpatient services for children and adolescents and specialist services that are provided at a regional rather than local level. Inpatient assessment and treatment and low secure services being provided at West Lane Hospital in Middlesbrough. West Lane Hospital is also the base for the specialist regional North East and North Cumbria eating disorder inpatient service for children and young people.

Although the four tier model provides a useful framework for understanding comprehensive CAMHS it is important to recognise that children and services rarely fall neatly into one tier. Children and young people may enter the system at any point and do not necessarily move up the tiers. Therefore, two services may span multiple tiers.

Health & Justice, North East & Cumbria

Forensic services are specialist services which treat patients referred by the criminal justice system because of mental health or learning disabilities conditions which have been a factor driving their offending. Tees, Esk & Wear Valley NHS Foundation Trust provide community, inpatient and rehabilitation forensic services for people with mental health problems and/or learning disabilities.

Inpatient services, including medium and low secure environments are based at Roseberry Park in Middlesbrough with step down units in Lanchester Road Hospital in County Durham and community rehabilitation services for people with learning disabilities at Oakwood in Middlesbrough. Community forensic services including

criminal justice liaison services that work across the whole offending behaviour pathway, for example street triage in Middlesbrough and the mental health service within all seven North East prisons are also provided.

The Clinical Commissioning Group's also have contracts with independent hospitals both in and out of the area. These provisions are utilised to support the most complex cases and offer a range of interventions.

Offenders are more likely to smoke, misuse drugs and/or alcohol, and/or suffer mental health problems, report having a disability, self-harm, attempt suicide and die prematurely compared to the general population. Nearly half of all prisoners have anxiety or depression and nearly a third of all 13 to 18 year olds who offend have a mental health issue. For many offenders who have a mental health issue or vulnerability, prison can make their situation worse.

A high proportion of both boys and girls in secure settings have mental health needs and substance misuse issues. Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem. 72% of male and 70% of female sentenced prisoners suffer from two or more mental health disorders.

Section 15 of the Health and Social Care Act 2012 gives the Secretary of State the power to require NHS England to commission certain services instead of Clinical Commissioning Groups. These include "services or facilities for persons who are detained in a prison or in other accommodation of a prescribed description".

It is NHS England's responsibility to directly commission health services or facilities for persons who are detained in prison or in other secure accommodation and for victims of sexual assault. NHS England carries out this function through 10 Health and Justice host area teams on behalf of the 27 area teams across England.

NHS England is responsible for planning, securing and monitoring an agreed set of services for:

- Prisons
- Young Offender Institutions (YOIs)
- Immigration Removal Centres
- Secure Training Centres
- Secure Children's Homes
- Police Custody Suites
- Court Liaison and Diversion Services
- Sexual Assault Services

FACT

Only 1 in 10 prisoners has no mental disorder.

NHS England is also responsible for specialised commissioning, for people who require a secure setting within a hospital. This is hosted by Cumbria, Northumberland and Tyne & Wear area team.

Primary Care Development

The National Institute for Health and Care Excellence (NICE) approved talking therapies cover a number of services ranging from counselling to primary care psychology. NHS England's programme of Improving Access to Psychological Therapies (IAPT) currently defines that Clinical Commissioning Group's must ensure that a proportion of the population should receive NICE approved therapeutic input to ensure recovery from primary care mental health conditions.

Across County Durham and Darlington there are 41 contracts across 30 individual providers of talking therapies. The structure of therapy available is diverse and varies significantly across localities. In some cases patient choice is restricted and there has been duplication identified in the access pathways.

Each Clinical Commissioning Group has approved a "case for change" paper and an engagement process will be developed to consult on a proposed new model for 2015/16. The focus of this model will be to streamline access into services, improve patient choice, provide stepped care and reduce waiting times for therapy during a period of increasing demand.

Research

There is an underpinning principle to the implementation plan of using evidence based practice to information interventions and programmes.

Mental health research is becoming increasingly enshrined in care delivery of Tees, Esk and Wear Valleys NHS Foundation Trust. The growth of research within the Trust is underpinned by collaborative partnership with Durham University, where strategic research priorities of primary care, youth mental health and drug safety are supported.

Mental health research has added complexity to that of other disease areas due to associated consenting and retention issues. This makes robust links between primary and secondary care all the more necessary in order to deliver quality research as integral to the best patient experience. Working across care sectors through robust research partnerships is the aim of the new Clinical Research Network structures of the National Institute of Healthcare Research.

Funding

No other health condition matches mental ill health in the combined extent of prevalence, persistence and breadth of impact[30]. The annual cost of mental ill-health in England is estimated at £105 billion[31]. By comparison, the total costs of obesity to the UK economy is £16 billion a year[32] and cardiovascular disease £31 billion[33].

[30] Promoting mental health & preventing mental illness, Freidli, L & Parsonage, M (2009)
[31] The Economic and Social Costs of Mental Health Problems in 2009/10 (2010) Centre for Mental Health
[32] Tackling obesities: future choices (2007) Project report Government Office for Science Foresight
[33] Prevention of cardiovascular disease at population level (2010) NICE

County Durham Clinical Commissioning Groups are actively involved in the development of a Clinical Quality and Innovation Scheme (CQUIN) which operates across the wider Tees Esk and Wear Valley area. Nationally mandated schemes are supplemented by local incentives which are jointly developed by Providers and Commissioners. CQUIN is used to continuously improve and drive the quality or services though financial incentives which, in total amount to 2.5% of the contractual value.

During 2014/15 the scheme has ten indicators, three of which are nationally defined and seven that have been developed locally. These cover a diverse range of services and in most cases are closely linked to the No Health without Mental Health strategy. The schemes are developed on an annual basis with indicators from the previous year moving into the generic requirements of the contract and others being further developed in the following year's scheme.

The Implementation Plan sets out to ensure that we are using existing funding efficiently and effectively to commission quality mental health services which meet the needs of our communities. Ensuring we achieve value for money is vital because of the constraints on available funding in future years.

Our Priorities

The aim of our implementation plan is to reflect the No Health without Mental Health outcomes strategy objectives into our local area. The priorities have been developed by the Task & Finish Group following the information gathering exercises and its analysis.

The priorities can be seen throughout the document and are summarised in Table 1.

Implementation & Governance

The Implementation Plan will be led by the Mental Health Partnership Board which is a sub group of the Health and Wellbeing Board and is a mechanism for engagement, consultation and involvement with service users and carers to support the work of the Health and Wellbeing Board.

The Task & Finish Group will become the No Health without Mental Health Implementation Group and be responsible for overseeing the priorities set out in this plan (Table 1). The purpose of this group is to support and drive the delivery of the priorities, oversee the work and will be accountable to the Mental Health Partnership Board. Each of the priorities has been aligned to one of the groups within the proposed governance structure, this includes:

- Countywide Service User & Carer Forum
- County Durham Mental Health Provider & Stakeholder Forum
- Public Mental Health Strategy Implementation Group
- Children and Young Peoples Mental Health & Emotional Wellbeing Group

- Mental Health Crisis Care Concordat Task Group
- Dual Diagnosis Strategy Implementation Group
- Pan CCG Mental Health and Learning Disabilities Commissioning Work stream

The Chair of each of the above groups will be required to offer the Implementation Group an update on progress of each of their priorities they are leading on using an agreed pro forma. This will help inform the group on progress as well as highlighting issues for escalation to the Mental Health partnership Board.

There will also be a reporting arrangement to the Mental Health/Learning Disabilities Joint Commissioning Group which will develop appropriate commissioning intentions.

Table 1

NHWMH Objective	Local Priorities	Lead Group
1. More people will have good mental health *More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well*	1.1 Undertake an assessment of the mental health needs of the population of County Durham	Public Mental Health Strategy Implementation Group
	1.2 Develop and implement programmes to increase resilience and wellbeing through practical support on healthy lifestyles	Public Mental Health Strategy Implementation Group
	1.3 Develop an Integrated Primary Care Model for access to talking therapies	Pan CCG Mental Health Group
	1.4 Continue to improve the emotional wellbeing of children and young people and provide effective, high quality mental health services to those who need it	Children & Young People's Mental health & Emotional Wellbeing (including CAMHS) Group
	1.5 Ratify and implement the County Durham Interim CAMHS Strategy 2014/15, whilst more detailed work is undertaken to develop a three year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan 2015-18. This will incorporate CAMHS.	Children & Young People's Mental health & Emotional Wellbeing (including CAMHS) Group
	1.6 Implement the multi-agency Public Mental Health & Suicide Prevention Strategy for Co Durham	Public Mental Health Strategy Implementation Group
2. More people with mental health problems will recover	2.1 Work together to find ways that will support the armed services community who have poor mental or physical health	Mental Health Joint Commissioning Group

More 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 need for living and working, improved chances in education, better employment rates and a suitable and stable place to live	2.2 Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment	Pan CCG Mental Health Group
	2.3 Implement the Recovery College to offer training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing opportunities to learn from others with similar experiences	Pan CCG Mental Health Group
	2.4 Ensure that all services adopt a Recovery orientated approach and use validated recovery measure to evaluate outcomes. By using relevant recovery related Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) enables service providers and service users to evaluate progress	Mental Health Joint Commissioning Group Public Mental Health Strategy Implementation Group
	2.5 Explore opportunities to embed co-production and peer support models within contracts	Mental Health Joint Commissioning Group
	2.6 Ongoing monitoring and awareness of the financial challenges and how the welfare reforms impact on the ability to access services	Co Durham Mental Health Provider & Stakeholder Forum Co Durham & Darlington Service User & Carer Forum
	2.7 Ensure service users and their carers have access to NICE recommended guidance and evidence based interventions	Pan CCG Mental Health Group

3. More people with mental health problems will have good physical health *Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health*	3.1 Develop a more integrated response for people with both mental and physical health conditions	Pan CCG Mental Health Group
	3.2 Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles	Public Mental Health Strategy Implementation Group
	3.3 Ensure that people with mental health conditions have their physical health needs actively addressed	Pan CCG Mental Health Group
4. More people will have a positive experience of care and support *Care and support, wherever it takes place, should offer access to timely, evidence-based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected*	4.1 Continue to improve access to psychological therapies and other interventions	Pan CCG Mental Health Group
	4.2 Improve experience of hospital discharge processes	Mental Health Joint Commissioning Group
	4.3 Through co-production involve individuals & carers more closely in decisions about the shape of future service provision	Co Durham Mental Health Provider & Stakeholder Forum
		Co Durham & Darlington Service User & Carer Forum
	4.4 Work together to give people greater choice and control over the services they purchase and the care that they receive	Mental Health Joint Commissioning Group

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

Appendix 1

Personal Story 1

This person was referred to the project for support into volunteer opportunities helping people and to complete some further education to improve his employment opportunities, mental health and well-being.

This person has barriers he faces on an on-going basis every day he has a diagnosis of HIV, faces discrimination within his community and as a result had suicide ideation every day with recurrent thoughts his life is over. This person advised how he felt he could overcome this and together find meaningful activities giving him a sense of purpose. Additionally this person was under threat of losing his benefits this caused him great distress and this also impacted on increased suicide ideation.

This person was supported to secure his aims of volunteering with a local Hospice, working in the Family Counselling Department; additionally he is working with the manager to develop a new project to support others with HIV and Aids, something he is extremely excited and passionate about. This person feels he doesn't have to hide his diagnosis in this environment and is fully supported by the staff.

The organisation supported this person in applying and securing a place at University to complete a Degree course in Psychology, filling out forms and securing funding for support with his dyslexia, he was successful in this and has been given the necessary aids to assist him. Additionally he has been allocated a personal tutor and mental health support worker from the university and they will provide additional assistance throughout his course with one to one support. He commenced with his course on 5th February and although he is finding it hard and wants to quit at times, however, he is continuing with his support and encouragement.

The organisation supported this person with completing his forms to secure long term DLA and he was successful in retaining full entitlement and a housing form to be re-homed away from his current address (awaiting outcome).

The organisation continue to work with this person and he has advised that because of his progression it has positively impacted on his life by reducing his suicide ideation, with the realisation he has meaning in his life through helping others.

Personal Story 2

A male in his early 50's was referred to the organisation's health trainer service via an occupational therapist to try and help improve his confidence in using a cooker independently. He was assessed and deemed safe to use the appliances within his own kitchen area. However despite the input of occupational therapy, he continued to eat unhealthily and not use his cooker to prepare meals. The Occupational Therapist (OT) had asked if the health trainer would work with him in order to give him more input to improve his diet and to increase his confidence in the kitchen. The OT had been aware of the organisation's previous healthy eating workshops and felt that the client may benefit from dedicated health trainer input.

The client had Asperger's syndrome and associated mental health difficulties and lived on his own. His mother, who previously prepared all of his meals, had been in a care home for the past two years. Since his mother has been in care he had only used a microwave to cook prepared meals. He also relied on his sisters to drop food off for him which he reheated in the microwave. He had very limited food choice due to his low confidence in cooking from scratch and not knowing what to buy from grocery stores which made him extremely anxious in public.

After an initial assessment it was evident that he was not getting enough fruit and vegetables in his diet. The health trainer identified what kind of foods he liked to eat and it was established that one of his favourite meals was spaghetti bolognaise. On their second appointment the health trainer brought along a healthy recipe for spaghetti bolognaise and supported the client to a local supermarket to cost up the ingredients and to help reduce his anxiety whilst in there. It was agreed that the following session he would have a go at cooking the meal from scratch which he successfully did.

The health trainer continued this work with the client for a couple of months and helped him to manage and cope with his anxiety through using the same familiar supermarket.

The client continues to shop on his own and at the end of his time with the health trainer service made a two course lunch at his home and invited the HT and the OT to join him proving to himself that he had achieved his goal of cooking and shopping independently.

Personal Story 3

Individual

- 45 year old male living on his own
- Diagnosed with mental health problems around seven years ago
- Formerly worked full time

Background / Presenting Problem

- Tendency to isolate himself from friends/family when mental health lapses
- Heavy smoker and occasional heavy user of alcohol
- Several visits to a crisis house for rest bite due to mental health relapses
- Very little engagement in any physical activity for a period of over a year.

Support / Intervention

- Referred to the organisation by care co-coordinator
- Referral to Health Trainer Service in 2013
- Now engages in weekly physical activities such as Gym and Badminton
- Social engagement at the centre and through weekly men's group also at the centre
- Following NHS Stop Smoking Programme provided by the Health Trainer Service

- Co-ordination between Health Trainer Service and care worker to establish better shopping and eating habits.

Results / Impact

- Improvements in physical health including weight loss and lowering of blood pressure
- Ability to make healthier lifestyle choices around diet and able to better control alcohol use
- Increased confidence in using gym equipment and public leisure facilities
- Successful attempt at quitting smoking after years of heavy smoking
- More active social life and friendships made/developed
- Accessing support services through the centre at local providers and educational institutions.

For the future

- Ongoing work with Health Trainer Service in classroom based and physical activities
- Continuing with education and building up of knowledge around his own mental health condition and staying well through local service providers and courses ran at the centre
- Attending men's Cree Group weekly to engage in social interaction and make of use services on offer such as welfare rights, help with finances and having a healthy meal.

Personal Story 4

Coming to the organisation has really helped me a lot with confidence and has changed me. Once, I never left the house, went on the bus by myself or mixed with other people, the organisation has helped me with my anxiety and depression and my understanding of them by mixing with people with the same illnesses. I love coming here, the staff are really friendly and supportive and I have made lots of new friends by attending the courses on offer. They are really helpful in learning new things and all help towards the future and my plans in what to do next. This organisation is the best place to come; I love it and the staff very much.

Personal Story 5

I have been using the service for over a year now. The reason I use the service is because I have been diagnosed with clinical depression and I did attempt suicide nearly 4 years ago, I was referred to the service by mental health professionals who said that physical activity would help my mental health, I refused to believe this at first.

My depression and suicidal thoughts led to me staying in the house and not wanting to leave or go out, hence my weight went up to 25 stone, this became my normal way of life and I would sit in the house and cry and be snappy and angry with anyone who came in to the house including family members, this deteriorated overtime and caused loads of arguments.

Since working with the Physical Activity service I have lost over 8 stone gradually and I am still losing weight, I have never been judged by anyone at the organisation and I have always been comfortable with the way I have been supported to achieve my goals. Through the fantastic support I get off all the staff not only has my weight decreased but my depression is subsiding and I feel a lot better in myself and my family life has improved.

I take part in the activities 4 day per week, playing badminton on a Tuesday, I attend Happy Wednesdays at Seaham and Happy Thursdays at Peterlee, we do a wide range of activities, i.e. Badminton, Bowls, Table Tennis, Short Tennis, Curling, Boccia, etc we also have board games, and it's great to meet new people and sit and chat in between activities, I have had a lot of support and encouragement from the staff and this has inspired me to do well. I wouldn't be where I am today in my life, my mental health issues are getting better and I am now in a position to cope with my depression, my family have also given me great support and encouraged me to take part in the groups and the physical activity and this has made us all much happier at home.

The staff has made such a difference to me and my family, I feel in a much better place than I was, I love going to the groups and doing exercise and meeting new people in a relaxed friendly environment that I feel safe in.

I would just like to say a big THANK YOU to the staff for the cracking job that they do and I can't compliment their service enough, I don't snap or get angry as much these days, I still have bad days and my depression hasn't gone, but I have lost weight and I am stable and with the support and keeping up with the physical activities I haven't got time to think about bad things and am mostly kept busy with the activities, I take part in. The staff have linked me in to other groups and activities such as the "Shape Up Activity" where we learn about how our bodies work and what portion size to eat and what to eat and when to eat, we also are shown relaxation methods and exercises "Its Fun" and interesting and I know that socially it's good for me.

With me attending the activity sessions and groups, my wife now comes along and that has helped her understand and come to terms with my illness and helps her with her mental health issues, my son has now been referred in to the organisation and this provides him with support for his depression, my son in law is seeing the impact this support is having on the family as a whole and he is going to attend. In the groups we get support with our mental health but also our general wellbeing

Another big step in my recovery is that I am now a volunteer for the Physical activity Service, I volunteer 4 days a week and it is so rewarding I get a lot out of it as well as keeping my self-fit, I enjoy meeting new people on the service as I know what they feel like and I enjoy helping them settle in and helping them to feel relaxed and enjoy themselves.

Personal Story 6

When I was growing up I perceived myself as different; I was withdrawn, found it difficult to socialise and maintain friendships and anxious. This wasn't to improve as I matured and when I was sixteen my life was about to change course drastically for

myself and my family; I was diagnosed with paranoid schizophrenia. At the time I was alone different from my contemporaries who seemed to achieving their goals I was on a different journey, a journey of self –discovery and a crash course in the mental health system. But it wasn't just devastating to myself my whole family were being dragged along in this destructive illness.

At sixteen, you don't expect to be walking the wards of a mental hospital in which, I deluded myself I was different but we were all people trying to cope with a debilitating illness. I felt I was a patient not a person my right to live a responsible life had been replaced with fear of who I was and what I may be capable of. But I quickly recognised I was ill after taking the medication which didn't eliminate my symptoms but helped me manage them. Although they seemed a bit of a catch 22, I put on weight became impotent and almost like being in a chemical straight jacket. I was thrown into day centres which made me feel even more like a patient and was crying out so called normality. I think what saved me at this time was I was always a conformist, I had an insight and I was open to talk about it to anyone who would listen. So I accepted my new situation and I adapted to it but I wanted to make myself functional and whole living a fulfilling life I wanted to make a difference to my lifestyle and I wanted a future outside the world of mental illness.
I came to Barnard Castle after years of struggling, it felt like I had no choices in the NHS and nobody took the time to look behind the wall I had put up to protect myself and I was dehumanised by some. It isn't always the spoken word that can reveal a person's stresses or turmoil, but if don't try to unlock the clues, then how can you solve the puzzle that is before you. But slowly I was given choices about my medication, listened to and I began to see small differences to my life there was a light glimmering at the end of my tunnel. I lost weight which boosted my self-confidence through exercise with the change of medication given CBT which helped with my ingrained behavioural traits due to years of voices and intrusive thoughts and I sought a relationship which intern opened my horizons and experiences. But I think what had been one of the foundations of my recovery was when I was taken out of my dysfunctional situation (probably due to my destructive illness) given my independence in my own home through the organisation and became part of their progressive organisation as a volunteer.

The organisation presented me with opportunities and the tools to empower myself to make a difference. They slowly encouraged me through my support workers to build on the qualities I already had but probably didn't realise it. It wasn't them and us we are a community working together towards improving people's lives with mental health that so many stigmatise and belittle their role in society. So being a volunteer gave me responsibility, an outlet for my lived experiences and the tools to improve my well- being and self –esteem. We have moved together so far but I think the thing that has made the biggest difference is studying Intentional Peer Support, The Wellness Recovery Action Plan and Mental Health First Aid alongside an NVQ in Health and Social Care. I think studying these gave structure to how we delivered our volunteering and something that made a positive impact on our own mental health perspective. I now see myself as a capable adult not a mental health patient or someone with a label. I am responsible with my illness and at the same time contributing and with intentional peer support giving something back through lived experience to those starting their journey and also validating my own life experience.

So what does recovery mean to me? It means I have found answers and finding fragments of my jigsaw put the pieces together and made a whole person. It's a story of hope not fear and I am have not settled for just managing and coping or using avoidance I have worked at having a future. We can see ourselves as fragile, be angry and resentful of our situation or we can accept, adapt and take positive risks and make ourselves resilient. There is only one person who can do this that's yourself but with support of your peers what seems impossible is achievable. So why settle for second best which is mental illness you have one life give it a future.

Personal Story 7

One Young Carer receiving support said that they were happy to have their words shared because they would like to help other young people who might be affected by similar situations and that they want to raise awareness about the impact that parental mental health has on the young person.

A 17 year old female who cares for her mother who has a diagnoses of fibromyalgia and depression.

Do you feel as though you have been emotionally impacted by your mams mental health?

"I hate it. It's hard not to get frustrated and I need to remember that it's her mental illness and not her who is deliberately forgetting stuff. I feel like it gets harder as I get older, she forgets more and it puts a big strain on our relationship. Now I'm older I do know more about her depression, but it's still hard. You need to know about it to deal with it. If you don't know then you don't know how to help. When I was younger I felt confused because I didn't understand why she would forget important stuff about me or anyone else".

Do you feel as though this has an impact on school?

"I felt out of it a lot at school. When I was in school I wasn't concentrating, and when I was out of school I would never think about school. School just didn't feel like my priority. School really stressed me out because they were always on my back. I know that they had to be on my back because my attendance was low, and I even understood at the time, I just had so much on my mind. Going to school just wasn't my priority. My work was good, my grades were good enough and I did quite a lot of work at home. When I went to school I would worry about my mam, sometimes I would just leave school through the middle of the day in a panic that she might have forgotten to do something important, or that she wasn't ok."

"Then people started rumours at school about me because my attendance was so low. They didn't realise that I was looking after my mam, they said I was anorexic. This made it really hard to go back to school. I did have problems with my eating and the rumours and gossip made it worse. It was really hard".

"I had the attendance officer on my back a lot and this could feel patronising. This would stress my mam out, and then I would have to deal with my mam, and then this would stress me out".

Do you feel like your mam's mental health impacted you socially?

"Yeah it did. I had one friend in school who I could speak to and who understood me. But all the other friends just joined in the rumours. They said that I had a disease, that I was pregnant and more stuff about anorexia. Now that I've finished school I don't really have many friends. I don't go out much and I have social anxiety, I get anxious about a lot of things. I have made some friends through being supported by Young Carers, but it is still a struggle. I can push people away, if I don't see them then I don't see the point, this happens because I feel like I can't leave the house sometimes because I freak out. I have ups and downs and sometimes feel fine to go out, other times I can't at all".

Do you feel like parental mental health has had an impact on your family relationships?

"Yes, I used to argue with my younger brother because he used to believe everything my mam would say. He has grown up now and matured and can see that not everything mam says is true. So now we don't clash as much as we used to. He understands more. I get on really well with my older sister. She understand exactly how I feel because she was my mams carer first, she had it the hardest. She understands what me and my brother go through. I don't get on as well with my mam as I used to, she can sprout lies about me to the rest of the family, and this makes tension between me and my mam and the rest of the family".

How do you feel about the work you have done with the Young Carers Service?

"Young Carers have done loads. They have helped with my social anxiety. I have been to London and met new friends. I feel like I have been able to relate to the other young people that I have met. I have been on a train and been to York with them, I have got to go to places I would never have been to before. It's felt really good to be a part of, I have experienced new things, I got to speak to MP's and had the chance to have my thoughts heard. I feel much more tolerant of people when I am out now, I used to be quite closed minded and even a little bit racist. But now I'm not at all, I'm much more open-minded through meeting new people and hearing about other people's situations. This has totally changed my views. I sometimes feel better in myself. Before I got involved with the Young Carers, I felt very sorry for myself, but now I have met other young people and it's opened my eyes. There are really young people doing so much for the people they care for and they are really happy, it has helped put a lot of things into perspective. So, I have realised that I could opt out of it and make changes for myself and stop feeling so sorry for myself."

Glossary

Our glossary lists some website links which may be useful to explain some of the terminology used within the document and to seek further information about the documents we have referred to.

Useful Websites

Mental Health A to Z
http://www.mind.org.uk/information-support/mental-health-a-z/

Types of Mental Health Problems
http://www.mind.org.uk/information-support/types-of-mental-health-problems/?gclid=CPmEn8yN6rwCFfLHtAod130Atg

A guide to Mental Health terminology
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

Mental Health: The Facts
http://www.health.vic.gov.au/mentalhealth/termnlgy.htm

North Durham Clinical Commissioning Group (ND CCG)
http://www.northdurhamccg.nhs.uk/

Durham Dales Easington & Sedgefield Clinical Commissioning Group (DDES CCG)
http://www.durhamdaleseasingtonsedgefieldccg.nhs.uk/

North of England Commissioning Support (NECS)
http://www.necsu.nhs.uk/

Durham County Council
http://www.durham.gov.uk/

Footnotes

1. Co-production: an emerging evidence base for adult social care transformation (2012) Social Care Institute for Excellence
www.scie.org.uk/publications

2. No Health without Public Mental Health, (2010) Royal College of Psychiatrists
http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf

3. No Health without Mental Health (2011) HM Government
https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

4. No Health without Mental Health, mental health dashboard, (2013) HM Government https://www.gov.uk/government/publications/mental-health-dashboard

5. The Care Act 2014
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

6. Children & Families Act (2014) HM Government
http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted

7. Closing the Gap: Priorities for essential change in mental health (2014) HM Government
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

8. Mental Health Crisis Care Concordat: Improving Outcomes for people experiencing mental health crisis (2014) HM Government
https://www.gov.uk/government/publications/mental-health-crisis-care-agreement

9. Whole person care: from rhetoric to reality (Achieving parity of esteem between mental and physical health) 2013 RCP
http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf

10. A Call to Action: Achieving parity of Esteem; Transformative ideas for commissioners (2013) NHS England http://www.england.nhs.uk/wp-content/uploads/2014/02/nhs-parity.pdf

11. Recognised, valued & supported: next steps for the Carers Strategy (2010) HM Government https://www.gov.uk/government/publications/recognised-valued-and-supported-next-steps-for-the-carers-strategy

12. The Spending Round 2013
https://www.gov.uk/government/topical-events/spending-round-2013

13. Transforming care: A national response to Winterbourne View Hospital (2012) HM Government https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

14. Welfare Reform Act 2012
http://www.legislation.gov.uk/ukpga/2012/5/contents/enacted

15. Removing barriers: the facts about mental health and employment Centre for Mental health (2009)
http://www.centreformentalhealth.org.uk/pdfs/briefing40_Removing_barriers_employment_mental_health.pdf

16. Building Homelessness Prevention Practice: COMBINING RESEARCH EVIDENCE AND PROFESSIONAL KNOWLEDGE: Maureen Crane, Ruby Fu and Anthony M. Warnes, Sheffield Institute for Studies on Ageing, University of Sheffield June 2004
http://www.kcl.ac.uk/sspp/kpi/scwru/pubs/2004/Crane-et-al-2004-Homeless-prevention.pdf

17. Melvin P (2004) A Nursing Service for homeless people with Mental Health Problems. Mental Health Practice, vol 7 no 8

18. Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services (2012) www.jcpmh.info

19. Community Mental Health Profile for County Durham (2013) http://www.nepho.org.uk/cmhp/

20. Co Durham Joint Health & Wellbeing Strategy http://content.durham.gov.uk/PDFRepository/County-Durham-Joint-Health-and-Wellbeing-Strategy-2014-2017.pdf

21. Co Durham Joint Strategic Needs Assessment http://content.durham.gov.uk/PDFRepository/FINAL_JSNA_2013.pdf

22. Co Durham Public Mental Health Strategy http://democracy.durham.gov.uk/documents/s35630/Item%208b%20-%20Public%20Mental%20Health%20Strategy.pdf

23. Co Durham & Darlington Dual Diagnosis
Not yet published, in draft form awaiting sign off

24. Resilience strategic framework for children and young people (2014-2017) Durham County Council
Not yet published, in draft form awaiting sign off

25. Children, Young People and Families Plan (2014-2017) Durham County Council Children Young People and Families Plan

26. Co Durham & Darlington Dementia Strategy
No yet published, in draft form awaiting sign off

27. Veteran Care http://www.veterans-uk.info/mental_health/announcement.html

28. Joint Commissioning Panel for Mental Health, Guidance for commissioners of perinatal mental health services (2012) www.jcpmh.info

29. Anthony WA (1993). Recovery from mental health illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal 16 (4): 11-23 http://www.psykiatri-regionh.dk/NR/rdonlyres/76749557-0ABA-41C2-B560-F33D9511644A/0/recovery_from_mental_llness.pdf

30. Promoting mental health & Preventing mental illness, Freidli, L & Parsonage, M (2009)
http://www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20(English).pdf

31. The Economic and Social Costs of Mental health Problems in 2009/10 (2010) Centre for Mental Health http://www.centreformentalhealth.org.uk/pdfs/economic_and_social_costs_2010.pdf

32. Tackling obesities: future choices (2007) Project report Government Office for Science Foresight https://www.gov.uk/government/collections/tackling-obesities-future-choices

33. Prevention of cardiovascular disease at population level (2010) NICE http://guidance.nice.org.uk/PH25

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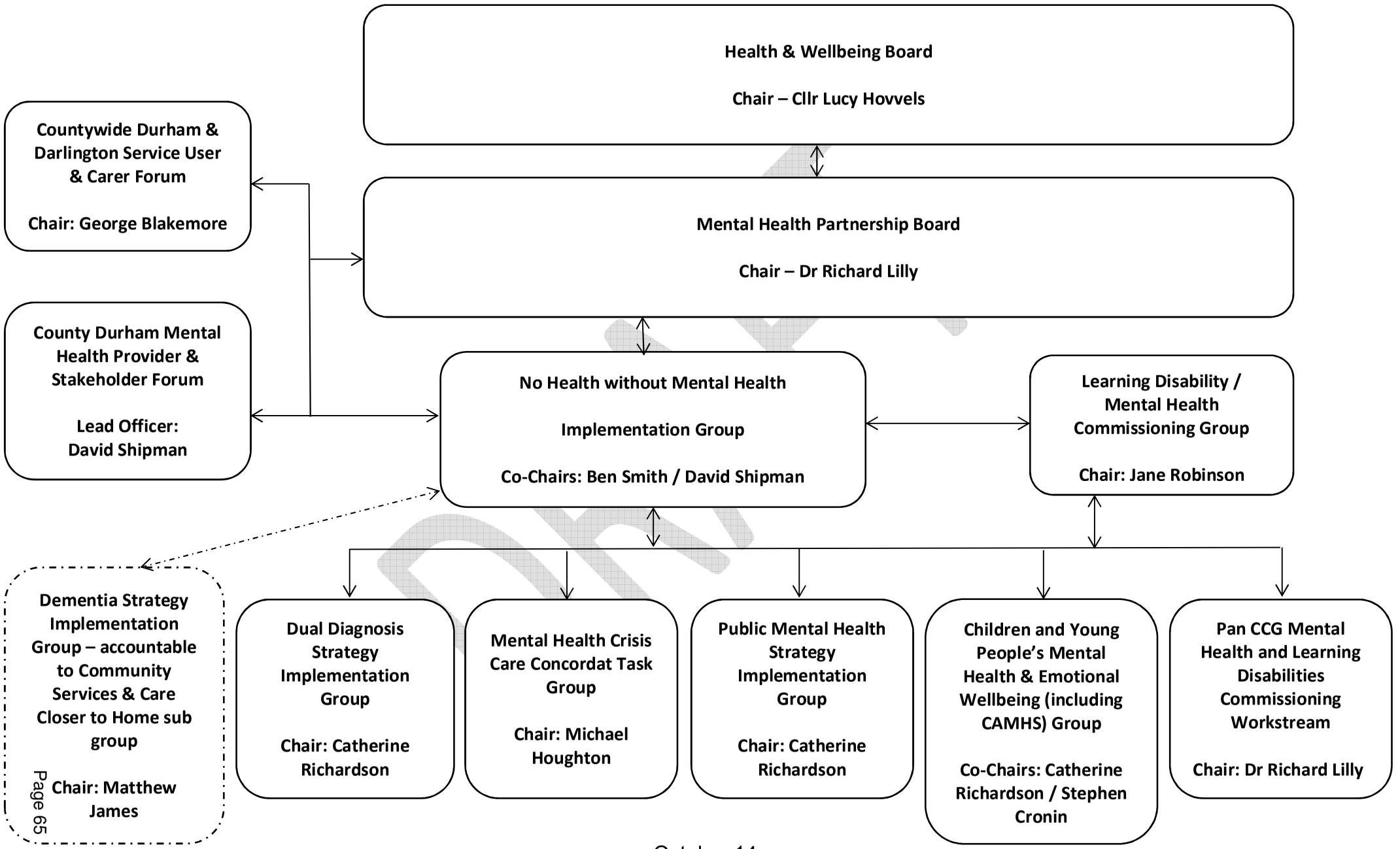
Proposed County Durham Mental Health Partnership Structure



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Health and Wellbeing Board

5 November 2014

Mental Health Crisis Care Concordat - Local Declaration and Response

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

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the local response to the mental health crisis care concordat and present the local declaration sign up and support.

2. A further report will be presented in March 2015 to consider and agree the final local joint action plan.

Background

3. The national mental health crisis concordat was launched a few months ago. One of the key aims of the concordat is to develop joined up service responses to people who are suffering from mental health crisis. There has been national sign up to the concordat by a number of key agencies and there is a specific emphasis on securing delivery of improved outcomes for people in mental health crisis at a local level. It is anticipated that partner organisations will demonstrate their commitment by signing up to a local declaration and agreeing a joint action plan to bring about the local improvements needed. The intention is that both the signed local declaration and the agreed action plan will be made available on a national website to demonstrate local coverage across England.

Mental Health in County Durham

4. Mental health is a key priority for the Health and Wellbeing Board and is a strategic objective within the Joint Health and Wellbeing Strategy. There is a significant focus on mental health partnership work in County Durham through the development of a number of joint strategies with Darlington Borough Council via the County Durham Mental Health Partnership Board and Darlington Mental Health Partnership Network:

- Public Mental Health Strategy
- Mental Health Strategic Implementation Plan – addressing national policy *No Health without Mental Health and Closing the Gap: priorities for essential change in mental health*
- Child and Adolescent Mental Health Strategy
- Multi-Agency Strategy for Supporting People with Dual Diagnosis

5. The crisis care concordat guidance outlines good practice examples to support the development of local actions plans. In County Durham many of these examples are established, in addition to crisis and response services for mental health, for example:

    - Acute psychiatric liaison service
    - Care home psychiatric liaison service
    - Childrens crisis service
    - Recovery college (launched in September 2014)

Developing the local response

6. There is agreement to develop the local declaration and action plan across County Durham and Darlington in conjunction with both Health and Wellbeing Boards. This is because a number of partners such as Tees Esk and Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust, Durham Constabulary and North East Ambulance Service NHS Foundation Trust operate across the populations of County Durham and Darlington.

7. A multi-agency task and finish group has been established to take forward the local declaration and development of the action plan to support improved outcomes for patients in mental health crisis. The task and finish group is led by the Clinical Commissioning Groups (CCGs) and a Director of North Durham CCG is taking the lead on behalf of the other CCGs.

Local Declaration

8. The proposed local declaration is attached at appendix two. This is based on a nationally published document. Local areas are expected to publish a final version that is signed up to and supported by statutory organisations and other partner organisations as recommended in the model declaration document. The declaration outlines several key principles based on organisations agreeing to work together and also highlights the importance of ‘parity of esteem’ between physical and mental health in relation to mental health crisis.

9. In signing the declaration the Health and Wellbeing Board in conjunction with other organisations is committing to support a focus on improving outcomes for people in mental health crisis. For many partner organisations this will also mean supporting or taking a lead role in

implementing priorities within a joint action plan, which is currently being developed.

10. Once confirmation of sign up and support from statutory organisations and other key organisations is received the declaration will be finalised and uploaded onto the national website as a publicly available document by the end of November 2014. There will be an opportunity for a press or media statement to be communicated to coincide with the publication of the final declaration.

Local Action Plan

11. The local action plan will be agreed and published before the 31 March 2015, which is in line with national timescales. The development of the action plan is underway and a near final draft is expected to be completed by the end of December 2014. This would enable partner organisations sufficient time in January and February to consider and sign off the action plan ahead of final version being received and supported by the Health and Wellbeing Board in March 2015.

12. Engagement with service users, members of the public and partner organisations is planned. This process will build on the recent 'big tent' engagement event held in County Durham.

Recommendations

13. The Health and Wellbeing Board are recommended to:

    - Sign up to and support the local mental health crisis care declaration
    - Note the approach to developing the local response to the crisis care concordat

Contact: Michael Houghton, Director of Commissioning and Development, North Durham CCG - Tel: 0191 605 3168

Appendix 1: Implications

Finance
No direct implications at this point

Staffing
No direct implications.

Risk
No direct implications.

Equality and Diversity / Public Sector Equality Duty
No direct implications.

Accommodation
No direct implications.

Crime and Disorder
Links with the Constabulary and Police and Crime Commissioner.

Human Rights
No direct implications.

Consultation
Engagement is planned building on the recent big tent event.

Procurement
No implications.

Disability Issues
Issues in relation to disability have been considered throughout the development of the local declaration.

Legal Implications
The Health and Social Care Act 2012 places clear duties on Clinical Commissioning Groups and local authorities for the commissioning of mental health services. There is national policy direction that requires local areas to publish a local declaration and action plan.

Appendix 2

DRAFT - The 2014 County Durham and Darlington Declaration on improving outcomes for people experiencing mental health crisis, 30 November 2014.

We, as partner organisations in County Durham and Darlington, will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need − whatever the circumstances − from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in County Durham and Darlington by putting in place, reviewing and regularly updating the attached action plan.

This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in County Durham and Darlington for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.

- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.

- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.

- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

(Guidance)Who should sign a local Declaration?

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis:

- Clinical Commissioning Groups
- NHS England Local Area teams (primary care commissioners)
- Commissioners of social services
- The Police Service
- Police and Crime Commissioners
- The Ambulance Service

- NHS providers of Urgent and Emergency Care (Emergency Departments within local hospitals)
- Public / independent providers of NHS funded mental health services
- Public / independent providers of substance misuse services

We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in County Durham and Darlington.

The list of organisations and logos will be listed here once finalised

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe
Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: “Recovery is a deeply personal, unique process changing one’s attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability” (Anthony, 1993) Further information http://www.imroc.org/

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Health and Wellbeing Board

5 November 2014

Securing Quality in Health Services

Report of Martin Phillips, Chief Officer, Darlington Clinical Commissioning Group

Dr Boleslaw Posmyk, Clinical Chair, Hartlepool and Stockton on Tees Clinical Commissioning Group

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the Securing Quality in Health Services Project.

Background

2. The Health and Wellbeing Board received a report in June 2013 on this project that spans Durham, Darlington and Tees.

3. The **securing quality in health services (SeQIHS) project** was initiated by primary care trusts and has now become the responsibility of the five clinical commissioning groups, working together with the local hospital foundation trusts, in the County Durham, Darlington and Tees region. We are also in discussion with the neighbouring Hambleton, Richmondshire and Whitby CCG.

4. Over the next ten years, both commissioners and providers of acute services face a range of challenges that threaten their long term sustainability. These include an ageing population, a rise in the number of people with long-term conditions, lifestyle risk factors in the young and greater public expectations of NHS provision. All this must be set against rising costs and constrained financial resources.

5. There is growing evidence that patient outcomes could be improved by increasing the number of hours that senior doctors are available in hospital wards to make decisions about the assessment and treatment of patients.

6. Taking into account the number of people currently training to work as health professionals in the region and the age profile of existing staff, we are likely to experience staff shortages in the medium to long term unless we take action.

7. These drivers, along with the requirement to ensure that the delivery of high quality clinical standards remains a priority for commissioners and providers alike, create the rationale and momentum for this project.

Overview of the project

8. This project is being delivered in three Phases:

    - Phase one aimed to establish a consensus in relation to the key clinical quality standards that should be commissioned in acute hospitals.
    - Phase two worked with individual organisations to update the assessment of where we are in terms of meeting the clinical quality standards now and where we will be by April 2015. It also included an assessment of the implications of meeting the standards and where there are challenges to this across the system.
    - Phase three will focus on how organisations and services might work together in the future to deliver the standards and identify a model of care across the Durham, Darlington and Tees area that will maximise our ability to meet the standards within the resources available.

Phase One

9. During Phase one, the following were undertaken:

    - a clinical quality assessment that considered national best practices, barriers and enablers
    - an economic assessment, taking into account the local financial environment
    - a workforce assessment that identified any constraints in relation to the achievement of agreed quality standards.

Phase two

10. During Phase two, clinical and other professional staff helped identify what the best possible care should look like in our hospitals and how we could go about delivering this, given increasing demand for services and the likely financial and workforce challenges ahead.

11. Between June 2013 and January 2014 an external feasibility study was a carried out which considered the implications of implementing the new standards across the Durham, Darlington and Tees region. A link to this document can be found below:

    Securing Quality in Health Services - Feasibility Analysis Report

12. The feasibility analysis was designed to provide an independent assessment at each hospital site of the timetable for implementing the

clinical standards. This included a review of the workforce implications; an investigation of affordability set against potential future financial allocations; a consideration of the overall achievability of planned milestones; and an assessment of the associated risks.

The key findings from the feasibility analysis

- Both providers and commissioners are committed to achieving the clinical standards agreed in Phase one.
- There is a strong alignment of the proposed clinical quality standards identified by the project and those highlighted by Sir Bruce's Keogh's Forum on NHS Services, Seven Days a Week.
- Appropriate monitoring mechanisms will need to be established to ensure confidence in the delivery of agreed clinical quality standards.
- There has been some progress towards the achievement of the agreed clinical standards since completion of Phase one. However trusts are unlikely to be able to deliver the required quality standards in seven key areas without further resources and/or a more system-wide approach (see below).
- The financial challenge for NHS and local authority partners has increased significantly since Phase one of the work was completed.

13. The analysis concluded that trusts would be unable to deliver the required quality improvements with significant additional funding or a change of approach in the following areas:

- Providing extended access to diagnostic services both out of hours and at weekends
- Providing extended access to other support services such as physiotherapy, pharmacy and social services both out of hours and at weekends
- Access to interventional radiology is currently extremely limited at all providers. Arrangements for out of hours cover and on-call need to be developed
- Workforce to provide 10 WTE on each level of middle grade medical rotas (impacting upon acute paediatrics, maternity and neonatal services, acute surgery and Acute medicine services)
- Trusts are close to achieving the 98 hours consultant cover at all maternity units within the region. However they are a long way from achieving the 168 hours best practice and clinical ambition agreed by the clinical advisory group
- The majority of the agreed end of life care standards are not going to be met by two of the trusts.
- The volume of neonatology services across the area means all providers fail to meet occupancy and staffing standards.
- The workforce assessment in Phase one identified that the current configuration of acute neonatal, maternity and paediatrics

services was unsustainable in the medium to long-term, and that a reduced number of sites should be considered.

Phase Three

14. The SeQIHS Project Board, which comprises NHS and local authority organisations from across the Durham, Darlington and Tees region, have confirmed their commitment to work together to continue to improve services and identify how the required clinical quality standards can be delivered within the available resources. All parties acknowledge that this could result in significant changes to the provision of services and could require significant engagement and formal consultation in due course.

15. This next stage of the project must be informed by a range of national and local initiatives including the Keogh report on urgent and emergency care, developments around integrated care, specialised services commissioning, seven day working, and the five-year plans of local CCGs. The following service areas are included in the scope of the project:

    - Acute Surgery;
    - Acute Medicine;
    - Intensive Care;
    - Acute Paediatrics, Maternity and Neonatology;
    - End of Life Care; and
    - Urgent & Emergency Care (added in phase 2 following the publication of the Keogh report on urgent and emergency care)

16. Following the completion of the feasibility analysis, the basis for moving forward was agreed as four sites [Middlesbrough, Hartlepool/Stockton, Darlington & Durham] across Durham & Tees Valley together with Friarage Hospital, Northallerton, all delivering a range of inpatient, outpatient, diagnostic and urgent care services.

17. It was also agreed that critical to consideration of any proposals to change the pattern of service delivery will be the need to reach agreement on the balance between quality, access and affordability.

18. To progress these discussions and to further develop the case for change and a service model for the area, a clinical leadership group has been established. The group is made up of senior clinicians from the three Foundation Trusts and the CCGs and Healthwatch colleagues, and is chaired by the chair of the Northern Clinical Senate who is independent of the organisations involved in the project.

19. The purpose of the Clinical Leadership Group is to provide clinical leadership, advice and challenge to the project. The group will make recommendations as to the future model of care for Durham, Darlington and Tees, for approval by the project board and it is anticipated that this will be in draft form in the new year.

Engagement

20. To date, there has been significant engagement with partners, Health and Wellbeing Boards and Overview and Scrutiny Groups. In the next phase of this work, the Board has acknowledged the need to incorporate wider involvement of the public and patients.

21. To this end we are commissioning independent research which will be carried out with the public to gain an understanding of what local people feel is important about hospital services, gauge levels of understanding of the balance that has to be achieved between quality, access and affordability and gauge levels of understanding about the need for change in the NHS generally.

22. We are also working with Healthwatch colleagues to obtain their advice about the further development of our engagement with local people.

Recommendations

23. The Health and Wellbeing Board is recommended to:

    - Note the contents of this report
    - Receive a further update from the project team in due course

Contact:	**Rosemary Granger, Project Director, NHS Darlington Clinical Commissioning Group**
Tel:	**01325 746 239**

Appendix 1: Implications

Finance
No Implications at this stage

Staffing
No Implications at this stage

Risk
No Implications at this stage

Equality and Diversity / Public Sector Equality Duty
No Implications at this stage

Accommodation
No Implications at this stage

Crime and Disorder
No Implications at this stage

Human Rights
No Implications at this stage

Consultation
No Implications at this stage

Procurement
No Implications at this stage

Disability Issues
No Implications at this stage

Legal Implications
No Implications at this stage

Health and Wellbeing Board

5 November 2014

Better Care Fund

Report of Rachael Shimmin, Corporate Director, Children and Adults Services, Durham County Council

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

Nicola Bailey, Chief Operating Officer, North Durham and Durham Dales Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1. To ratify the Better Care Fund (BCF) Plan.

Background

2. In June 2013, the Government announced that it would be allocating £3.8 billion to a pooled budget, initially called the Integration Transformation Fund, now called the Better Care Fund (BCF). County Durham's allocation is £43.735m in 2015/16.

3. This budget is to be deployed locally on health and social care initiatives through pooled budget arrangements from 2015/16. The BCF will support the aim of providing people with the right care, in the right place, at the right time, including a significant emphasis upon care in community settings, with the express aim of reducing admissions and readmissions to secondary care and alleviating pressures on the acute sector.

4. An initial draft of the County Durham BCF plan, following national guidance at that time, was submitted to the Durham Darlington and Tees Area Team on 14 February 2014 and following an assurance process a revised plan, incorporating the additional information requested, was resubmitted on 4 April 2014.

5. The Health and Wellbeing Board has received updates and agreed the Better Care Fund plan at its meetings on 21 January and 5 March 2014, and at the development session on 3 September 2014.

6. Ministers confirmed that no BCF plans would be formally signed off in April 2014 and it was noted that refreshed national guidance would provide further detail on the changes to risk sharing, pay for performance framework and the full range of performance metrics to be included in the BCF.

The revised guidance and planning templates were subsequently published on 25 July 2014, with a requirement for BCF plans to be resubmitted on 19 September 2014.

7. Supplementary guidance was published on 20 August 2014 to provide further clarification for CCG's and Councils on the extent of flexibility available in setting the scale of ambition to reduce the total number of emergency admissions to hospital, based on the planning assumption in the guidance issued on 25 July 2014, that each Health and Wellbeing Board would plan to reduce the total number of emergency admissions to hospital by a minimum of 3.5%.

8. The BCF Plan was agreed by the Health and Wellbeing Board on 3 September 2014 and submitted to the NHS England Area Team on 19 September 2014, with a copy provided to members of the Health and Wellbeing Board.

Better Care Fund Planning Templates

9. The vision for the BCF in County Durham remains as **"Improve the health and wellbeing of the people of County Durham and reduce health inequalities"**

10. The five priorities for transformation remain as:

- Intermediate Care
- Support for care homes
- Non Fair Access to Care Services (FACS) reablement
- Combating social isolation
- Seven day services

11. The seven work programmes and levels of investment remain as follows:

- **Short term intervention services** which includes intermediate care community services, reablement, falls and occupational therapy services **(£13,428,000)**
- **Equipment and adaptations for independence** which includes telecare, disability adaptations and the Home Equipment Loans Service **(£8,562,000)**
- **Supporting independent living** which includes mental health prevention services, floating support and supported living and community alarms and wardens **(£5,005,000)**
- **Supporting Carers** which includes carers breaks, carer's emergency support and support for young carers **(£1,361,000)**
- **Social inclusion** which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services **(£1,121,000)**
- **Care home support** which includes care home and acute and dementia liaison services **(£1,774,000)**
- **Transforming care** which includes maintaining the current level of eligibility criteria, the development of IT systems to support joint working and implementing the Care Act **(£12,484,000)**

12. The performance-related element of the BCF for Durham in 2015/16 will be £11.327m. The target of 3.5% for reducing emergency admissions means that circa 70% of the monies included in the performance element of the BCF (£8.086m) would be passported automatically to the BCF. The remaining £3.241m would be at risk, and would only be added to the BCF subject to meeting the admissions target. If part of the target was met, then a proportion of this element would be added to the BCF.

13. No payment will now be linked to any other metrics, and there are no changes to the following metrics agreed by the Health and Wellbeing Board on 5 March 2014:

    - Permanent Admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
    - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
    - Delayed Transfers of Care from hospital per 100,000 population (average per month)
    - The number of carers who are very/extremely satisfied with the support or services that they receive
    - The Number of People in receipt of Telecare per 100,000 population

National Consistent Assurance Review Process

14. A nationally consistent assurance review (NCAR) process has been developed by the national Better Care Fund programme team to ensure that a transparent and consistent approach is applied across all BCF plans.

15. Letters communicating the outcome of this review process and outlining the approval status of BCF plans are expected at the end of October 2014 which will include details of the next steps.

Recommendations:

16. The Health and Wellbeing Board is recommended to:

    - Note the content of this report
    - Ratify the BCF Plan

Contacts:
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Peter Appleton, Head of Planning and Service Strategy, Durham County Council Tel: 03000 267 388
Mark Pickering, Chief Finance Officer, DDES CCG - Tel: 0191 3713216
Richard Henderson, Chief Finance Officer, North Durham CCG
Tel: 0191 6053166

Background Papers:
County Durham Better Care Fund Plan Part 1 Template
County Durham Better Care Fund Plan Part 2 Template

Appendix 1: Implications

Finance – The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers.

The June 2014 Spending Round set out the following:-

- **2014/15**: A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned
- **2015/16**: £3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from £1.9bn of additional NHS funding based on existing funding in 2014/15 that is allocated across the health and wider care system as follows:

- £130m Carers' Break funding
- £300m CCG reablement funding
- £354m capital funding (including £220m Disabled Facilities Grant)
- £1.1bn existing transfer from health to adult social care.

The £3.8bn Fund therefore includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement.

The Disabled Facilities Grant has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

DH Adult Social Care capital grants (£134m) will also reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund.

In addition, it was announced as part of the Spending Round that the Better Care Fund would include £135m of revenue funding for costs to councils resulting from the Care Act in 2015/16. This revenue funding will be identified from the £1.9bn of NHS funding, and will cover a range of new duties on councils relating to the Care Act, (including new entitlements for carers, national minimum eligibility threshold, advocacy, safeguarding and other measures in the Care Act).

On 18 December 2013 the Local Government Finance Settlement covering the period 2014/15 and 2015/16 was published. Social Care funding allocations to DCC in 2014/15 were as expected (£12.936m) and the revenue element of the BCF in

2015/16 (which includes the DCC Social Care Funding of £12.936) was confirmed as being £39.193m.

Indicative 2015/16 capital allocations for the Disabled Facilities Grant (£2.970m) and Community Capacity Grant (£1.572m), which also form part of the BCF pooled budget, have been released. The BCF planning total is therefore £43.735m.

Indications are that the performance-related element of the BCF for Durham in 2015/16 is £11.327m. Assuming Durham sets a target of 3.5% for reducing emergency admissions, circa 70% of the monies included in the performance element of the BCF, £8.086m, would be passported to the BCF. The remaining £3.241m would be at risk, and would only be added to the BCF subject to meeting the admissions target. If part of the target was met, then a proportion of this element would be added to the BCF.

Any balance not added to the BCF would be available to CCG's to spend in consultation with the Health and Wellbeing Board. In effect, the implication is that any balance would be made available to the Foundation Trusts (FT's) to compensate for additional demand pressures as a result of admissions targets not being met. It is assumed in these circumstances that funds would have been deducted from Trust contracts at a level commensurate with the reduction in emergency admissions targets, although this would depend upon local factors. The "real" risk level for Durham is anticipated to be less than the £3.241m, reflecting the relative strong financial position of our local CCG's and the relative financial stability of CDDFT. This is clearly not the case across the whole of the country where reductions in excess of 3.5% are being required to address pressures within health budgets.

Staffing - Workforce capacity and capability has been highlighted as an issue across the health and care system when the BCF plans are implemented.

Risk - The Health and Wellbeing Board need to jointly agree a local BCF proposal for County Durham, which sets out how the pooled funding will be used and the ways in which the national and local targets attached to the £1bn proportion of the BCF linked to a reduction in total emergency admissions

For the proportion of the £1bn funds linked to a reduction in total emergency admissions, money will be released from the CCG into the pooled budget on a quarterly basis, depending on performance on achievement of agreed performance targets.

As part of the performance reward element of the BCF and the requirements for pooling budgets, a clear framework for local risk sharing of activity forming part of the BCF will also need to be introduced. This will not extend to Local Government being accountable for overspending on acute activity but CCG's and the Council sharing risk and reward (including any under and overspending) for activity within the BCF.

Equality and Diversity / Public Sector Equality Duty – No implications

Accommodation - No implications.

Crime and Disorder - No implications.

Human Rights - No implications.

Consultation – The updated BCF templates have been prepared jointly by officers of the Council and the CCG's, with support from the Area Team. There is now also a requirement for projected non-elective activity data to be shared with local acute providers, and providers have submitted their commentary in response to those figures to confirm the extent to which they agree with the projections, and set out that those assumptions are built into their own two year plans.

Procurement - No implications at this stage.

Disability Issues - No implications at this stage

Legal Implications - This report sets out the requirement to establish a plan for how the Better Care Fund will be deployed in County Durham in order to meet the Governments requirements.

Health and Wellbeing Board

5 November 2014

Safeguarding Framework

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

Lee Alexander, Safeguarding & Practice Development Manager, Children and Adults Services, Durham County Council

Pixley Clarke, Local Safeguarding Children Board Business Manager, Children and Adults Services, Durham County Council

Purpose of the Report

1. Following discussion at the Health and Wellbeing Board development meeting on 3rd September 2014, this report seeks formal agreement and ratification from the Health and Wellbeing Board on the Safeguarding Framework.

2. The Safeguarding Framework outlines the joint working arrangements between the Local Safeguarding Children's Board (LSCB) and Safeguarding Adults Board (SAB) with the Health and Wellbeing Board, Children and Families Partnership and the Safe Durham Partnership. The Safeguarding Framework is attached at Appendix 2.

Background

3. A Safeguarding Framework was developed initially in 2012 to provide assurance during a period of transition in the NHS. It set out the transitional arrangements with the Shadow Health and Wellbeing Board, Local Safeguarding Children's Board and Safeguarding Adults Board. It was agreed at the Shadow Health and Wellbeing Board on 8th November 2012.

4. Following the Health and Wellbeing Board becoming a committee of Durham County Council and the establishment of Clinical Commissioning Groups in April 2013, a review of the Safeguarding Framework was undertaken to ensure that, post-transition, robust arrangements are in place across the partnership boards who have a priority to protect children and adults from abuse and harm. It is important that the Safeguarding Frameworks sets out the shared agenda to ensure all partners have a joined up approach which adopts a "Think Family" approach.

Safeguarding Framework

5. The Safeguarding Framework outlines the statutory responsibilities of the LSCB and SAB, and how their work interfaces and complements the work of the Partnership Boards and has been updated to reflect recent legislation and guidance including the Health and Social Care Act 2012 and the Care Act 2014.

6. The Care Act 2014 places the Safeguarding Adults Boards on the same statutory footing as the Local Safeguarding Children's Board. This will give the Safeguarding Adults Board a clear basis in law for the first time and will strengthen the existing arrangements that are in place.

7. In addition to the statutory requirements, the Safeguarding Framework details the functions of the safeguarding boards and outlines the governance, chairing and membership arrangements.

8. The Safeguarding Framework demonstrates that there are close working arrangements in place and documents the commitments from the partnership boards and the LSCB and SAB to work together in protecting vulnerable children and adults from harm.

9. The Safeguarding Framework has been agreed by the following boards:

    - Children and Adults Services Senior Management Team
    - Durham County Council Corporate Management Team
    - Safeguarding Adults Board
    - Local Safeguarding Children Board
    - Children and Families Partnership
    - Safe Durham Partnership

Next Steps

10. A communications plan will be produced to ensure that the Safeguarding Framework is circulated to relevant staff and organisations, to ensure there is an awareness and understanding of the joint working arrangements between the Partnership Boards and the Local Safeguarding Children Board and Safeguarding Adults Board.

Recommendations

11. The Health and Wellbeing Board are recommended to:

    - Formally agree and ratify the Safeguarding Framework and note the partnership arrangements in place to protect vulnerable children and adults from harm.

Contact: Andrea Petty, Strategic Manager, Policy, Planning & Partnerships – Tel: 0300 267312
Lee Alexander, Safeguarding & Practice Development Manager – Tel: 03000 268180
Pixley Clarke, Business Manager – Tel 03000 265775

Appendix 1: Implications

Finance – No direct implications.

Staffing - No direct implications.

Risk - No direct implications.

Equality and Diversity / Public Sector Equality Duty - No direct implications.

Accommodation - No direct implications.

Crime and Disorder – No direct implications.

Human Rights - No direct implications.

Consultation – The Safeguarding Framework has been completed in consultation with LSCB and SAB partners. It will be shared according to the communications plan.

Procurement - No direct implications.

Disability Issues – No direct implications.

Legal Implications – Legal implications are considered in the Safeguarding Framework

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SAFEGUARDING FRAMEWORK

July 2014

County Durham Health and Wellbeing Board

County Durham Children and Families Partnership

Safe Durham Partnership

Introduction

A Safeguarding Framework was initially agreed at the Shadow Health and Wellbeing Board meeting on 8th November 2012. The document set out the transitional arrangements with the Shadow Board and Local Safeguarding Children's Board and Safeguarding Adults Board.

Protecting vulnerable children and adults is a key priority of the Health and Wellbeing Board, Children and Families Partnership, and Safe Durham Partnership; and it is important that there are close links with these Partnership Boards and the statutory Local Safeguarding Children's Board and Safeguarding Adults Board.

This revised Safeguarding Framework clarifies the joint working arrangements between the Boards. This document should be read in conjunction with the Collaborative working and information sharing protocol between professionals to protect vulnerable children and adults

Local Safeguarding Children Board (LSCB)

Statutory responsibilities

Section 13 of the Children Act 2004 requires each Local Authority (LA) that is a Children's Services Authority to establish a LSCB for their area and specifies the organisations and individuals that should be represented on LSCBs.

Since 2006 the LSCB has been the statutory body for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in County Durham.

The LSCB encapsulates the guidance contained in Working together to safeguard children (March 2013)

Statutory objectives and functions of LSCBs

Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004, are as follows:

1(a) developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to:

(i) The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

(ii) Training of persons who work with children or in services affecting the safety and welfare of children;

(iii) Recruitment and supervision of persons who work with children;

(iv) Investigation of allegations concerning persons who work with children;

(v) Safety and welfare of children who are privately fostered;

(vi) Cooperation with neighbouring children's services authorities and their Board partners;

(b) Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so

(c) Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

(d) Participating in the planning of services for children in the area of the authority; and

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (2) which relates to the LSCB Serious Case Reviews function and regulation 6 which relates to the LSCB Child Death functions are covered in this framework.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

Annual report

- Working Together 2013 requires each LSCB to produce and publish an annual report evaluating the effectiveness of safeguarding in the local area. The annual report should be submitted to the Chief Executive, Leader of the Council, Local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board. The Durham LSCB annual report is also shared with LSCB partner agency senior management teams and the Children and Families Partnership.

Governance arrangements

The Local Authority and Corporate Director of Children and Adults Services in Durham hold a key responsibility in ensuring the LSCB is established and effective. Durham LSCB has a robust Governance and Memorandum of Understanding in place that forms the formal agreement between the board and all partner agencies.

The LSCB's role is to scrutinise local arrangements and it should therefore have a separate identity and an independent voice. It should not be subordinate to, nor subsumed within, other local structures in a way that might compromise it.

Chairing and Membership Arrangements

From April 2011 all LSCBs were required to appoint an independent chair of the Board and up to two lay members. The board continues to be chaired by an independent person and has one lay member and is actively looking to appoint a further lay member, recognising the valuable contribution they make to the wider work of the board in ensuring the public has a voice on the LSCB.

The LSCB has a broad membership from County Council Services, including Children and Adults Services, NHS Health Trusts, Probation, Police, Voluntary and Community sector, Schools and Colleges, Clinical Commissioning Groups and NHS England. The Lead Member for Children and Young People Services attends the Board as an observer.

All partner agencies are required to identify a representative at a sufficiently senior level who can fully represent their agency in Board decision making without the need to refer back to their organisation. They should be people with a strategic role in relation to safeguarding and promoting the welfare of children within their organisation and be able to:

- speak for their organisation with authority;
- commit their organisation on policy and practice matters; and
- hold their organisation to account.

The LSCB has a number of standing sub groups which have clear terms of reference and are commissioned to undertake detailed work specific areas of board business, reporting back to the LSCB on results and outcomes. These are:

- Policy and Procedures Sub Group
- Quality and Performance Sub Group
- Strategic Training Sub group
- Serious Case Review Monitoring Group
- Missing and Exploited Sub Group
- Child Death Overview Panel

Other Board business priorities can be managed through the operation of time limited task and finish group work. Such work can only be effectively completed if all agencies contribute the resources to each of these groups, ensuring appropriate representation.

The Board also has strong links with the Multi-Agency Public Protection Panel (MAPPA: Multi Agency Public Protection Arrangements) which focuses on the management of adults who pose a serious risk to vulnerable people and children.

The voice of Children and Young People

- The LSCB has established a link with *Investing in Children* to strengthen the voice and influence of children and young people in helping the Board to set its priorities and focus on issues that affect young people's safety and wellbeing. A young people's reference group is in place and they meet regularly with representatives of the Board.

Relationship with Children and Families Partnership

The LSCB's role is to ensure the effectiveness of the arrangements made by the partnership and individual agencies to safeguard and promote the welfare of children. Whilst the work of the LSCB contributes to the wider goals of improving the wellbeing of children, it has a narrower focus on safeguarding and protecting children. This fits with the vision of the CFP to ensure that 'All children, young people and families believe, achieve and succeed'

- The LSCB is not subordinate to nor subsumed within the Children and Families Partnership arrangements.

- The LSCB has a separate identity and an independent voice.
- The LSCB is able to challenge and scrutinise effectively the work of the Children and Families Partnership and partners.
- The LSCB forms a view of the quality of local safeguarding activity.
- The LSCB challenges organisations with an independent voice.
- The Children and Families Partnership is chaired by the Corporate Director of Children and Adult Services who is also a statutory member of the County Durham Health and Wellbeing Board.
- The Chair/Vice Chair of the LSCB is a member of the Children and Families Partnership, contributing to the Children, Young People and Families Plan (CYPFP) and undertaking actions within the plan.
- The LSCB have a working relationship to the Children and Families Partnership which is included in the governance structure.
- The LSCB annual report is presented to the Children and Families Partnership for information and the LSCB is involved and contributes to the development of the Children, Young People and Families Plan and has certain actions carried out by the LSCB.

Under Strategic Objective 3 in the CYPFP 'A think family approach is embedded in our support of families', the following actions will be led, or jointly led by the LSCB:

- Implement the Early Help Strategy to better support families who have additional needs.
- Implement the revised Working Together to Safeguard Children guidance with partners to ensure the most vulnerable children receive early help and support.
- Implement the sexual violence action plan which includes joint agency response to child sexual exploitation / sexual violence and children who go missing from home and care.
- Carry out Section 11 audits on an annual basis to ensure all services and functions have regard to the need to safeguard and promote the wellbeing of children and young people.
- Agree an inter-agency protocol for collaborative working and information sharing between agencies working with vulnerable children and adults

The LSCB interface arrangements are illustrated on page 22.

Relationship with the Health and Wellbeing Board

The Health and Social Care Act 2012, gives Health and Wellbeing Boards the overall strategic responsibility for assessing local health and wellbeing needs in the Joint Strategic Needs Assessment (JSNA) including safeguarding, and agreeing the Joint Health and Wellbeing Strategy.

Statutory organisations working with children and young people have a responsibility to ensure that they are safeguarded from harm. The Health and Wellbeing Board are sighted on the work of the Local Safeguarding Children's Board to ensure an awareness of forthcoming priorities to ensure an effective working relationship is maintained between both Boards.

This fits with the vision of the Health and Wellbeing Board to 'Improve the health and wellbeing of the people of County Durham and reduce health inequalities'

Under strategic objective 5 in the Joint Health and Wellbeing Strategy 'protect vulnerable people from harm' the following action will be led by the LSCB:

- Work in partnership to support vulnerable adults and children at risk of harm and work to stop abuse taking place.

The LSCB will need to link effectively with the Health and Wellbeing Board, including the Corporate Director of Children and Adults Services and the Director of Public Health County Durham, in order to inform and draw from the Joint Strategic Needs Assessment (JSNA) and the annual report of the Director of Public Health County Durham.

The Health and Wellbeing Board will ensure that the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy recognise and take account of children's' safeguarding issues.

The Health and Wellbeing Board has an interest in the work of the LSCB to ensure it remains sighted on its effectiveness and interfaces, in order to provide assurance for its work, however, there is no legal responsibility to hold the LSCB to account.

The LSCB should not be subordinate to or subsumed within local structures that might compromise its separate identity and voice. There needs to be a clear distinction between the roles and responsibilities of the LSCB and the Health and Wellbeing Board, to ensure the maximum effectiveness of both.

The annual report of the Local Safeguarding Children Board is shared with the Health and Wellbeing Board to ensure priorities are shared and understood.

Relationship with the Safe Durham Partnership Board

The Safe Durham Partnership Board is chaired by the Corporate Director of Children and Adult Services who is also a statutory member of the County Durham Health and Wellbeing Board.

A member of the Local Safeguarding Children Board sits on the Safe Durham Partnership Board.

Protecting Vulnerable People from Harm is a priority of the Safe Durham Partnership. The vision of the Safe Durham Partnership Plan is that 'every adult, child and place in County Durham will be, and will feel, safe'.

The Safe Durham Partnership will receive a copy of the annual report of the Local Safeguarding Children Board to ensure priorities are shared and understood.

Regulatory bodies
The Local Safeguarding Children Board is not accountable to or monitored by a Regulatory Body.

Inspection Arrangements
The Ofsted Single Inspection Framework (SIF), published on 7th November 2013, brings together an inspection framework for child protection, services for looked after children and care leavers, and local authority fostering and adoption services. It replaces the previous inspection frameworks and includes the Local Safeguarding Children Board.

Each judgement will be graded as: outstanding, good, requires improvement or inadequate, as will overall effectiveness. The overall effectiveness of the Local Safeguarding Children Board will be judged on the same four-point scale.

Serious Case/Child Death Review /Incident Reviews
The LSCB is responsible for undertaking Serious Case Reviews (SCR) of children's cases where abuse is a factor and Child Death Reviews of all deaths of children in accordance with statutory guidance

The increased leadership from CCGs has led to an increased focus on serious case reviews and domestic homicide reviews in health. Serious Case Reviews (SCR) must be carried out when a child dies and abuse is known or suspected to be a factor in the death. The LSCB must also consider holding a SCR when a child sustains a potentially life-threatening injury or serious and permanent impairment through abuse or neglect. Such consideration must also be given in cases where a child has been seriously harmed as a result of sexual abuse and in cases of parental domestic homicide

The LSCB undertake reviews of serious cases and advise the local authority and Board partners on lessons to be learnt. The LSCB also has a well-established programme of seminars to disseminate findings and outcomes to managers and practitioners. The outcome of a serious case Review is published on the LSCB website.

The findings of a SCR are taken into consideration by Ofsted as part of their inspection of local safeguarding arrangements.

The LSCB also carry out multi-agency Learning Lesson Reviews where the criteria for a SCR are not met but it is considered there are lessons to be learned. These reviews involve single agency 'Round Table' reflective discussions with those involved with the case and a multi-agency workshop to take forward the action planning and learning.

Child Death Reviews
From 1 April 2008, the LSCB acquired compulsory functions regarding all child deaths. Durham and Darlington have joined together into a single Child Death Review Panel to carry out this function which includes collecting and analysing information about the deaths of all children normally resident in County Durham and Darlington with a view to:

- Identifying any matters of concern including any case giving rise to the need for a SCR.

- Identifying any general public health or safety concerns arising from the deaths of children.

This panel is presently chaired by an independent chair who is a Consultant in Public Health Medicine.

Distinction between commissioning roles, directly delivered services and purchased/externally commissioned services

The LSCB do not commission or deliver services other than the delivery of Safeguarding Training and the commissioning of independent persons to write Serious Case Review overview reports.

Safeguarding Adults Board (SAB)

Statutory responsibilities

Safeguarding Adults is a shared responsibility and a high priority for all agencies working in County Durham. The Government's 'No Secrets' guidance (2000) required Local Authorities to set up an inter-agency framework between statutory agencies to facilitate joint working to safeguard adults. The Safeguarding Adults Framework of Standards (ADASS 2005) later endorsed this guidance by setting out good practice standards to be followed by Safeguarding Adults Boards (SAB). Following the review findings of 'No Secrets' in 2009, the Law Commission recommended Safeguarding Adults Boards should be placed on a Statutory footing. The Care Act, due to be implemented in 2015/16 has placed SABs on a statutory footing. This will give the board a clear basis in law for the first time and will strengthen the existing arrangements that are in place.

The SAB in County Durham is chaired by the Head of Adult Care. It is supported by three thematic sub groups, focussing on Performance and Quality; Policy and Practice; Communication, Engagement and Training

The main aims of the SAB are:

- To safeguard and promote the welfare of adults at risk in County Durham through inter-agency collaboration
    - The SAB safeguards and promotes the welfare of adults at risk in County Durham through inter-agency collaboration and co-ordinates the safeguarding activity undertaken by each organisation represented on the SAB. The SAB also gives strategic direction to partner agencies and organisations across County Durham in relation to safeguarding activity.
- To coordinate the safeguarding activity undertaken by each organisation represented on the board
- To ensure the effectiveness of what is delivered by each organisation for that purpose
    - The SAB ensures the effectiveness of what is done by each organisation in relation to Safeguarding Adults activity.
- To promote public confidence in safeguarding systems and ensure human rights are balanced with protecting the public from harm
    - It promotes public confidence in safeguarding systems within County Durham and ensures human rights are balanced with protecting the public from harm.
- To understand the nature of adult abuse and foster strategies that reduce incident and effect
- To give strategic direction to partner agencies and organisations across County Durham in relation to safeguarding activity

Functions

Thresholds, policies and procedures

The Policy and Practice Sub Group of the SAB is responsible for developing and implementing inter-agency Safeguarding Adults policies and procedures across County Durham, and establishing thresholds for intervention.

Currently, the threshold for safeguarding adults is met when a person is suffering harm or exploitation and is likely to have eligible social care needs, and where abuse cannot be ruled out.

Training
The SAB has agreed to ensure that the safeguarding adults policy and accompanying procedural guidance are available to, and understood by, the widest possible audience.

- The Board therefore oversees a Communications, Engagement & Training sub group, which addresses all multi-agency safeguarding adults related workforce development and training issues, as well as communications and raising awareness. The remit of this group is to build and oversee the implementation of a safeguarding adults workforce development strategy that is jointly and appropriately resourced;
- Ensures that multi-agency training meets relevant national occupational standards for each of the target groups (e.g. National Qualifications Framework/Learning Disabilities Awards Framework, Post Qualifying Social Work Award, NHS Knowledge and Skills Framework).
- Encourages all partner agencies to engage in inter-agency training that is designed and delivered on behalf of the SAB to ensure required standards are fulfilled.
- Oversees communications with the public and organisations in County Durham. Its role is to highlight the need to safeguard adults at risk and raise awareness of how this can be achieved.
- Is responsible for overseeing communications with the public and organisations in County Durham. Its role is to highlight the need to safeguard adults at risk and raise awareness of how this can be achieved.

Quality Assurance, Monitoring and Evaluation
The Performance and Quality Sub Group is responsible for monitoring and evaluating safeguarding activity across partner agencies and is essential to improving practice.

Safe recruitment, management and supervision of people who work with adults at risk:
The SAB is committed to working towards ensuring that staff and volunteers within each of the statutory partner agencies along with the wider social care and health community meet jointly agreed safeguarding competency requirements - based on national occupational standards - appropriate to their individual roles.

The Care Quality Commission has representation at the SAB. The Commission is involved in safeguarding adults activity where there is concern that an adult who uses a regulated service is or may be suffering from abuse.

Investigation of allegations concerning people working with adults at risk:
It is now a criminal offence for anyone who has been barred by the Disclosure and Barring Service (The CRB and ISA merged to become the DBS) to work or apply to work with vulnerable adults in a variety of regulated and controlled activities.

Participating in planning and commissioning
The Safeguarding Adults Board and its sub groups will be required to participate in the local planning and commissioning of services for Adults at risk ensuring they take safeguarding adults into account.

DCC's Children and Adults Commissioning Service work very closely with Safeguarding Practice Officers to ensure providers and services are safe and compliant with agreed standards and contracts. Safeguarding Practice Officers form a small integrated team consisting of personnel from social work and occupational therapy professions. They work closely with dedicated safeguarding personnel employed by the two CCGs in County Durham.

Commissioning staff also have a responsive approach to contributing to Executive Strategy Meetings.

Annual Report
The SAB produces and publishes an annual report on the effectiveness of safeguarding and promoting the welfare of adults at risk in the local area.

The Care Act 2014 states that every SAB must send a copy of its annual report to:

- The Chief Executive and leader of the local authority;
- The local policing body;
- The Local Healthwatch;
- The Chair of the Health and Wellbeing Board

Governance arrangements
The SAB was formed to improve the inter-agency activity associated with protecting 'adults at risk'. The accountabilities, responsibilities and authorities of the 'parent' organisations remain unaltered in terms of their legal, statutory and public accountabilities and responsibilities. Delegating responsibility for these actions to the Safeguarding Adults Board does not negate individual agency authority.

The Safeguarding Adults Board has a role in co-ordinating and ensuring the effectiveness of local individuals and organisations work to safeguard Adults at risk, it is not accountable for their operational work.

Each member of the Board retains their own existing lines of accountability for safeguarding and promoting the welfare of Adults at risk by their services. The SAB does not have a power to direct other organisations. However it has a clear role in terms of leadership and is able to question partners in relation to seeking assurance of their ability to deliver a robust safeguarding framework.

Chairing and Membership Arrangements

Schedule 2 of the Care Act specifies that members of an SAB must include at least the local authority that established it, the NHS clinical commissioning group and the chief officer of police. Core SAB members can decide who else should be a member, such as housing authorities or provider organisations. SABs will be required to produce a safeguarding plan, progress on which they must report annually.

The Board is currently chaired by the Head of Adult Care and is resourced by allocated staff within the Safeguarding Adults Unit in Children and Adults Services, Durham County Council. The SAB is in the process of recruiting an independent chair jointly with the LSCB.

NHS England and Clinical Commissioning Groups are key board partners on the SAB. The NHS England Area Team do not have direct attendance at SAB, however CCG board nurses represent the interests of the area team.

Members of the SAB should be people with a strategic role in relation to safeguarding and promoting the welfare of adults within their organisation. They should be able to:

- speak for their organisation with authority;
- commit their organisation on policy and practice matters; and
- hold their organisation to account.

Board members will have the delegated responsibility and authority from their agencies to make decisions in the following areas:

- Safeguarding Adults Board policy;
- Safeguarding Adults Procedures;
- Commitment of agencies' staff and time;
- Commitment to Serious Case Reviews;
- Deployment of the current Safeguarding Adults Board budget;
- Identification of additional staff to be nominated to sub groups.

The SAB has a broad membership including County Council Services, CCGs (who represent the NHS England Area Team), NHS Health Trusts, Children and Adults Services, Probation, Police, Voluntary Services, Prison Service, Department of Works & Pensions, Care Quality Commission, and Victim Support.

Strong links are maintained between the SAB and the LSCB through a reciprocal membership agreement whereby the Head of Adult Care and the Head of Children's Services attend both Boards.

Relationship with Children and Families Partnership

The Children and Families Partnership and the SAB will ensure that any issues which overlap between the two through the Think Family approach will be shared accordingly and appropriately.

Relationship with Health and Wellbeing Board

The Health and Social Care Act 2012, gives Health and Wellbeing Boards the overall strategic responsibility for assessing local health and wellbeing needs in the Joint Strategic Needs Assessment (JSNA) including safeguarding, and agreeing the Joint Health and Wellbeing Strategy.

The Health and Wellbeing Board has an interest in the work of the SAB to ensure it remains sighted on its effectiveness and interfaces, in order to provide assurance for its work, however, there is no legal responsibility to hold the SAB to account.

The Health and Wellbeing Board receive information on the priorities and performance of the SAB to ensure effective working relationships are maintained and that vulnerable people are safeguarded from harm.

Under Strategic Objective 5 in the Joint Health and Wellbeing Strategy 'protect vulnerable people from harm' the following actions will be led by SAB.

- Provide protection and support to improve outcomes for victims of domestic abuse and their children
- Safeguarding children and adults whose circumstances make them vulnerable and protect them from avoidable harm

The SAB should not be subordinate to or subsumed within local structures that might compromise its separate identity and voice. There needs to be a clear distinction between the roles and responsibilities of the SAB and the Health and Wellbeing Board, to ensure the maximum effectiveness of both.

The SAB will need to link effectively with the Health and Wellbeing Board, including the Director of Public Health. In doing that, the SAB should both inform and draw on the Joint Strategic Needs Assessment.

The Care Act 2014 states that the annual report of the SAB is shared with the chair of the Health and Wellbeing Board to ensure priorities are shared and understood.

Relationship with Safe Durham Partnership Board (SDPB)

The Safe Durham Partnership Plan includes a strategic objective "Protecting vulnerable people from harm". Actions include:

- Prevent abuse from happening by challenging the attitudes and behaviours which foster it and intervening early to prevent it
- Take action to reduce the risk to people who are victims of these crimes and ensure that perpetrators are brought to justice
- Provide adequate support where abuse does occur and work in partnership to obtain the best outcome for victims and their families

The SAB interface arrangements are illustrated on page 23.

Regulatory bodies

The SAB is not subject to a Regulatory Body however, the Association of Directors of Adult Social Services places a duty on Local Authorities to create and maintain safeguarding adults boards with local oversight from the Corporate Director of Children and Adults Services. In Durham, SAB has some accountability to the Overview and Scrutiny Committee.

Inspection Arrangements

The Safeguarding Adults Board is accountable for its work to the public and partner agencies. Agreement from partner agencies is required for all work that has implications for policy, planning and the allocation of resources.

Under the Care Act, from April 2015 The Safeguarding Adults Board will have a statutory requirement to produce a strategic plan. The SAB currently produces an Annual Report in October each year. A business plan and training strategy are also agreed in April of each year.

The arrangements for inspection of the activity of the SAB are via peer-led inspections across local councils. The North East ADASS Safeguarding Adults Network has supported and enabled peer review and feedback.

Standards and probes for adult safeguarding peer reviews have been developed as part of a sector-led response in which Local Government and partners take responsibility for improvement. This process aims to use the skills and expertise of professionals, managers, people who use services, councillors and partners within the sector.

These standards have been developed in partnership by the:

- Local Government Group (LG)
- Association of Directors of Adult Social Services (ADASS)
- NHS Confederation
- Social Care Institute for Excellence (SCIE).

Locally, the findings from these peer-led inspections are then fed into the Council's Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, and prioritised as a corporate priority jointly by the Council and by the NHS.

Serious Case/Incident Reviews

As defined by the multi-agency policy, the SAB will take lead responsibility for conducting a SCR in respect of adults at risk who have been involved in a serious incident when serious abuse or harm has occurred; the process results in advice on lessons to be learned.

In addition, there are internal management reviews or investigations that may be undertaken by various organisations following a serious incident or high impact event. Where such an incident/ event involves a patient/ service user who may be considered to be an 'Adult at Risk' as defined by the Safeguarding Adult Procedures, a senior manager from Children and Adults Services should be invited to the management review or investigation. This includes:

- Incident Co-ordination Group
- Serious Untoward Incident
- Any other Co-ordination Group
- The Constabulary's Gold Group process - the first meeting determines who is invited.

This will ensure compliance with the Safeguarding Adults Inter-Agency Procedural Framework as full consideration will be given as to whether an Executive Strategy meeting or Serious Case Review should be commissioned.

Domestic Homicide Reviews

Although not a statutory requirement under the safeguarding adults agenda, there is a requirement under the Domestic Violence, Crime and Victims Act (2004) for Local Authorities, Police, Strategic Health Authorities, Probation and NHS Trusts to participate in Domestic Homicide Reviews (DHRs). Local arrangements in County Durham exist in terms of commissioning these reviews and this is the responsibility of the Safe Durham Partnership Board.

Distinction between Commissioning roles, directly delivered services and Purchased/externally commissioned services

The SAB does not commission or deliver services other than the delivery of adult safeguarding training – both to commissioners and providers of services.

The CAS Commissioning Service within DCC has strong links within the Safeguarding Adults Team and jointly addresses poor practice issues and contractual compliance issues.

Current government policies and drivers

There are three current pieces of legislation particularly relevant to safeguarding adults activity.

The Community Care Act (1990) is the primary legislation within adult care and sets out the primary duties of the local authority. This will be replaced by the Care Act in April 2015.

The Mental Capacity Act (2005) contains the core principles that: adults should be assumed to have mental capacity to make their own decisions unless it is proved otherwise; people should be supported to make their own decision before anyone concludes that they cannot make their own decisions; people have the right to make unwise or eccentric decisions; anything done for or on behalf of a person who lacks capacity must be done in their best interests; and that anything done for or on behalf of a person who lacks capacity must be the least restrictive of their basic rights and freedoms.

The Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) came into force in April 2009 as an amendment to the Mental Capacity Act, 2005. They were introduced to protect the human rights of people who lack capacity and authorise their care in a registered care home or hospital. Deprivation of Liberty Safeguards may only be sanctioned when it is in the best interests of the vulnerable person. DoLS is an important and developing safeguard of the right to liberty of some of the most vulnerable people in our community.

In April 2013, the responsibility for acting as supervisory bodies i.e. completing DoLS assessments and authorising or refusing DoLS applications in hospitals transferred from the Primary Care Trusts to local authorities. While Local Authorities already held this responsibility for care homes the addition of hospitals meant that they assumed sole responsibility for the administration of DoLS in all settings where it applies.

There are a number of recent policy developments, which are important within the safeguarding arena and will impact on service delivery in the future.

Between 2010/13 some major national policy developments took place which contribute to changes in adult care, these include:

- A vision for adult social care: Capable communities and active citizens
- Think Local, Act Personal
- Adult Social Care Law Reform - Law Commission
- Health and Social Care Act 2012
- The Care Act 2014

The Care Act will implement statutory Safeguarding Adults guidance that will identify the duties and responsibilities of the Local Authority and its statutory partners in undertaking safeguarding investigations. It will also lay out the role of Safeguarding Adults Boards, and in doing so will place them on a statutory footing.

CCGs responsibilities in relation to safeguarding children and adults:

- Have clear lines of accountability, robust governance and leadership for safeguarding within the CCG, including regular board reports.
- Take an active membership role of the Safeguarding Adults Board (SAB) and the Local Safeguarding Childrens Board (LSCB) including resources to support these groups. Directors of Nursing for both North Durham and Durham Dales, Easington and

Sedgefield CCG attend SAB and LSCB. Designated Professionals for both adults and children also attend the respective boards and associated sub groups.

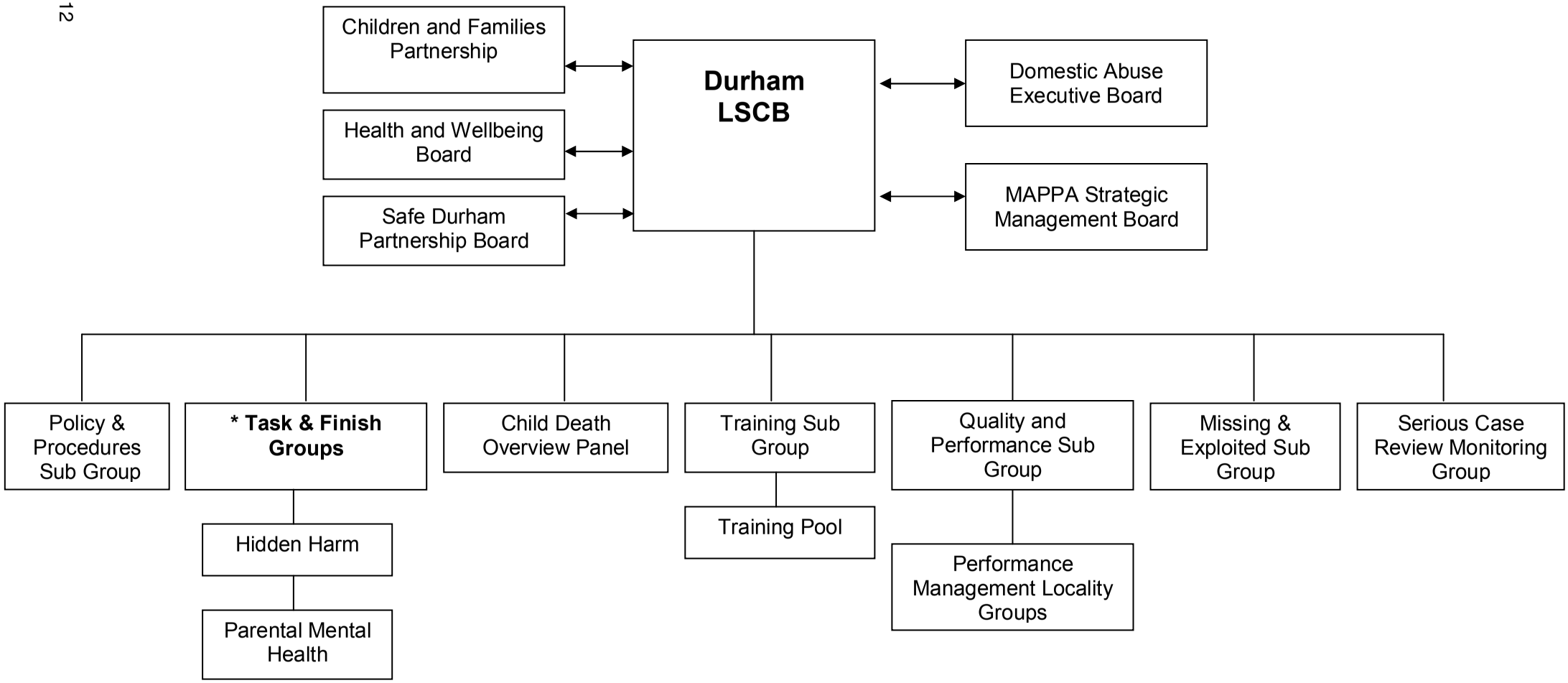
- Provide assurance that commissioned health services have appropriate arrangements in place to safeguard children and adults (i.e. policies, governance, leadership, training, partnership working, senior membership of safeguarding boards and safe recruitment processes). Contractual clinical quality review mechanisms, commissioning assurance visits, CCG safeguarding adult and children policies and multiagency policies are in place.
- Ensure information is shared with partner agencies (e.g. social care, police) to safeguard children and vulnerable adults. This will be achieved from commissioning support clinical quality, designated professionals and CCG leads.
- Ensure commissioned health services participate in Local Authority led case reviews should a safeguarding incident occur, disseminate learning and monitor implementation of improvement actions. This will be delivered through designated safeguarding children leads and safeguarding adult team
- Lead a local NHS investigation process if a safeguarding incident falls outside the remit of either of the safeguarding boards, but there is potential learning for health services. This will be delivered through designated safeguarding children leads and the safeguarding adult team
- In partnership with the Local Authority, provide assurance that health funded commissioned packages of care, both in and out of area, comply with the standards of the NHS contract. This is overseen by the CCG Director of Nursing and undertaken through the contracting of individual packages of care, supported by the clinical quality, continuing healthcare and safeguarding teams.
- The two Clinical Commissioning Groups in Durham have developed a 'hosting' arrangement for Safeguarding, representation on LSCB and SAB groups and designated named professional's representation. North Durham CCG hosts the safeguarding adult and children teams. A memorandum of Understanding has been signed by all parties.
- Support an effective multi-disciplinary response to failing services, especially those investigated under Executive Strategy processes as part of the Safeguarding Adults procedures. This includes support from the Medicines Management service in the undertaking of investigations. This is delivered through the designated professionals within the Safeguarding Adult Team under the direction of the lead CCG Director of Nursing.
- Provide representation at regular information sharing meetings held between Safeguarding Adults, DCC Commissioning Service and CQC to ensure continuity in the sharing of information. This is delivered through the designated professionals within the Safeguarding Adults Team under the direction of the lead CCG Director of Nursing.
- Provide full and active participation of health professionals in safeguarding children and adults' investigations as appropriate. This will be coordinated by the designated professionals and safeguarding adults leads under the supervision of the lead CCG Director of Nursing.
- Are members of the Quality Surveillance Group and safeguarding forums chaired by NHS England Area Team.
- CCG colleagues are statutory members of the Safe Durham Partnership and the Health and Wellbeing Board and are represented on the Children and Families Partnership.

Glossary of Terms

ADASS	Association of Directors of Adult Social Services
BASW	British Association of Social Workers
CCA	Community Care Act
CCG	Clinical Commissioning Group
CDDFT	County Durham & Darlington NHS Foundation Trust
CDOP	Child Death Overview Panel
CDRP	Child Death Review Panel
CIN	Child in Need
CP	Child Protection
CQC	Care Quality Commission
CQRG	Clinical Quality Review Groups
CRB	Criminal Records Bureau (Merged with ISA to become DBS)
DBS	Disclosure & Barring Service (ISA and CRB merged to create DBS)
DDES	Durham Dales, Easington, Sedgefield
DfE	Department for Education
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
ESM	Executive Strategy Meeting
ISA	Independent Safeguarding Authority (Merged with CRB to become DBS)
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked After Children
LADO	Local Authority Designated Officer
LAT	Local Area Team
LSCB	Local Safeguarding Children Board
MAPPA	Multi-Agency Public Protection Arrangements
MCA	Mental Capacity Act
NECS	North East Commissioning Support
NHSCDD	NHS County Durham & Darlington
OSC	Overview & Scrutiny Committee
PCT	Primary Care Trust
NHS	National Health Service

NSPCC	National Society for the Prevention of Cruelty to Children
SAB	Safeguarding Adults Board
SAFS	Safeguarding Adults Framework of Standards
SIF	Single Assessment Framework
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SDPB	Safe Durham Partnership Board
SHA	Strategic Health Authority
SPO	Safeguarding Practice Officer

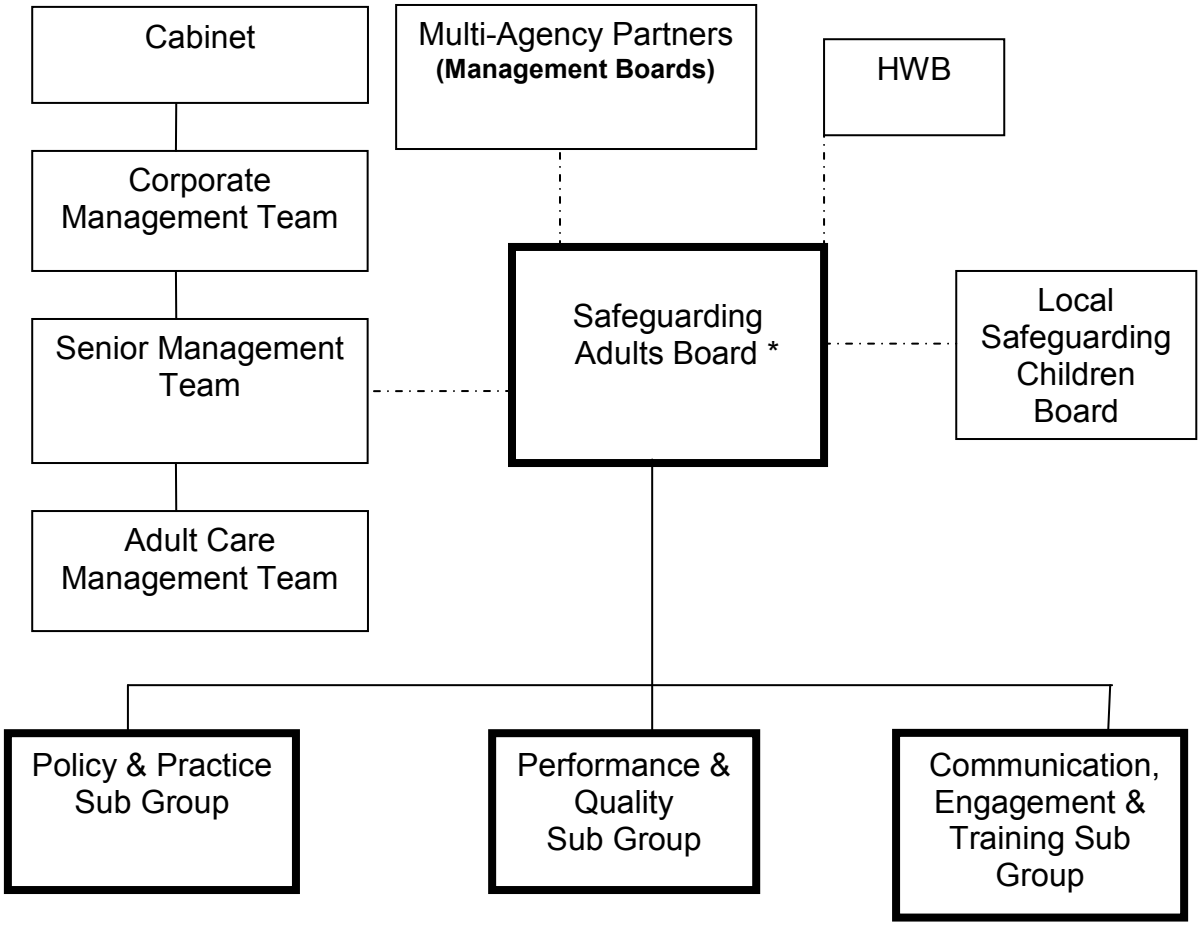
LSCB Interface Arrangements



*The task and finish groups are not standing groups, but are implemented when there is specific purpose.

SAB Interface Arrangements

----- Denotes linkage between chair/s members of respective groups.



* Safeguarding Adults Board undertakes actions within the Safe Durham Partnership Plan in relation to safeguarding adults.

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Health & Wellbeing Board

5 November 2014

County Durham Drug Strategy 2014-17

Report of Anna Lynch, Director of Public Health County Durham, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to present the Health and Wellbeing Board with the first County Durham Drug Strategy 2014-2017. (Attached at Appendix 2)

Background

2. The Government's Drug Strategy *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* was published in 2010. It focusses on three themes:

    - *Reducing Demand* – creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so;
    - *Restricting Supply* – making the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks; and
    - *Building Recovery in Communities* – build on the investment that has been made into treatment to ensure more people are tackling their dependency and recovering fully.

3. A multi-agency Strategic Drug Strategy Group was established to develop and drive forward its implementation. A stakeholder event was held in January 2014 with professionals, council members, service users and carers to identify priorities for 2014-2015. Stakeholders provided feedback on the draft objectives and identified areas for action for the forthcoming year. The final draft was circulated for consultation and comment and the organisations involved are detailed in the strategy document. In addition, the draft has been considered by the Safe Durham Partnership and the Children and Families Partnership and comments received were incorporated into the strategy.

4. The aim of the Strategy is *to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life, whilst minimising the impact on communities and families.*

5. The Strategy has 6 strategic objectives under the three themes of the Strategy:

    Theme: Preventing Harm

    Strategic objectives:

    - Increase awareness and understanding of drugs in order to reduce drug misuse across the population

- Have fewer people taking up drug use and to break the inter-generational path to drug misuse and dependency

Theme: Restricting Supply

Strategic objective

- Reduce the supply of drugs and number of drug related incidents impacting upon families and communities.

Theme: Building Recovery

Strategic objective

- Ensure recovery is understood and visible in the community.
- Support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug use.
- Involve and support families and carers living with drug related issues.

6. The Drug Strategy is underpinned by an action plan and performance framework. The summary of the action plan is detailed on Section 8 of the strategy. It is important to note that as this is the first County Durham drug strategy further key performance indicators will need to be developed. The group will consider a quarterly performance report as well as monitor progress against the action plan. Any key issues will be escalated to the Safe Durham Partnership, Health and Wellbeing Board and/or Children and Families Partnership as appropriate.

Recommendations

7. The Health & Wellbeing Board is asked to note the following:

- Receive a copy of the Drugs Strategy (2014-2017) for agreement.
- Note that the Drug Strategy has been subject to consultation and discussed widely and comments incorporated accordingly.

Contact: **Lynn Wilson, Consultant in Public Health, Durham County Council**
Tel: **03000 267680**

Appendix 1: Implications

Finance
No additional financial implications as a result of the implementation of the strategy.

Staffing
Existing staffing already members of the strategy group to be involved with the implementation of the strategy.

Risk
No risk identified in implementing the strategy.

Equality and Diversity / Public Sector Equality Duty
People with drug issues and their families are often identified as priory groups for support.

Accommodation
No implications.

Crime and Disorder
A key strand of the strategy is to tackle the supply of drugs, this is already led by Durham Constabulary.

Human Rights
None identified.

Consultation
The strategy was developed by a range of stakeholders and multi-agency consultation events were held which included service users as well as partner organisations.

Procurement
No additional procurement issues as a result of the strategy.

Disability Issues
Some people with drug issues also have co-morbidities with mental health (referred as dual diagnosis). These are identified as a priority group in the strategy.

Legal Implications
There are no legal implications.

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Altogether safer

Safe Durham Partnership

Altogether healthier

County Durham Health and Wellbeing Board

Altogether better for children and young people

County Durham Children and Families Partnership

County Durham Drug Strategy

2014 - 2017

Contents

Foreword

Welcome to the County Durham Drugs Strategy

I am delighted to provide the introduction on behalf of a range of partners to the first County Durham Drug Strategy.

Our vision is for all agencies and partners to work together to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life. This needs to be achieved whilst minimising the impact on our communities and families within County Durham. Whilst it is crucial to treat drug misuse, we also need to reduce the number of people taking drugs in the first place, and do this whilst tackling the drugs trade. In line with the Government's *Drug Strategy (2010) Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* our strategy sets out a clear and ambitious vision with recovery at its heart.

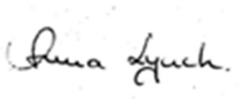
The purpose of our strategy is to provide a framework that support and enables the active contribution of all partner agencies. Partners in County Durham are committed to working at a local level to tackle drug misuse across the county and to support the delivery of the national strategy in our communities.

The Drug Strategy for County Durham was developed by the drug strategy Development Group comprising key partners, service users and carers. It is based on the comprehensive identification of needs and identifying evidence based practice to ensure the needs of individuals, families and communities are safeguarded.

We are committed to working together to make a real difference to our communities in County Durham. Drug misuse is a serious issue not only to the health and wellbeing of the individual that is affected but that of their families and the wider community. Tackling drug misuse requires a coordinated approach across a whole range of services including Education, Health, Social Care, Youth Offending, Probation and the Police. Individuals and the wider community also have a role to play in reducing and preventing drug misuse.

The strategy aims to build a healthier, more productive and resilient society which supports recovery from dependency; promotes health and wellbeing and challenges health inequalities.

We hope that together we can make a difference to the lives of our communities across County Durham. Comments and feedback on the strategy are very welcome and will support the monitoring of the action plan.



Anna Lynch
Director of Public Health, County Durham

1. Executive Summary

Vision: ***County Durham is committed to preventing harm, restricting supply and sustaining a future for individuals to live a drug free and healthy life, whilst minimising the impact on communities and families***.

	Objectives	Examples of Key Actions for 2014/15
Preventing Harm	Increase awareness and understanding of drugs in order to reduce drug misuse across the population	• Develop a social marketing plan to raise awareness about the harms of drugs • Work with schools and families to promote awareness of the risks associated with drug misuse • Gain a better understanding of the needs around New Psychoactive Substances (NPS). • Support schools and colleges in the delivery of drug education and ensure the development and implementation of drug policies
	Have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency	• Ensure the delivery of Prevention Champions Training to drug and alcohol staff • Involve and support young people, families and carers (including young carers) living with drug related issues in order to break the cycle of drug misuse. • Strengthen the pathway between Children and Family Services and specialist drug and alcohol services to ensure vulnerable families and children are supported with their substance misuse and related problems.
Restricting Supply	Reduce the supply of drugs and number of drug related incidents impacting upon families and communities	• Improve the quality of data collection to understand the full impact of drugs on health, crime, offending and re-offending • Increase public reassurance and reduce the fear of drug related crime. • Create a forum to debate the decriminalisation of drug users' to ensure a shared County Durham response. • Tackle the supply chain within HMP System by ensuring the supply and demand strategy is fully implemented
Building Recovery in our communities	Ensure recovery is understood and visible in the community	• Further develop a recovery community in County Durham, including HMPS which celebrates and promotes recovery. • Develop a communications plan for promoting the Community Drug Service (CDS) and recovery community in County Durham • Further develop the work on recovery including recruiting, training and supporting Ambassadors and peer mentors
	Support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse	• Undertake a review of community based drug and alcohol specialist treatment service • Ensure services are attractive and accessible to underrepresented groups, e.g. pregnant women and veterans • Commission and deliver effective treatment and recovery services in both community and criminal justice settings in line with national guidance. • Explore joint commissioning opportunities between drug, alcohol and mental health services.
	Involve and support families and carers living with drug related issues	• Commission family support services and ensure the needs of carers are met. • Improve access to family support for offenders.

2. Drug Strategy: Vision and Objectives

The Vision:

County Durham is committed to preventing harm, restricting supply and sustaining a future for individuals to live a drug free and healthy life, whilst minimising the impact of drugs on communities and families.

Objectives:

Preventing Harm

1. Increase awareness and understanding of drugs in order to reduce drug misuse across the population.
2. Have fewer people taking up drug use and to break the inter-generational path to drug misuse and dependency.

Restricting Supply

3. Reduce the supply of drugs and number of drug related incidents impacting upon families and communities.

Building Recovery in Communities

4. Ensure recovery is understood and visible in the community.
5. Support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse.
6. Involve and support families and carers living with drug related issues.

3. Definitions

Drugs: Within this strategy the term 'drugs' is taken to mean those substances that are controlled under the Misuse of Drugs Act 1971, and medicines regulated under the Medicines Act 1968. This strategy does not include reference to alcohol or tobacco, although it is acknowledged that there should be a greater alignment of approaches to address all drug misuse. This strategy will also allow for the inclusion of the misuse of a wide range of products such as gases, glues and aerosols (also known as Volatile Substance Abuse, or VSA).

In addition to this there is emerging evidence that people are taking new psychoactive substances instead of or as well as other drugs and that this is increasing. New psychoactive substances (NSPs) are drugs which are not currently controlled under the UK's Misuse of Drugs Act 1971, but which mimic the effects of illegal drugs. Most of these substances have never been tested for use by humans and the immediate risks they pose or the long term damage they are doing, are often not immediately apparent. It is due to this changing profile of drug use across the UK and County Durham that this strategy will include these new psychoactive substances within the term 'drug'.

In the UK, there are no clear recommendations for daily caffeine limits, either for children or adults. The British Soft Drinks Association recommends labelling energy drinks as not suitable for children or pregnant women. However, these drinks are widely available and accessible to children and young people. There have been concerns about the amount of caffeine consumed by young children particularly in soft drinks and chocolate. Although much of the evidence around high caffeine drinks and young people is anecdotal, through consultation with our stakeholders this concern was raised and will therefore be included in the strategy to be further explored.

Recovery: The term 'recovery' in the context of this document has been defined by County Durham Ambassadors. Ambassadors are ex drug treatment service users, are currently drug and crime free and have undergone training as volunteers. Ambassadors advocate, offer guidance and provide support for service users currently still in treatment. They listed some key principles and thoughts around what 'recovery' means to them:-

- Design for a new way of life
- Sense of well-being
- Different for everyone but abstinence is preferred
- Freedom and peace of mind
- Hope
- A journey
- Giving something back to the community

4. Policy Drivers

4.1 National Policy Drivers

The *Misuse of Drugs Act 1971* categorises drugs (or 'controlled substances') according to their perceived harmfulness and makes their 'production, supply and possession' illegal except in clearly defined circumstances, as set out in the *Misuse of Drugs Regulations 2001*. This is the primary legislation for the United Kingdom and came fully into effect in 1973.

Whilst much of this Act consolidated earlier legislation, it introduced some important changes, which included the setting up of the Advisory Council on the Misuse of Drugs (ACMD), the concept of irresponsible prescribing and it also introduced the term "controlled drugs". Historically, there has been very little movement of drugs between the three classes since the Misuse of Drugs Act was introduced in 1971 and this has led to prolonged disagreements over whether certain drugs have been classified correctly according to their relative harms.

Establishing a class system necessarily means there will be a class of drugs deemed more harmful than the lower class of drugs. The drugs in the lower class(es) still present significant risk. It is important that within this strategy it is clearly understood that every drug within the classification system presents significant harms and that misusing or illegally supplying those drugs is a serious matter.

The government's ***Drug Strategy (2010) Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*** was published in 2010 and focusses on 3 themes:

> *Reducing Demand* – creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so;
>
> *Restricting Supply* – making the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks; and
>
> *Building Recovery in Communities* – build on the investment that has been made into treatment to ensure more people are tackling their dependency and recovering fully.

The strategy signifies a fundamentally different approach to preventing drug use, putting more responsibility on individuals to seek help and calling on those involved in tackling the issue to look at wider issues such as employment, offending and housing. As well as addressing the traditional drug use, it also warned about dependency on prescription drugs and New Psychoactive Substances. This reflects the changing nature of drug use over the last few years.

In September 2012, the Department for Education (DfE), jointly with the Association of Chief Police Officers (ACPO), published its non-statutory ***Drug Advice for Schools (2012)*** to address the twin approach of delivering quality drug education and having a clear disciplinary approach to drug related problems within schools.

The Health and Social Care Act (2012)

This Act strengthens Health and Wellbeing Boards to provide democratic legitimacy by bringing together locally elected and accountable councillors, Directors of Adult Social Services, Children's Services, Public Health, Clinical Commissioning Groups (CCGs) to work together to improve the health and wellbeing of their local population and reduce health inequalities. The Act also gave responsibility for the commissioning of specialist community based drug and alcohol services to local authorities.

Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders. Governments Response (2011)

The government identified a key priority to get offenders off drugs and alcohol for good; address offenders' mental health problems; get offenders into work; and reduce barriers to resettlement. There has been a move to a system focused on recovery which does not maintain heroin users on prescription alternatives such as methadone, unless absolutely necessary. Drug Recovery Wings are being piloted – focused on providing short-sentenced, drug-dependent prisoners with continuity of treatment between prison and the community.

The Police Reform and Social Responsibility Act (2011)

The Police Reform and Social Responsibility Act replaced the Police Authority with a Police and Crime Commissioner (PCC). The PCC will play a full role in tackling drug and alcohol problems.

Transforming Rehabilitation: A Strategy for Reform (2013)

This strategy sets out how the Government will transform the way they rehabilitate offenders, to make progress in driving down reoffending rates. Overall reoffending rates have barely changed over the last decade and the same faces come back through the system – almost half of all offenders released from custody in 2010 reoffended within a year. The reasons why offenders turn to crime vary widely. Unemployment and substance misuse rates are also high amongst offenders. *Transforming Rehabilitation* has these principles at its centre:

- offenders need to be supported 'through the prison gate', providing consistency between custody and community;
- those released from short-sentences, who currently do not get support, need rehabilitation if their prolific reoffending is to be brought under control;
- public protection is paramount, and the public sector must take the key role in keeping people safe;
- the voluntary sector has an important contribution to make in mentoring and turning offenders' lives around;
- local partnerships are key and bring together the full range of support, be it in housing, employment advice, drug treatment or mental health services.

Social Justice: Transforming Lives (2012)

This strategy sets out an ambitious new vision for supporting the most disadvantaged individuals and families in the UK. That vision is based on two fundamental principles.

First, prevention throughout a person's life, with carefully designed interventions to stop people falling off track and into difficult circumstances. This starts with support for the family – but also covers reform of the school and youth justice systems, the welfare system, and beyond to look at how we can prevent damaging behaviours like substance abuse and offending.

Second, the strategy sets out a vision for a 'second chance society'. Anybody who needs a second chance in society should be able to access the support and tools they need to transform their lives.

Serious and Organised Crime Strategy (2013)
This is a new strategy to deal with the challenges that are faced from serious and organised crime. Organised crime includes drug trafficking. The aim of this strategy is to substantially reduce the level of serious and organised crime affecting the UK and its interests. The strategy uses the framework that has been developed for counter-terrorist work and has four components: prosecuting and disrupting people engaged in serious and organised crime (Pursue); preventing people from engaging in this activity (Prevent); increasing protection against serious and organised crime (Protect); and reducing the impact of this criminality where it takes place (Prepare).

Guidance for local authorities on taking action against 'head shops' selling new psychoactive substances (NPS) (2013)
New psychoactive substances, also known as 'legal highs', are an emerging threat, both in the UK and worldwide. This guidance focuses on the criminal or civil offences that head shops may be committing, it is also highlights the importance of minimising the harms caused by these outlets and requires wider engagement with local partners. It advises of the need to engage with all the relevant partners to identify the issues of most concern, agree the most appropriate tools to tackle the unique local situation and construct a coordinated response.

4.2 Local Policy Drivers

This strategy will support the vision and engage with the challenges outlined in the County Durham Joint Health and Wellbeing Strategy and the Safe Durham Partnership Plan.

<u>County Durham Joint Health and Wellbeing Strategy 2014-2017</u>

The Health and Social Care Act 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 strategic objective 2 aims to reduce health inequalities and early deaths through:

• Implementation of the Drugs Strategy to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life, whilst minimising the impact of drugs on communities and families.

Safe Durham Partnership Plan 2014-2017

The Safe Durham Partnership is made up of 'responsible authorities' (police, council, clinical commissioning groups, fire service and probation service). The Partnership has a statutory duty to carry out an annual strategic assessment to identify its priorities. It also has a duty to develop and implement a Partnership Plan that describes how partners will work together to deliver those priorities in a way that reduces crime and disorder and combats substance misuse in County Durham. The new Safe Durham Partnership Plan will align with the Police and Crime Commissioner's Policing Plan and the Health & Wellbeing Strategy which both end in March 2017.

4.3 Linked local strategies

- County Durham Sustainable Community Strategy 2010-2030
- Council Plan 2014-2017
- County Durham Alcohol Harm Reduction Strategy 2012-2015
- County Durham Domestic Abuse Strategy 2012-2015
- County Durham and Darlington Dual Diagnosis Strategy 2014-2017
- County Durham Children, Young People and Families Plan 2012-2016
- County Durham & Darlington Sexual Violence Strategy 2011-2014
- Safe Durham Partnership Reducing Re-offending Strategy 2014-2017
- County Durham Homelessness Strategy 2013-2018
- County Durham Think Family Strategy 2012-15
- County Durham Public Mental Health Strategy 2014-2017
- County Durham Protocol for Working Together in the delivery of services to adults and children 2010
- Durham Local Safeguarding Children Board Neglect Strategy 2010
- Police and Crime Commissioners Plan 2013-2017
- North East Prisons Substance Misuse Strategy Document 2013- 2016

5. Drug Misuse in County Durham

5.1 Adult Substance Misuse Treatment Services

It is estimated that County Durham has 2,186 opiate and 526 crack using residents. The data also suggests that 62% (1,358) of the opiate users are injecting (Hay, G. et al, 2011). There is no prevalence data available for the use of non-opiate substances such as amphetamine and cocaine or for young person substance misuse. However, data collected locally gives us an idea of specific drug trends and problems as they occur.

Between 1st April 2012 and 31st March 2013, County Durham Community Drug Service (CDS) received 1,389 referrals from a variety of referral sources (see Table 1) for structured treatment relating to the use of opiate and non-opiate substances. This equated to 1,142 individuals, 227(19%) female, 915 (81%) male.

Table 1 – Source of referrals to County Durham Community Drug Service 2012/13

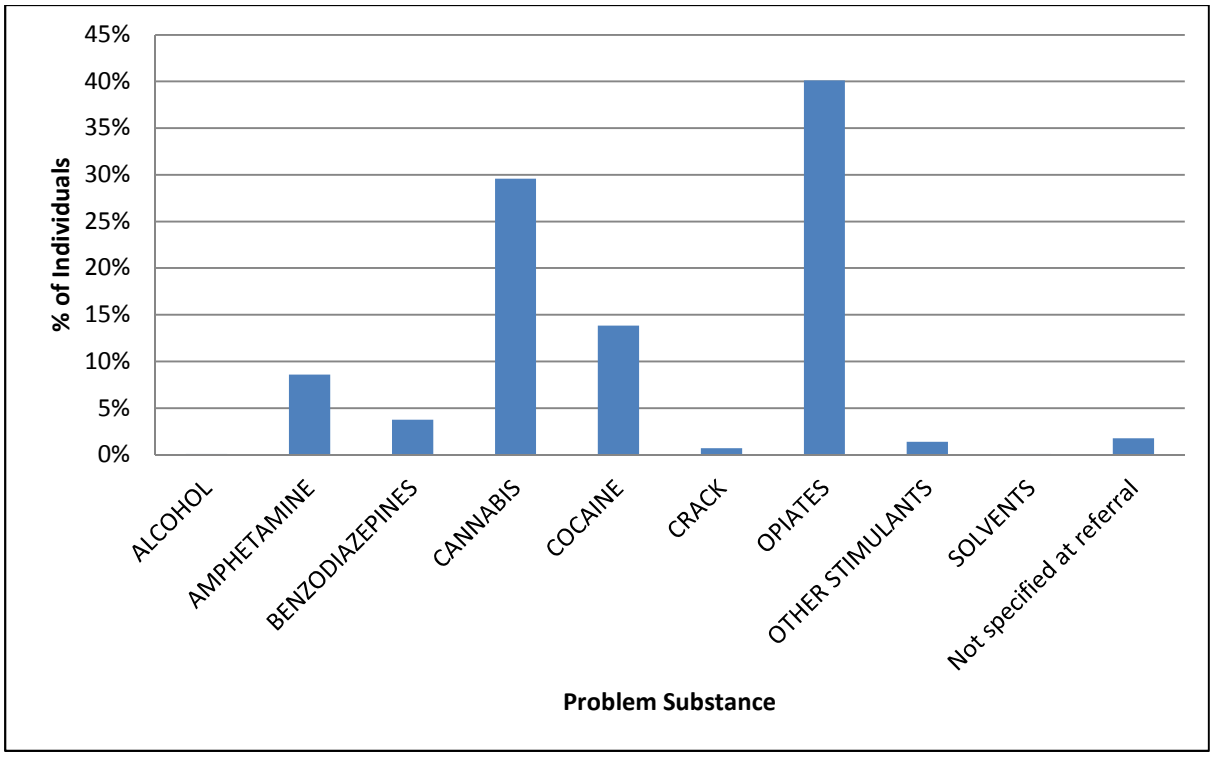
Referral Source	Number Referred	Number assessed	Engagement Rate
Hospital/A&E	24	7	37%
***Criminal Justice**	433	188	56%
Alcohol Service	21	14	82%
Friend/Family/other	45	34	87%
****Drug Service**	195	102	91%
GP	158	80	57%
Housing Provider	0	0	0%
Employment Service	7	3	60%
Mental Health Provider	21	12	67%
Self	457	308	81%
Social Services/ Children and Family services	18	10	67%
Other	75	46	81%

Data Source - POPPIE Referral report March 12 to April 13

***DIP referrals are included within the Criminal Justice category.**

****** Other drug services**

Graph 1 - Individuals referred to CDS by Substance - 2012/13



Data Source - POPPIE Referral report March 12 to April 13

Graph 1, shows the primary substance for each individual referred during the reporting period (April 2012-March 2013).

The age breakdown of the referrals shows that most individuals are aged between 18 – 34 years at the time of referral with a few outliers in the 65+ age group.

828 (70%) individuals referred to CDS in 2012/13 attended an assessment appointment.

688 (83%) of the individuals assessed between 1st April 2012 and 31st March 2013, received a structured intervention from the Community Drug Service.

1,902 individuals in total received a structured treatment intervention during 2012/13; 1,472 (77.4%) opiate clients and 430 (22.6%) non opiate clients. 261 individuals successfully completed treatment giving a 13.7% successful completion rate; 7.4% for opiates and 35.4% for non-opiates. Nationally the successful completion rate was 14.5%; 8.1% opiates and 40.1% non-opiates. County Durham is performing below the national average for successful completions.

5.2 Drug Related Deaths

Between 1st April 2012 and 31st March 2013 there were 13 deaths within County Durham highlighted as possible drug related deaths. The age of these individuals ranged from 18 to 48 years and 92% were male.

5.3 Dual Diagnosis

During 2012/13, the Community Drug Service received 21 referrals from mental health services for clients assessed as having a substance misuse problem. This equates to 1.4% of all referrals received by the service in 2012/13.

It is not possible to identify how people involved with mental health services have been assessed for substance misuse. However, a report produced to inform the County Durham Dual Diagnosis strategy suggests that 9% (166) of those accessing substance misuse treatment within 2012/13 reported dual diagnosis and that many of these were not referred via their CPN (Community Psychiatric Nurse) or mental health professional.

5.4 Substance Misuse reported in Primary Care (GPs)

Data based on information collected by GP's has been provided for 50% of surgeries within County Durham. The other half did not give consent to share within the time scale for the development of the strategy.

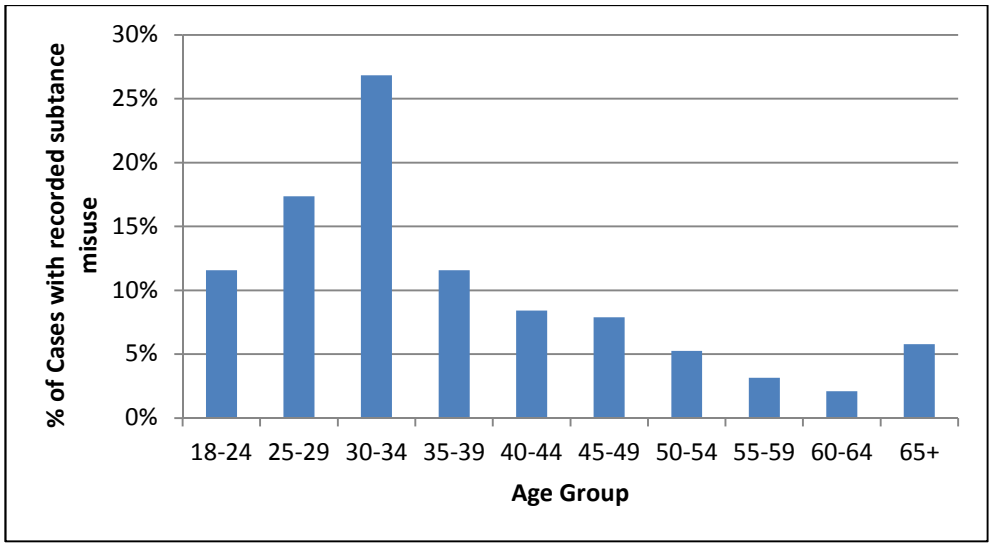
The data available identifies that GP's recorded 190 incidents of substance misuse issues against registered clients. During the same reporting period, 11% (158) of referrals made to CDS were received from GP's, which could suggest that 32 of the cases of recorded substance misuse did not lead to an onward referral to the CDS. The demographics of those identified through the GP data is as follows:

Table 2 - Gender breakdown of Substance misuse cases in Primary care

	% of cases
Male	71%
Female	29%

Data Source – Primary Care data (March 12 to April 13)

Graph 2 - Recorded Substance Misuse in GP data by age –March 2012-April 2013



Data Source – Primary Care data (March 12 to April 13)

The most prevalent age group identified above is between the ages of 30 – 34years.

5.5 Substance Misuse reported in emergency ambulance call outs

Northeast Ambulance Service (NEAS) recorded 72 call outs where drugs use/abuse have been the main factor. In 37 (51%) of these cases, Naloxone was required to be administered to counteract an opiate overdose.

The ambulance service does not refer directly to CDS but the majority of individuals given Naloxone would be taken to A&E. CDS received 24 referrals from A&E and Hospital wards between April 2012 and March 2013.

5.6 Substance Misuse related Hospital Admissions

There were 521 drug related hospital admissions within County Durham during 2012/13. 386 (74%) of the hospital admissions were emergency admissions, 98 (19%) elective admissions, 7% of admissions were classified as “other”.

Table 3 - Drug related hospital admissions by area of residence.

	Number of Drug related hospital admissions	%
Durham and Chester-le-Street	100	19.2%
Derwentside	104	20%
Durham Dales	91	17.4%
Easington	125	24%
Sedgefield	85	16.3%
Unknown	16	3.1%

Data Source – Hospital Episode data – CDDFT (March 12 to April 13)

5.7 Housing

It was reported that 291 individuals presented to Housing Solutions within County Durham between April 2012 - March 2013 who were identified as having substance misuse issues. Housing Solutions provide housing for those considered in priority need and also homelessness support and advice.

5.8 Employment

The referral data taken from the CDS patient records for 2012/13 suggest that 7 referrals were received from employment agencies, 5 from Job Centre Plus. Job Centre Plus have recorded that they made 2 referrals to Drug services during 2012/13 which highlights some data discrepancies.

5.9 Carers

In 2012/13, 93 individuals who cared for people with substance misuse problems were referred to Liberty from Addiction (Liberty from Addiction work with and support carers and families of drug and alcohol misusers). The referrals were made from a range of sources, including GP surgeries, Community Health Teams and self-referrals. All of these referrals were effectively engaged by Liberty from Addiction and received a care plan. 43% of referrals were relating to alcohol misuse, 57% drug use. The drug types recorded were:

- Cannabis
- Cocaine
- Benzodiazepines
- Illicit use of Methadone and Subutex
- Crack
- LSD

5.10 Safeguarding Children

In 2012/13, it was reported that 23% of the children who became subject of an initial child protection plan, became so as a result of parental drug use. 20% of children who became the subject of a review were attributed to parental substance misuse.

5.11 Stronger Families

Families with a substance misuse issue are identified through the nomination process which is based on informed consent to share information and engage with the multi-agency support offered. This is not separated between drug or alcohol issues, but is identified collectively.

During 2012/13 (year 1 of the programme), 2.8% of families (10 out of 357) were identified as having a substance misuse issue.

As of 10 December 2013 (2013/14), 19.4% (173 out of 893 families) were identified as having a substance misuse issue. This change is likely to be as a result of significant increases in the use of the family nomination process by partner agencies, as the programme has developed throughout 2012/13.

Please note that as the identification of families with a substance misuse issue relies upon the family divulging this to the lead professional or another professional before they are nominated, it is likely that the substance misuse needs of the 'troubled families' cohort is somewhat under-reported.

5.12 Crime and Disorder

Durham Constabulary has carried out a public consultation exercise across the force area. A total of 942 members of the public completed a Priority Questionnaire. The Constabulary gathered 2,102 comments as to what they think the police should be tackling within their local area. Listed below are the findings:

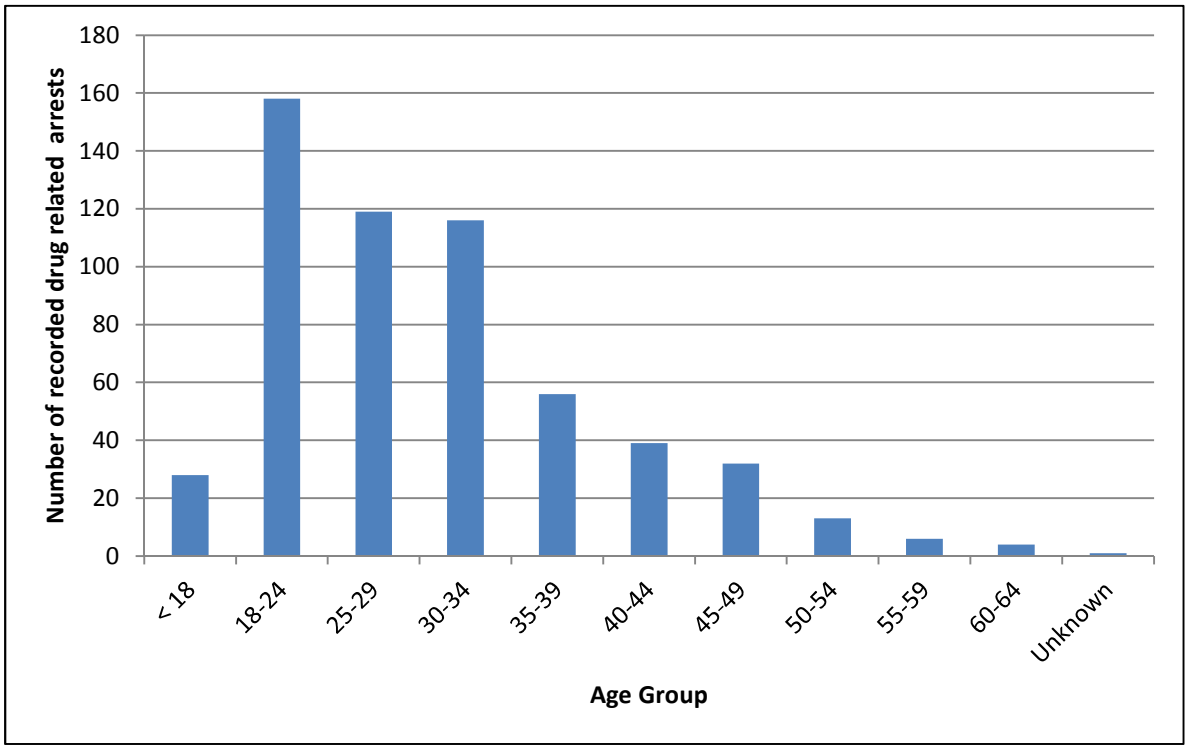
Table 3 - Top 3 issues the respondents rated highest within the priority questionnaire.

Issues to be tackled by police	Count	Percentage
Anti-Social Behaviour (ASB)	**395**	**19%**
Youths (Including Underage Drinking)	**237**	**11%**
Drugs (dealers and users)	**212**	**10%**

Durham Constabulary Data – Perception Survey results (March 12 to April 13)

In County Durham, between 1st April 2012 - 31st March 2013 Durham Constabulary recorded 2,050 drug related incidents. This equates to 1.4% of all incidents recorded within that time period.

Graph 3 - Drug Related arrests by age – April 2012 – March 2013



Durham Constabulary Data – drug related arrest (March 12 to April 13)

Graph 3 shows the age breakdown for drug related arrests in 2012/13. The average age of individuals arrested for drug related offences was between 18 to 34 years old. The majority were male (86.4%).

232 (40.6%) of the drug related offences recorded resulted in the individual receiving a simple caution. 136 (24%) were charged and bailed to court, 37 (6.5%) charged and detained for court. 94 (16.4%) individuals were released with no further action.

8 occurrences for "drug driving" were recorded in addition to 1,249 drug seizures by police officers. The primary substances recorded within the drug seizure data were identified as cannabis, amphetamines and cocaine.

5.13 Drug Intervention Programme (DIP)

During 2012/13, the Drug Intervention Programme (DIP) team in County Durham approached 5,208 people from within police custody or courts and referred 240 to the CDS. The DIP provides interventions for drug misusing offenders throughout their criminal justice journey.

79% of individuals approached by the DIP team refused to engage with services available. 80% of those approached within Police custody declined and 73% of those seen through the courts declined.

Within 2012/13, 251 referrals to CDS were recorded as coming via DIP and Arrest Referral routes. This suggests that the links between DIP and structured treatment services are strong. It also suggests that County Durham CDS received 96% of DIP referrals from the County Durham team. The other 4% may have been referred to County Durham CDS from DIP teams from other areas.

5.14 Substance Misuse in Prisons

Adult Prisons

Table 4 – New Receptions into Prison commencing Drug treatment 2012 - 13

	Number commencing Drug Treatment	% of new receptions
HMPYOI Deerbolt	122	14%
HMP Durham	1122	26%
HMP-YOI Low Newton	476	58%
HMP Frankland	20	6%

NDTMS (National Drug Treatment Monitoring System) Quarter 4 Establishment report (March 12 to April 13)

During 2012/13 1,112 individuals who were actively engaged in structured drug treatment within the prison estate were released. 547 (49%) of these individuals were referred to the Criminal Justice Intervention Team and/or a community treatment provider to continue their drug treatment in the community.

Of the 547 that were referred, 454 (83%) commenced structured treatment with a Community Drug Service somewhere within England and Wales; CDS received 244 referrals via a Prison/CARAT (Counselling, Assessment, Referral, Advice, Through-care) or Drug Intervention Programme during 2012/13.

The most prevalent problematic substances reported within each prison treatment population for 2012/13 is shown in Table 5. The information is based upon the number of individuals in treatment within 2012/13, reporting each substance as their main problematic substance.

Table 5 – Most prevalent problematic substances reported by clients in treatment within prison 2012 - 2013

	1st	2nd	3rd
HMPYOI Deerbolt	Cannabis	Alcohol	Amphetamines
HMP Durham	Heroin	Alcohol	Benzodiazepine
HMP-YOI Low Newton	Heroin	Alcohol	Benzodiazepine
HMP Frankland	Alcohol	Cannabis	Heroin

NDTMS Quarter 4 Establishment report (March 12 to April 13)

5.15 Young People Substance Misuse Treatment 2012-13

4Real is a substance misuse service designed specifically for people under the age of 18. The service is commissioned by Durham County Council.

During 2012/13, 151 referrals were made to 4Real for an intervention relating to their primary substance misuse. This equated to 57% of all referrals received by the service during 2012/13, compared with 43% for primary problematic alcohol use.

In total, 232 young people received a structured intervention from 4Real within the reporting period. Some of these individuals were referred and commenced treatment between April 2012 – March 2013, some commenced treatment prior April 2012. 133 (57%) of the young people in structured treatment between April 2012 and March 2013 successfully completed their treatment intervention and were discharged from 4Real.

Nationally 49.5% of young people receiving a structured intervention successfully completed their treatment. 4Real is performing above the national average in relation to successful completions.

5.16 Youth Offending Service

All young people pre and post court are assessed by County Durham Youth Offending Service (CDYOS). During this assessment the Case Manager determines the extent to which the young person's substance misuse, if any, is associated with the likelihood of further offending. The rating is on a scale from 0 to 4, with 0 being 'not associated at all' and 4 being 'very strongly associated' i.e. clearly and directly related to any offending.

Following this assessment, all young people, under the age of 14 who score 1-4, and all young people aged 14 and over who score 2-4, are subsequently screened using the

4Real Screening Tool, to determine the level of intervention required. If specialist treatment within the community (tier 3 intervention) or within a hospital setting (tier 4 intervention) is required, a referral is made to 4Real for specialist substance misuse intervention. If a brief advice, information and guidance (tier 1 or 2 intervention) is required in relation to their substance use, CDYOS will deliver this.

During 2012/13 65 young people (57 male and 8 female) were referred to 4Real by CDYOS for tier 3 and 4 interventions. The main substance used by 36 of these young people was cannabis. 25 of the young people used alcohol as their main substance and other drugs were used by the remaining 4 young people referred. 345 young people received a tier 1 or 2 intervention from CDYOS.

5.17 Children and Young Person's Secure Settings

Between January and December 2012, there were 189 new presentations in Hassockfield Secure Training Centre (STC). 144 (84%) required a structured intervention in relation to their substance misuse. The main problematic substances reported within the treatment population for this period was Alcohol, Cannabis and Nicotine. Heroin and other opiates were not high on the list of substances used by the Young People within this secure centre (9% of those in treatment reported heroin use).

Between April 2012 - March 2013, there were 72 new presentations to Aycliffe Secure Centre. 71 (92%) required a structured intervention in relation to their substance misuse. The main problematic substances reported within the treatment population for this period was Alcohol and Cannabis. 8% of the treatment population reported using Heroin.

5.18 Education - Drug and Alcohol Related Exclusions

It was reported, that between 3rd September 2012 and 30th July 2013 there were 2,657 exclusions from school issued in County Durham. 73 (2.7%) were attributed to drug and alcohol use.

Summary of Key Points

- County Durham has an estimated 2,186 Opiate and 526 Crack using residents, 62% of the opiate users are injecting.
- During 2012/13 there 1,389 referrals into the County Durham Drug Service(CDS) 457 were self-referrals into the (CDS)
- The most prevalent age group of referrals received by the CDS is 18-34 years
- County Durham is below the national average for those successfully completing treatment.
- During 2012/13 there were 521 drug related hospital admissions; 74% were emergency admissions.
- During 2012/13 23% of children, who became subject of an initial child protection plan, became so as a result of parental drug use.
- 10% of comments gathered by Durham Constabulary with members of the public prioritised drugs to be tackled in their local area.
- During 2012/13, Durham Constabulary recorded 2,030 drug related incidents and 1,249 drug seizures
- During 2012/13, 1,740 people who entered into the prison estate in County Durham commenced drug treatment.
- During 2012/13, 57% of young people successfully completed their treatment and the 4Real service is performing above the national average in relation to successful completions

6. Current Provision

This section outlines the current provision in County Durham. Due to the complex nature of drug use there are correlations between the three key objectives: preventing harm; restricting supply; and building recovery.

Commissioning Drug and Alcohol services locally

The responsibility for the commissioning of community based adult and young people's drug and alcohol services, including family support transferred to Local Authorities on 1st April 2013 as part of their new public health responsibilities. The Health and Justice (North East and Cumbria) Commissioning Team working as part of NHS England took over responsibility for all substance misuse services within the North East Prison Estate, including young people's secure estate. The Police and Crime Commissioner is also key to tackling drug problems at a force wide area.

6.1 Objective One: Preventing Harm

- *Increase awareness and understanding of drugs in order to reduce drug misuse across the population*
- *Have fewer people taking up drug use and to break the inter-generational path to drug misuse and dependency*

What are we doing in County Durham?

6.1.1 County Durham Youth Offending Service (CDYOS)

CDYOS is a statutory multi-agency partnership in Children and Adults Services, Durham County Council.

CDYOS works with young people aged 10-17 across the whole youth justice spectrum. This encompasses a whole range of work including anti-social behaviour referrals; provision of bail/pre-sentence services; pre court/out of court work; post court (ensuring the orders of the court are delivered); alternatives to custody (e.g. intensive supervision and surveillance); and working with young people in custody (both sentenced and remanded) and on release from custody. The service also works with the families of young people who offend to help them to support/address their son/daughter's behaviour. Restorative practice is a core element of all CDYOS work and the service has a statutory duty to work with and support victims of youth crime.

All young people are screened for substance misuse (alcohol and substances) using the national assessment tools. All case managers in CDYOS use the additional screening tool provided by 4Real if young people require triage.

The Service has implemented a range of specialist Offending Behaviour Programmes, including, substance misuse/alcohol.

6.1.2 4Real

4Real is the County Durham young person's drug and alcohol service. The overall aim of the service is to reduce the harm caused by drugs and alcohol to young people under

18, and to support their parents and carers. Helping young people achieve their potential and have better lives. There are two elements to 4Real, prevention (see below) and treatment (see page 29).

Prevention: Education workers provide specialist and bespoke input into schools, colleges and youth settings across the county offering age/key stage appropriate work with pupils in a variety of formats informed by the PHSEE (Personal, Social, Health and Economic Education) guidelines. The trainers offer a range of accredited and non-accredited courses to promote 4Real, the Community Alcohol Service and Community Drugs Service.

6.1.3 Community for Recovery

Funded by the Department of Health, Community for Recovery (www.communityforrecovery.org) is a new virtual support service for people misusing volatile substances (gases, aerosols, glues and other solvents), and for their families and friends. A web-hub at www.communityforrecovery.org offers information about volatile substance abuse, and the option to email or instant-message questions. The service also provides online counselling for those aged 18 and over who cannot currently access local substance misuse service support.

They also make referrals into local substance misuse support services.

6.1.4 FRANK

FRANK is the national drugs information and advice service provided by the Department of Health, the Home Office and the Department for Education. FRANK provides a universally accessible service for anyone wanting help, information or advice about any aspect of drugs. It is available 24 hours a day, 365 days a year. The service is free, confidential and operated by fully trained advisers. The service can be accessed through a number of channels including the helpline, the FRANK website, SMS, email and the FRANK BOT (an interactive service delivered via MSN messenger). Marketing has successfully raised awareness of the service and established FRANK as one of the most trusted source of drugs information amongst young people.

*Both FRANK and Community for Recovery resources, including leaflets are promoted and used within 4Real with clients, young people, parents and professionals.

6.1.5 Housing Solutions Service (HSS)

The Housing Solutions Service provides a holistic support and advice service enabling clients' needs to be assessed and met through prevention, housing options and the Council's statutory responsibilities.

The service assists all those in housing need, including those with multiple and complex needs. At a strategic level the service has developed a number of responses to assist those facing chronic exclusion from housing, including implementing a local response to the national No Second Night out Service for rough sleepers and a Making Every Adult Matter (MEAM) pilot for female offenders in Durham City.

6.1.6 Changing Lives – The Fells

An emergency direct access accommodation facility based in Chester le Street. The accommodation based service is staffed 24/7 and works with individuals on entry to identify problematic drug use and make referrals to specialist services.

6.1.7 County Durham Stronger Families Programme

In County Durham, the Stronger Families programme (known nationally as Troubled Families) aims for lasting change, resulting in families achieving positive outcomes. The programme aims to provide support to families in the County experiencing problems or difficulties, including those who:

- have children who don't attend school or who are excluded;
- are involved in antisocial behaviour or crime (including Domestic Abuse);
- are not in work; and
- result in high cost services such as families with children on the child protection list, families affected by parental substance misuse, domestic abuse and mental health problems.

This is part of a 'Think Family' approach to service design and delivery in County Durham, so that support can be provided to those families who need it. These are not new families but families who are often known to many services, which despite numerous interventions, over many years, their problems persist and are in many cases intergenerational.

The aim is to ensure that children, young people and adults who are parents or carers receive holistic, coordinated help and support at the earliest opportunity no matter which service they first enter. This involves services working together differently, utilising a 'think family' model, avoid duplication, maximise impact and deliver services that are genuinely designed around the needs of families.

6.1.8 Durham Constabulary Drug Education

Durham Constabulary has trained members of staff who deliver drug education across County Durham. This education is co-ordinated by a strategic lead within the partnerships department.

There are several mechanisms that Durham Constabulary use to communicate education to young people including:

1. Safety Carousels
2. Junior Neighbourhood Watch
3. Junior Neighbourhood Watch Plus
4. Jet and Ben (Police dogs who attend educational settings throughout County Durham and Darlington providing stranger danger, drug/alcohol awareness and internet safety advice with their handler)
5. Targeted Education
6. Responding to external requests

A Young People's Liaison & Drug Intervention Co-ordinating role ensures that emerging trends in reference to drugs misuse are identified. In partnership with other agencies education and awareness programmes are implemented to divert young people away from drugs and drug related offending and to fast track those who persistently offend taking an integrated offender management approach.

Police involvement in diversionary schemes, such as the EDDY (Engage, Divert, Develop Young People) project, aims to deliver personal development programmes which enable disaffected and disadvantaged young people and those at risk of substance misuse to develop their personal and social skills through interactive education and learning.

6.1.9 Durham Agency Against Crime (DAAC)

The DAAC commission sessions on drugs and alcohol for young people that they work with, these are often carried out by a member of staff from Durham Constabulary or the DAAC team. They also fund educational enterprises such as the Methodrone training video.

6.1.10 Breaking the Cycle (BtC)

BtC work to support and empower families where parents have substance misuse issues to improve their family functioning and family life and to provide an environment where their children can thrive. BtC are co-located with the Community Drugs Service and work across County Durham. Workers provide an individually designed care package, which takes into account the needs of the whole family. This package includes a wide range of services to help people overcome their problems (such as personal counselling, or help with accessing other services, such as housing associations or health clinics).

6.1.11 Local Safeguarding Children Board

Neglect continues to be the main reason for children becoming subject of a child protection plan. Neglect is often associated with parental risk factors around their use of drugs and alcohol, whether there is a history of domestic abuse or mental health problems. These could be single risk factors or act in combination.

Multi-agency work is encouraged to identify risks to children at an early stage and support families rather than wait until there is a significant risk of harm.

The LSCB has developed a comprehensive strategy for neglect, as well as the provision of specialist training and assessment tools. The LSCB has a performance management framework which captures data around child protection conferences which are convened arising from the impact of parental drug misuse and which embraces audits of practice around information sharing and compliance with child protection procedures.

6.1.12 Schools

As part of the statutory duty on schools to promote pupils' wellbeing, schools have a clear role to play in preventing drug misuse as part of their pastoral responsibilities. To

support this, the Government's Drug Strategy (2010) ensures that school staff have the information, advice and power to:

- Provide accurate information on drugs and alcohol through education and targeted information, including via the FRANK service;
- Tackle problem behaviour in schools, with wider powers of search and confiscation;
- Work with local voluntary organisations, health partners, the police and others to prevent drug or alcohol misuse.

Schools across County Durham have a long history of providing good substance misuse education. This is usually delivered through the PSHE (Personal, Social, Health Economic) education and Science curriculum from Key stages 1 to 4 but is also part of a wider and overall responsibility of schools to identify and meet student personal development and wellbeing needs.

Schools liaise closely with other services and providers to support those who are at risk from substance misuse or to support children and young people where substance misuse may be taking place within the family.

School governors have overall responsibility for the school's policy, provision and delivery of substance misuse education within the school environment. Continuing professional development is available to all school staff and governors with responsibility for this area of school life.

6.2 Objective Two: Restricting Supply

- *To reduce the supply of drugs and number of drug related incidents impacting upon communities and families.*

What are we doing in County Durham?

6.2.1 Durham Constabulary

Durham Constabulary proactively tackles open and closed drug markets operating in the county and these interventions are marketed through policing operations known as NIMROD and SLEDGEHAMMER respectively.

NIMROD aims to:

- Reduce visible dealing of Class A drugs in residential and other public areas of County Durham.

- Reassure the public that positive action is being taken against those who deal Class A drugs.

- Target Class A drug dealers who conduct business in public areas and who are engaged in other crimes.

NIMROD seeks to distinguish between prolific dealers and/or prolific volume crime offenders and those selling only to finance their own habit. As such, prosecutions are sought against the former and interventions to treat & rehabilitate sought for the latter. This inevitably requires a partnership approach.

SLEDGEHAMMER is the force response to tackling serious and organised crime. This type of criminality, which is often, but not exclusively drug related, is not always as visible to communities as the open drugs markets, hence reference to the term “closed drug markets”. By the very nature of these types of investigations covert policing techniques are often utilised. Specialist resources are prioritised against competing demands. Great disruption work is done in communities by local neighbourhood policing teams to ensure organised drug related crime at all levels receives the attention it deserves. An organised crime partnership disruption and intervention panel strengthens activity in this area. It also seeks to identify those at risk of becoming involved in organised crime, for example as drugs couriers, and to divert them away from an organised crime pathway. The proceeds from drug related crime are often visible to the community. Legislation is used to deprive criminals of the proceeds of their offending and this positive action assists in improving public confidence in policing.

It is recognised that there are individuals and/or elements of the community who may be more vulnerable to drugs and associated criminality than others. The police provide an operational and intelligence response to identify the most vulnerable, protects them through partnership working, and investigates offences.

Police and Communities Together (PACT) meetings/events promote regular dialogue with communities to encourage open communication to assist in identifying and tackling individuals involved in drug related crimes/activities.

The aims of Restorative Approaches is to:

- Reduce the risks of offenders re-offending in the future
- Help offenders take responsibility for their behaviour and make reparation to their victims and the community
- Help victims achieve closure
- Enhance community confidence in the Criminal Justice system
- Reduce the costs to the Criminal Justice system and public expenditure more generally
- Adopt an evidence based approach

Durham and Darlington IOMU (Integrated Offender Management Unit) continue to use restorative approaches within their offender management and victim support. The aims of restorative justice are now fully integrated into the day to day operation of the IOMU.

Case Study One:

An offender was sentenced to 16 months imprisonment for a dwelling burglary and placed in a local prison. They were motivated to address their offending behaviour and also whilst in prison worked with drug treatment staff to address their drug and alcohol addictions.

Whilst in prison they met with the victim from the burglary and a full restorative approach conference was held. This allowed the victim to fully explain to the offender the harm that they had caused, and for the offender to understand the impact that their actions, which were driven by their addictions, had had on the victim.

After the conference the offender said, ‘the RA conference had a massive impact, meeting the victim really made me think’.

6.3 Objective Three: Building Recovery

- *Ensure recovery is understood and visible in the community*
- *Support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse*
- *Involve and support families and carers living with drug related issues*

Treatment

There is good quality evidence and guidance provided by NICE (National Institute for Clinical Excellence) around the clinical management of drug use disorders, prescribing guidance for drug dependency and substitute medication (please see Appendix 2). Commissioned services in County Durham are based on NICE guidance.

Recovery

There is a growing body of research to support the recovery approach and the use of mutual aid groups. The most common mutual aid groups in the UK are 12-step fellowships and SMART Recovery.

Evidence shows that treatment is more likely to be effective, and recovery to be sustained, where families, partners and carers are closely involved. A whole family approach to the delivery of recovery services should be taken, and consideration should be made to the provision of support services for families and carers in their own right.

What are we doing in County Durham?

6.3.1 County Durham Drug Service (CDS)

County Durham Community Drugs Service (CDS) is an integrated multi-agency treatment service working across multiple sites, which brings together statutory and third sector providers to work in partnership to provide treatment to those with a substance misuse problem. CDS provides a range of interventions, including harm reduction, Psychosocial Interventions (PSI), Recovery Interventions, abstinence-orientated treatment and substitute prescribing for adults who have recognised problematic substance use.

A Recovery Coordinator is appointed to the client and upon entering the service a ‘recovery plan’ is put in place. This is reviewed routinely as well as opportunistically at a frequency determined by the needs of the client, but as a minimum every 12 weeks. The recovery plan must address drug and alcohol misuse, general health needs, offending behaviour and social functioning. Recovery coordination will include assisting with access to suitable housing, employment, education and training opportunities, and parenting support, as required.

6.3.2 4Real

4Real is the County Durham young person's drug and alcohol service. It provides one to one support through specialist assessment, care planned interventions and treatment often in collaboration with colleagues from other services. Brief intervention workers provide screening and identify people early and reduce further harm.

Case Study Two:

'S' is a 12 year old girl who lives with her Grandmother. She was referred to a brief intervention worker via the SPOC (Police Single Point of Contact) as she had been caught with a bottle of Cider in a public place. 'S' was consuming strong white cider and disclosed having experimented with cannabis and other substances. The grandmother was in desperate need for support with her challenging behaviour. Concerns were raised relating to hidden harm and potential neglect. It was identified that it was appropriate for 'S' to work with the 4Real team due to her vulnerability and other concerning factors.

'S' has been working with 4Real on a weekly basis for several months and has explored her relationship with alcohol and other substances. The worker helped her to explore and identify risky behaviours, set goals, monitor her use and develop alternative coping strategies as part of her care planned interventions. She has been supported to attend her GP following a health assessment with the team. She has made positive changes especially with regard to constructive use of leisure time. Her family have been working with the pathfinder team and now the One Point Service to get additional family support. The case has also been discussed with the sexual exploitation worker in County Durham and work has been undertaken with her with regard to her vulnerability.

6.3.3 Harm Minimisation Services/Needle and Syringe Provision (NSP)

There remains dedicated specialist staff in each treatment centre within the County Durham Community Drugs Services (CDS) who provide a comprehensive range of harm minimisation interventions to the drug using population. These interventions include:

- Comprehensive range of needle exchange and associated equipment.
- Provision of Blood Borne Virus (BBV) testing and referral to treatment services for HCV+ (Hepatitis C) individuals.
- Hepatitis A and B vaccination offered to all service users.
- Safer injecting advice.
- Overdose prevention advice.
- Health screening.
- Comprehensive range of harm reduction information and advice on all aspects of drug use.

- Individual motivational work to encourage access to other interventions within CDS.
- Delivery of an overdose prevention training programme for service users and carers which includes the provision of Naloxone for use by users and carers in emergency opioid overdose situations the community.
- Participation in the National PHE Unlinked Anonymous Monitoring People Who Inject Drugs (UAMPWID) as described above.
- Currently there are 3 pharmacies provide needle exchange services supported by staff from CDS

6.3.4 DISCUS – Drugs in Sport Clinic and User Support

DISCUS is a dedicated harm reduction service for individuals who use image and performance enhancing drugs (IPEDs). The DISCUS service is currently provided within the Chester-Le-Street Community Drugs Service and offers dedicated harm reduction services to IPED users from across the North East region and there are currently 1200 individuals registered with the service.
The DISCUS service gives access to the following services:

· Full range of injecting equipment and needle exchange service
· Health Screening
· Blood testing
· ECG (Electrocardiogram)
· Responsible Medical Officer
· Harm reduction information and advice on all aspects of performance and image enhancing drug use.
· Onward referral if appropriate with the consent of the client
· Hepatitis A and B vaccinations
· Hepatitis B, Hepatitis C and HIV testing
· Up to date resources on drugs and sport

The DISCUS service has been identified as an example of good practice and the services provided are described by the Advisory Council on the Misuse of Drugs as being of the “Gold Standard” service provision which should be provided to users of IPEDs.

6.3.5 Recovery Injectable Opioid (RIO)

Recovery Injectable Opioid (RIO) is a pilot health service in Easington funded by the Department of Health, for patients living in County Durham, engaged in treatment at the Community Drugs service (CDS) with chronic injecting heroin dependence where standard treatment has not been successful. RIO aims to help patients stop using street heroin, stop injecting and achieve recovery. RIO works by providing time limited supervised injectable opioids with intensive psychosocial interventions based on a recovery model.

6.3.6 RAD (Recovery Academy Durham)

The Recovery Academy Durham is a quasi-residential 12 step rehabilitation service where all service users are expected to move into the therapeutic accommodation provided. The service delivers a Twelve Step programme, which has long been an important part of the recovery process and the basis for many recovery programmes.

There have been a number of developments which have consolidated the RAD; the development of coordinated 'move on' accommodation, supported by Durham County Council's Housing Solutions Team and East Durham Homes; the emergence of five Narcotics Anonymous (NA) meetings in a county which had no NA presence prior; the development of 'Oxford Housing' to support individuals who would wish to live in a communal setting in order to gain mutual support as an aid to their continued recovery; and a visible show of recovery as part of the Miner's Gala and the development of a recovery banner.

6.3.7 Mutual Aid

Mutual aid groups are a source of structure and continuing support for people seeking recovery from alcohol or drug dependence, and for those directly or indirectly affected by dependence, such as partners, close friends, children and other family members. The evidence base shows that clients who actively participate in mutual aid are more likely to sustain their recovery.

County Durham has seen mutual aid groups grow as more people move into visible recovery. Groups such as SMART (Self-Management and Recovery Training)/NA (Narcotics Anonymous)/AA (Alcoholics Anonymous)/CA (Cocaine Anonymous) are becoming an intrinsic part of the treatment system in County Durham. The Community Drugs Service has mutual aid workers whose role is to educate, engage and support clients into mutual aid groups. They work in partnership with the mutual aid facilitators to ensure clients have a smooth journey into groups with support from the mutual aid workers.

6.3.8 Ambassador Scheme/peer mentor scheme

The central purpose of the Ambassador Scheme is to improve the experience of people in the treatment system, whether they are graduating from treatment, currently in treatment, or at the point of entering treatment. Ambassadors are ex-service users who have completed treatment drug free and they act as "recovery champions" for the treatment system. The Ambassador programme is part of a wider context to ensure recovery is possible and visible.

Each Ambassador must complete a ten week accredited training package. Once qualified the Ambassadors will become volunteers and work in treatment centres, community venues and professional settings.

Case Study Three:

"My recovery journey has involved different recovery experience's, firstly engaging with the private treatment sector where I paid for different recovery procedures, including detoxes and implants. I have undertaken natural recovery, completing self-detoxes abroad in Europe on at least 10 occasions, I've spent as much trying to get off heroin and methadone as I have on it. Due to finances, I began methadone maintenance in the NHS treatment centres, the second time round I successfully reduced off it without using on top. I could always get clean, that wasn't the problem, and it was always a few months after getting clean when life was going well that I made bad decisions. I have greater awareness now of self and self as a process, managing my mental health symptoms more successfully. My time at The Recovery Academy Durham (RAD) taught me basic emotional skills and an ability to handle feelings without having to 'self-medicate'. I have made mistakes, having learnt more from my mistakes than my successes. Being involved with the Ambassador scheme was a great learning process especially our involvement with the treatment centre audits.

Qualifications, training courses, work experience and most importantly the on-going support I have from my family is the reason why I am where I am today, living in the community, working full time, studying part time for a degree and being an effective and caring parent to my two daughters. Recovery has no set definition; recovery for me is personal and individual, with the duration and nature of it varying across people and settings."

6.3.9 Cornforth Partnership

The Cornforth Partnership aims to provide a wide variety of services to support people of all ages and abilities that live or work in Cornforth and surrounding areas across County Durham. A new project within the Partnership will be helping drug users and their families in their recovery from dependency, focussing on the role of mutual aid.

6.3.10 Family Support Services

Liberty from Addiction (LFA)

Liberty from Addiction (LFA) is a unique charitable organisation working with carers of substance misusers (drug and alcohol). They are a county wide service. LFA was originally set up as a support group by parents and carers who were concerned about a loved one misusing drugs and/or alcohol.

Liberty from Addiction provides a variety of interventions for the range of challenges families and carers face, offering support and care but not drug and alcohol treatment.

They offer:

- Direct access to a worker/trained volunteer in times of carer crisis, including direct access over the phone
- Counselling
- Family progression program/ Family relapse prevention program
- Welfare rights and debt advice
- Carers Breaks
- Volunteering opportunities

Free the Way

Free The Way provides a drop in centre for anyone with an addiction; they also have facilities to provide temporary accommodation for those who are at risk of homelessness.

Parents and carers can also benefit from experienced staff who can advise both through their own experiences and training. Free the Way offer a wide range of services including outreach work and visiting families and carers in their own homes. The main purpose is to provide care, counselling and support with the long term aim of re-educating and rehabilitating individuals back into the family and community so that they can become productive and responsible members of society.

6.3.11 Jobcentre Plus

The drug and alcohol recovery and employment agenda is a key priority for the Department for Work and Pensions (DWP), and therefore for Jobcentre Plus, as it is estimated that 1 in every 15 benefit claimants are dependent on drugs or alcohol. As such, Ministers have agreed a Jobcentre Plus offer for people who are drug or alcohol dependent to be available across Great Britain.

The DWP drug strategy has now been widened to include an offer for all claimants on any benefit with a dependence on any drug or alcohol within Great Britain.

Jobcentre Plus advisers can refer claimants whose dependency is a barrier to work for a voluntary discussion with a treatment provider.

Jobcentre Plus supports case conferencing, limited to education, training and employment needs, with treatment providers whenever possible to ensure the claimant is receiving the support they need and to collaboratively agree employment focused goals. Jobcentre advisers can tailor the Jobseeker's Agreement to take account of any treatment commitments claimants might have.

6.3.12 Prisons (HMPS)

The North East prison partnership brings together all substance misuse treatment providers under one single partnership. The aim is to provide an integrated approach, both within prisons and also for prison transfers to the community. The North East is home to between 5,000 and 5,500 prisoners, a large proportion of whom have substance misuse issues. They are housed in a variety of prisons each of which, despite being very different establishments, has a DART (see below). In 2012/13 the

North East region has reviewed the treatment offer relating to substance misuse and has embraced a new way of working which focuses on recovery.

6.3.13 Drug and Alcohol Recovery Teams (DART)

Since 2012, Drug and Alcohol Recovery Teams (DART) have been working within each prison within the North East. DART is an integrated multi-disciplinary treatment service working across multiple sites, which brings together statutory and third sector providers to work in partnership to provide treatment to those with a substance misuse problem. DART offers a range of interventions, including harm reduction, Psychosocial Interventions (PSI), Structured day care, abstinence-orientated treatment and substitute prescribing for prisoners within the North East prison estate. It provides support and treatment for both young people and adults who have recognised problematic substance use. The range of activities offered also includes - access to counselling services, physical exercise, complementary therapies such as Acupuncture, listeners/buddies, peer mentors, purposeful activity, detoxification, recovery wings and specialist programmes.

6.3.14 Integrated Offender Management Programme (IOM)

The Integrated Offender Management Team (IOM) is called The Castle Project in County Durham. It is a multi-agency team including police, probation, drug workers, housing officers and mentors who are supported by other local community services. They manage the most prolific and priority offenders in County Durham who display complex needs and are responsible for committing multiple crimes. Individuals are offered the opportunity to engage with the scheme to address their offending needs.

For individuals with substance misuse issues or who are subject to a Drug Rehabilitation Requirement the DIP (Drug Intervention Programme) is aligned with the IOM scheme to target and support individuals into drug treatment.

6.3.15 Drug Rehabilitation Requirements (DRRs):

The main purpose of the drug rehabilitation requirement is to reduce or eliminate illicit drug use and associated offending. The offender is required to attend appointments with the treatment provider, to submit to regular drug testing and to engage with activities to address their substance misuse. The offender is also required to attend appointments with their Offender Manager to address their offending behaviour through the Citizenship Programme.

DRRs can be of Low, Medium or High Intensity levels; this is dependent upon the individuals need and offence. Additionally all DRRs of 12 months or more are subject to mandatory court review. Shorter orders may be reviewed if so directed by the court.

6.3.16 The County Durham Drug Interventions Programme (DIP)

DIP work exclusively with adults with a drug misuse problem within the criminal justice system. The DIP team operate across three main disciplines with all members of the team multi-functional, working across these areas as and when required to ensure a seamless and professional service. The three areas of work are 1) arrest referral and court work, 2) working alongside the police, probation and other agencies within the Integrated Offender Management Units with Priority and Prolific Offenders and 3) based within the Community Drug Service treatment centres working with DIP clients and those released from prison.

All team members provide assertive outreach to those individuals who have failed to keep appointments to ensure as few as possible drop out of treatment. DIP staff carry out the required assessments, follow up assessments and restriction on bail appointments for those tested positive within Durham Force area or those who reside in County Durham but were tested positive in another force area.

Case study Four:

"Brian" was a recreational cocaine user, this increased to crack and heroin. He began to sell things from the house, eventually beginning to offend. Put before the courts he was given DRR's (Drug Rehabilitation Requirement), community orders and custodial sentences but the offending and substance misuse continued. "Brian" was sentenced to 5 years for burglary.

In prison he gradually reduced his methadone script and applied to go onto I wing in HMP Durham (drug free wing facilitated by RAD (Recovery Academy Durham) involving 12 step approach). DIP became involved with "Brian" at the release plan stage. The plan was for him to go directly to RAD, but after over 2 years in prison he decided he did not want to continue with this intense recovery programme and would rather use community support.

DIP worked with "Brian" initially meeting him twice weekly for the first month. They looked at motivational work, coping strategies and relapse prevention. "Brian" found it very difficult in the community and was nervous about going out and about. "Brian" did lapse and at one point started to transfer his addiction to alcohol. To his credit he recognised this and with support from his DIP worker completed the short duration alcohol programme. "Brian" is currently at Finchale College.

7. Summary of Action Plan 2014-2015

We have consulted with and continue to seek feedback and comments on our priorities for action. We commit to having an annual stakeholder event to help prioritise the action plan for the coming year. Service users and carers continue to have an important role within this strategy and action plan, and their views have been crucial to its development and in identifying the priorities.

7.1 Preventing Harm

What we will do:

- Develop a social marketing plan to raise awareness about the harms of drugs.
- Work with schools and families to promote awareness of the risks associated with drug use
- Support schools and colleges in the delivery of drug education and ensure the development and implementation of drug policies
- Ensure the delivery of Prevention Champions Training to Drug and Alcohol staff
- Include drugs, caffeine and NPS's (New Psychoactive Substances) in the Good practice guidance for schools, colleges and youth settings.
- Develop a key messages document in relation to drugs for use by all partners
- Ensure there is a minimum data collection on drug misuse, particularly where this is currently limited, e.g. primary care and acute trusts
- Map and improve existing drug forums
- Gain a better understanding of the needs around New Psychoactive Substances
- Involve and support young people, families and carers (including young carers) living with drug related issues in order to break the cycle of drug misuse.
- Strengthen the pathway between Children and Family Services and specialist drug and alcohol services to ensure vulnerable families and children are supported with their substance misuse and related problems.
- Ensure that there are appropriate harm minimisation interventions for those who are experimenting with and/or using drugs recreationally.
- Local Safeguarding Children's Board to undertake themed audits of cases linked to parental alcohol and drug use and present findings to the performance management sub group
- Local Safeguarding Children's Board trainer to provide relevant training to professionals on the impact of drugs on children's protection

7.2 Restricting Supply

What we will do:

- Improve the quality of data collection to understand the full impact of drugs on health, crime, offending and re-offending
- Work with the Police and Crime Commissioner to ensure that funding is allocated to reduce drug related crime and anti-social behaviour
- Create a forum to debate the decriminalisation of drug users to ensure a shared County Durham response
- Tackle the supply chain within HMP prison system by ensuring the Supply and Demand Strategy is fully implemented
- Increase public reassurance and reduce the fear of drug related crime by the implementation of the communications strategy

7.3 Building Recovery

What we will do:

- Further develop a recovery community in County Durham, including HMPS which celebrates and promotes recovery
- Review the referral pathways into and from GP practices, primary mental health and acute hospital trusts
- Raise awareness of referral protocols into and out of custody
- Review and monitor the drug related deaths in County Durham
- Further embed the joint working arrangements between treatment services, HMPS, Jobcentre Plus and work programme providers to address the employment related needs of substance misusers, contributing to positive employment, treatment and recovery outcomes
- Build peer support into the induction process in custody
- Undertake work to understand the transition of young people to adult treatment services
- Further develop the work on recovery including recruiting, training and supporting Ambassadors and peer mentors
- Listen to the views of carers and service users to continually improve the quality of services
- Increase the number of adults and young people accessing and successfully completing treatment and recovering from their dependency
- Ensure families needs are assessed and understood and they receive a collaborative multi-agency whole family response from Team around te Family
- Ensure services are attractive and accessible to underrepresented groups, e.g. pregnant women and veterans
- Develop a communications plan for promoting the Community Drugs Service (CDS) and recovery community in County Durham
- Undertake a review community based drug and alcohol treatment services in County Durham

- Explore joint commissioning opportunities between drug, alcohol and mental health services.
- Commission and deliver effective treatment and recovery services in both community and criminal justice settings in line with national guidance
- Commission family support services and ensure the needs of carers are met.
- Improve access to family support for offenders.
- Improve PRS (Private Rented Sector) management standards through inclusion with Durham Key Options
- Ensure that there are appropriate harm minimisation interventions for those who are experimenting with and/or using drugs recreationally.

8. Strategic Framework and Accountability

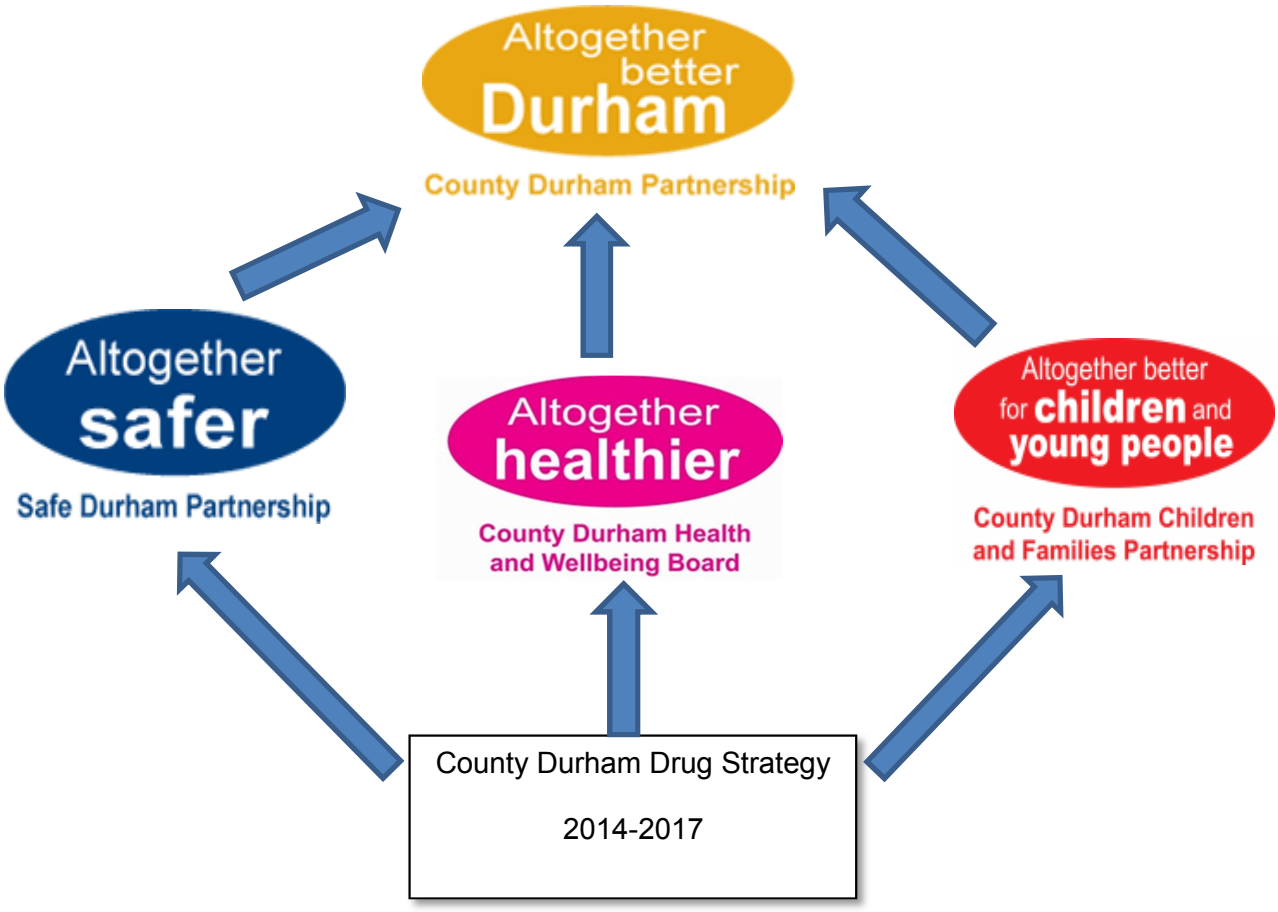
The performance management framework aligns to the priorities identified within the *Drug Strategy (2010) Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life (HMSO, 2010).* The Drug Strategy group will report to the County Durham Safe Durham Partnership Board, the Health and Wellbeing Board and the County Durham Children and Families Partnership. Progress on delivery against strategic objectives and action plan will be reported on a six monthly basis.

The Drug Strategy Group will consider a quarterly performance report which will contain a range of performance indicators. The Drug Strategy Group will maintain an action plan appropriate to the issues raised from the performance report. Any key issues will be escalated to the relevant Board as appropriate.

Some of the Key Performance measures include:

- Increasing the number of staff trained in drug awareness
- Increasing the knowledge and understanding of drugs across our workforce, schools, families and wider community
- Reduce drug related crime
- Increasing the numbers of families and carers accessing appropriate support
- Increasing the numbers of people in treatment
- Increasing the number of people successfully completing their treatment
- Reducing the number of people who represent to treatment
- Increasing the number of people who access mutual aid and receive peer support

8.1 County Durham Drug Strategy Group Structure



8.2 Delivery of the Strategy and framework

There is a need for an overarching drugs strategy, but the key areas should be deliverable by other existing partners and agencies as part of their core business.

This work forms the basis of the new strategy, together with a broad understanding of the emerging agendas, including:

- the impact of the Police and Crime Commissioner, and recent and planned changes to policing structures;
- the development of the Health and Well-Being board;
- the changes to commissioning arrangements for local authorities, clinical commissioning groups and NHS England.
- the emerging agenda around Recovery, as opposed to more traditional 'treatment';
- the opportunities offered by the Think Family agenda;

- the impact of localism as it applies to County Durham;
- the changing nature of drug use in the county;
- how we manage the transition from nationally or regionally prescribed approaches to tackling the drugs agenda, to a more locally defined model;
- the changing economic climate.

A strategy alone can achieve nothing without the full and explicit commitment of all key partner agencies and stakeholders, including local communities.

Securing a shared vision and commitment with a clear rationale for tackling drugs misuse in County Durham is essential. The strategy recognises and builds on the actions already being taken by partner agencies to reduce the impact of drugs.

Appendices

Appendix 1: Glossary of terms/abbreviations

A&E or ED	Accident and Emergency Department or Emergency Department of a hospital
ACMD	Advisory Council on the Misuse of Drugs
ACPO	Association of Chief Police Officers
ADEPIS	Alcohol and Drug Education Prevention Information Service
Alcohol AUDIT	Alcohol Use Disorders Identification Test. A simple 10 question test developed by the World health Organisation to determine if a person's alcohol consumption may be harmful.
BBV	Blood Bourne Virus
BtC	Breaking the Cycle
CARAT	Counselling, Assessment, Referral, Advice, Throughcare. CARAT works with prisoners who misuse drugs to help them with treatment in prison and offer support when released.
CDS	Community Drugs Service
Clinical Commissioning Groups (CCGs)	Groups of GP practices, including other health professionals who will commission the great majority of NHS services for their patients
DART	Drug and Alcohol Recovery Teams
DCC	Durham County Council the local authority for the County Durham area
DfE	Department for Education
DH	Department of Health
DIP	Drug Intervention Programme
DISCUS	Drugs in Sport Clinic and User Support
Domestic abuse/violence	Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 or over, who are or have been intimate partners or family members, regardless of gender and sexuality.
DRR	Drug Rehabilitation Requirement
Dual diagnosis	People who have mental illness as well as substance misuse problems
DWP	Department for Work and Pensions
EDDY	Engage, Divert, Develop Young people
GP	General practitioner also known as family doctors who provide primary care
HCV	Hepatitis C Virus
HIV	Human immunodeficiency virus
HMPS	Her Majesty's Prison Service

HSCIC	Health and Social Care Information Centre
Head Shop	A shop that sells smoking implements and accessories for cannabis.
IOMU	Integrated Offender Management Unit
IPEDs	Image and Performance Enhancing Drugs
IRT	Initial response Team
Joint Health and Wellbeing Strategy (JHWS)	The Health and Social Care Act 2012 places a duty on local authorities and CCGs to develop a Joint Health & Wellbeing Strategy to meet the needs identified in the local Joint Strategic Needs Assessment (JSNA)
Joint Strategic Needs Assessment (JSNA)	Health and Social Care Act 2012 states the purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages
LGBT	Lesbian, Gay, Bi-sexual and Transgender
MEAM	Making Every Adult Matter is a coalition of four national charities – Clinks , DrugScope, Homeless Link and Mind
Mutual Aid	Mutual aid refers to members of a group that give each other support at every stage of their recovery from drug or alcohol dependence.
NA	Narcotics Anonymous
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOMS	National Offender Management Service
NTA	National Treatment Agency
Naloxone	A drug used to counter the effects of opiate overdose, for example heroin.
PACT	Police and Communities Together
PCC	Police and Crime Commissioner
PCT	Primary Care Trust
PHE	Public Health England
PRS	Private Rented Sector
PSHEE	Personal, Social, Health and Economic Education
PSI	Psychosocial Intervention
Quasi-residential	Combining local accommodation and housing support with an off-site treatment programme
RAD	Recovery Academy Durham
RAPPO	Restorative Approaches Prolific and Priority Offenders
RIO	Recovery Injectable Opioid
RJ	Restorative Justice
Safe Durham Partnership	The Community Safety Partnership for County Durham
Sexual Exploitation	Exploitative situations, contexts and

	relationships where young people (or a third person or persons) receive “something” (e.g. food, accommodation, drugs, alcohol, cigarettes, affection , gifts , money) as a result of them performing, and/or another or others performing on them, sexual activities.
SMART Recovery	‘Self-Management And Recovery Training’.
SPOC	Single Point of Contact
STC	Secure training centres (STCs) are purpose-built centres for young offenders up to the age of 17. They are run by private operators under contracts. There are four STCs in England.
Tiers 1-4	Department of Health has a tiered system of treatment modalities (different therapies). Tier 1: Non-specific (general) service; Tier 2: Open Access; Tier 3: Community Services; Tier 4a: Specialist Services (residential); Tier 4b: Highly specialist (non-substance misuse) services.
Think Family	An approach which makes sure that the support provided by children’s, adults’ and family services is co-ordinated and focused on problems affecting the whole family
Triage	A process of prioritising needs
UKDPC	UK Drug Policy Commission
4Real	Children and Young People’s Substance Misuse Service in County Durham
12 Step Programme	A set of guiding principles and spiritual foundation for personal recovery from the effects of addiction, i.e. drugs, alcohol

Appendix 2: Examples of NICE Guidance

- National Institute for Clinical Excellence (NICE) (2012) Quality Standard for Drug Use Disorders. (QS 23) London: NICE
- NICE (2007) Drug Misuse: Psychosocial interventions. (CG 51) London: NICE
- NICE (2007) Drug Misuse: Opioid detoxification. (CG 52) London: NICE
- NICE (2007) Methadone and Buprenorphine for managing opioid dependence. (NICE technology appraisal 114) London: NICE
- NICE (2007) Naltrexone for the management of opioid dependence. (NICE technology appraisal 115) London: NICE
- NICE (2007) Interventions to reduce substance misuse among vulnerable young people. (PH 4) London: NICE
- NICE (2007) The most appropriate generic and specific interventions to support attitude and behaviour change at population and community levels. (PH 6). London: NICE
- NICE (2009) Needle and Syringe Programmes. (PH 18) London: NICE
- NICE (2010) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (CG 110) London: NICE
- NICE (2013) Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection. (PH 43) London: NICE
- NICE (2013) Hepatitis B (chronic): Diagnosis and management of chronic hepatitis B in children, young people and adults. (CG 165) London: NICE

Appendix 3: Organisations involved in the development of the County Durham Drug Strategy

Addaction

County Durham Ambassadors

County Durham and Darlington Foundation Trust (CDDFT)

DAAC (Durham Agency Against Crime)

DISC

Durham County Council including representatives from:-

- 4Real
- Children's Services
- Drug and Alcohol Commissioning Team
- Housing Solutions
- Public Health
- Safer Communities
- Youth Offending Service (YOS)

Durham Constabulary

Her Majesty's Prison Service (HMPS)

Jobcentre Plus

Liberty From Addiction

North East Council on Addiction (NECA)

NHS England (Health and Justice)

North of England Commissioning Support (NECS)

Probation Services

Public Health England

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

Appendix 4: Bibliography

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- NICE (2007) Drug Misuse: Opioid detoxification. (CG 52) London: NICE
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- NICE (2007) Interventions to reduce substance misuse among vulnerable young people. (PH 4) London: NICE
- NICE (2007) The most appropriate generic and specific interventions to support attitude and behaviour change at population and community levels. (PH 6). London: NICE
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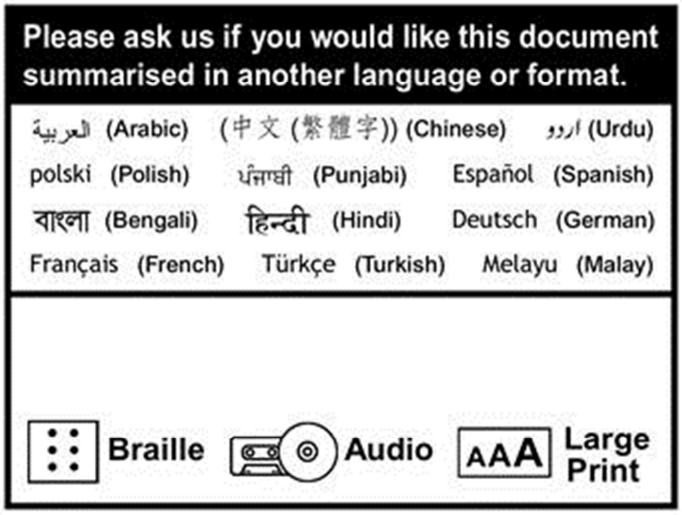

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Health & Wellbeing Board

5 November 2014

Strategy for Prevention of Unintentional Injuries in Children and Young People (0-19year)

Report of Anna Lynch, Director of Public Health County Durham, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to present the Strategy for the Prevention of Unintentional Injuries in Children and Young People in County Durham attached at Appendix 2 for agreement.

Background and Evidence base

2. Unintentional injury is a leading cause of morbidity and death amongst children and young people aged 1–14years, second only to cancer. The National Institute for Health and Care Excellence (NICE) guidance identifies several factors which make some children more vulnerable than others. These include the child's age, whether they are disabled, have a learning difficulty, the family income and their home environment. NICE guidance also provides evidence based recommendations for preventing unintentional injuries in children and young people.

3. Every year, 1 million children under the age of 15 are taken to accident and emergency (A&E) units after injuries occur in the home. Many more are treated at home or by their GP. In the UK, injuries that occur in and around the home are the most common cause of death in children over the age of one.

4. Children who are injured have to stay out of school and require a parent/carer to stay away from work to be with them. Caring for a child who has been seriously injured can stop a parent from returning to education or work, or plunge an already disadvantaged family further into poverty.

5. In 2010 - 2011, hospital admissions for unintentional injuries in County Durham were higher than both the regional and England averages.

6. Accidents & Emergency admissions due to unintentional injuries in the 0-18 years gradually increased in County Durham from 2008 - 2011.

7. Most of these injuries were due to non-transport causes and resulted from falls in the 0 -15 year olds. Most falls in the 0 - 5 year olds occurred in the home whilst the 6 -15 year olds occurred at outdoor play & leisure areas.

8. Transport injuries occurred predominately in the 6 – 15 year olds and resulted from 'pedal cyclist injured in transport accident'.

9. Child road casualties occurred mostly in the deprived wards of the county.

10. Injury has a wide and long-term impact on health including stress, physical disability, social impairment and lower educational attainment and employment prospects. As well as wider heath care costs, there are social care costs, social security costs and productivity losses.

11. Prevention of all child road casualties over a five year period, 2007 - 2011, could have saved the County Durham economy over £36.5 million.

Current service

12. A wide range of agencies are involved in unintentional injury prevention in children and young people and there are some examples of good practice and innovation. However there are areas where further improvements and action can be focused to improve outcomes for children and young people.

13. Consultation via Investing in Children was clear that children and young people report that, on average, they were well informed on road and fire safety but received very limited information on water safety. Parents and other families were identified as playing a significant role in the provision of such information. They suggest that safety messages need to 'get in their heads'.

What is being proposed?

14. The strategy recommends that:

- A local injury prevention strategy group should be developed with relevant partners to lead on implementing the strategic action plan. The strategy group to report to the Children and Families Partnership with links to the Local Safeguarding Children's Board through the Director of Public Health;
- Explore child injury including prevention in relevant strategies;
- Include child injury prevention into specifications for school nursing and health visiting services;
- Monitor and evaluate data and feedback to relevant partners to support actions to reduce unintentional injuries in children and young people;
- Focus on home safety issues with relevant multi-agency partners;
- Continue to consult with children, young people and their parents when programmes are developed;
- Support the development of clinical protocols across agencies to ensure quality of care for children and young people involved in accidental injury;
- Explore how to promote safety education in areas that target parents and carers.

15. Successful delivery of the strategy will require strong partnership working to deliver the action plan. Currently there are no identified budgets to progress relevant actions and the strategy group will need to explore options to progress the strategy based on a prioritisation process and funding opportunities.

Recommendations

16. The Health & Wellbeing Board is requested to:

    - Agree the Strategy for the Prevention of Unintentional Injuries in Children and Young People in County Durham

Contact*:* Esther Mireku, Public Health Portfolio Lead, Durham County Council
Tel: 03000 267665

Appendix 1: Implications

Finance
The report makes reference to possible financial implications for commissioning. Implementation of the strategy will be an investment to save. This will be achieve from long term reductions in cost for hospital admissions, cost for respite and parent/carer time, and costs to social services.

Staffing
There are no implications to staffing identified

Risk
There is a potential risk of widening the health inequality gap for vulnerable families with young children if the actions identified in the strategy are not implemented.

Equality and Diversity / Public Sector Equality Duty
There may be implications especially in relation to child poverty and increased risk for development of a disability for CYP of at risk families if the actions identified in the strategy are not implemented.

Accommodation
There are no implications for accommodation

Crime and Disorder
There are no implications for crime and disorder

Human Rights
There are no implications for human rights

Consultation – Children and Young people were consulted as part of the process for developing the strategy. Colleagues in police, fire and rescue, health visiting, school nursing, voluntary sector and road safety were also consulted.

Procurement – There may be implications for procurement if new programmes are commissioned as a result of implementation of the strategy.

Disability Issues
There are no issues for disability identified

Legal Implications
There are no legal implications identified

Strategy for the Prevention of Unintentional Injuries in Children and Young People (0-19years) County Durham (2014 – 2017)

Reader Information	
Title	Strategy for the Prevention of Unintentional Injuries in Children and Young People-County Durham
Department	Public Health
Author(s)	Esther Mireku- Public Health Portfolio lead, DCC
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Reviewer(s)	
Circulated to	
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Version	7.0
Status	Draft
Date of release	
Review Date	
Number of pages	
Purpose	
Description	This document analyses need, current services and multi-agency working to reduce unintentional injuries in children and young people (0-19) in County Durham and makes recommendations for future commissioning
Superseded documents	N/A
Contact details	esther.mireku@durham.gov.uk
Related information	Altogether Safer-Road casualty reduction delivery plan

Table of Contents

1.0 Executive Summary

Unintentional injury is a leading cause of morbidity and mortality amongst children and young people aged 1–14years, second only to cancer. NICE guidance identifies several factors which make some children more vulnerable than others. These include the child's age, whether they are disabled, have a learning difficulty, the family income and their home. NICE guidance also provides evidence based recommendations for preventing unintentional injuries in children and young people. The World Health Organization identified three levels of prevention: primary, secondary and tertiary.

The Child Accident Prevention Trust found that partnership work is a major driver for success in reducing death and serious injury from preventable childhood accidents. They state that 'creative partnership projects that pool resources and share opportunities can make a real difference at a local level'.

This strategy aims to:

- Highlight the extent of unintentional injury among children and young people indicating where inequalities exist in County Durham, regional and national;
- Outline national and local priorities for action and relevant targets;
- Map current service provision;
- Provide recommendations for further action in order to reduce unintentional injuries in children and young people by benchmarking against recommendations from NICE guidance; and
- Suggest any actions which could further reduce inequalities in County Durham.

Scope and targets

This strategy applies to all children and young people 0 to 19years living within County Durham.
Specific child injury outcome indicators from the Public Health Outcomes Framework are:

- Hospital admissions caused by unintentional and deliberate injuries in under 18s; and
- Killed and serious injured casualties on England's roads.

Summary of findings showed that:

Data analysis

- Hospital admissions data from injury is readily available but limited data exist for Accidents and Emergency attendances;
- County Durham has a similar proportion of under 5year olds to the North East region but lower than England. The proportion of 5 to 16 year olds is similar to the region and England;

- In 2010 to 2011, rate of hospital admissions for unintentional injuries in County Durham was higher than both the regional and England averages:
- Rate of Accidents & Emergency admissions attributed to unintentional injuries in the 0-18 years gradually increased in County Durham between 2008 to 2011. A similar trend was observed in all localities, except in Easington, where there was an observed reduction from 2009/10 to 2010/11;
- Most of these injuries were due to non-transport causes and resulted from falls in the 0-15year olds. Most falls in the 0-5year olds occurred in the home whilst the 6-15year olds occurred at outdoor play & leisure centers; County Durham had higher levels of hospital admissions from falls than the region and England;
- Transport injuries occurred in the 6-18year olds but predominately in the 6-15year olds. Injury in the 6-15year olds resulted from 'pedal cyclist injured in transport accident', whereas 'car occupant injured in transport accident' was the major cause in the 16-18year olds;
- Child road casualties occurred mostly in the deprived wards of the county;
- County Durham had the lowest number of hospital admissions from unintentional poisoning in the region and similar to England average;
- County Durham had higher rates of hospital admissions from injuries resulting from smoke, fire and flames than the region and England;
- County Durham had a lower rate of hospital admissions from burns than the region but higher than England average;
- County Durham had similar rate of hospital admissions due to drowning or submersion compared to the region and England; and
- Prevention of all child road casualties over a five year period, 2007 to 2011, could have saved the County Durham economy over £36.5 million.

Current service

- A wide range of agencies are involved in unintentional injury prevention in children and young people and there are many examples of good practice and innovation. Road safety prevention programs are better established than for home and water safety;
- Routine education for preventing injuries is not provided to all relevant staff groups who work with children and there are no local protocols in place to ensure coordination of care and support at the different levels;
- Limited commissioned services exist currently, to provide support for infrastructure to vulnerable families to prevent injuries in the home for children;
- Impact of road safety interventions on behavioral change is not routinely evaluated by seeking the views of CYP and their families; and

- It is not clear if information and data from services is used to design continuous improvement programmes for outdoor and leisure play.

Stakeholder consultation

Children and Young People report that, on average they were well informed on road and fire safety but received very limited information on water safety. Parents and other family members were identified as playing a significant role in the provision of such information. They suggest that safety messages need to 'get in their heads'.

Conclusion

It is concluded that the type of injuries in children is age related. Non-transport injuries occurred predominantly in the 0-15year olds, whilst transport injuries occurred mostly in the 16 years and over. The major cause of injury in children in County Durham was a result of falls and there were no differences between localities. Transport injuries occurred mostly in the deprived areas of the county. County Durham has higher rates of hospital admissions from unintentional injuries compared to the region and England. Interventions to prevent injuries in children locally are better established for road than for water and home safety. Parents and other family members play a significant role in reducing injuries for CYP.

Recommendations

It is recommended that:

- A local injury prevention strategy group should be developed with relevant partners to lead on implementing the strategic action plan. The strategy group to report to the Children and Families Partnership with links to the Local Safeguarding Children's Board through the Director of Public Health;
    - Explore child injury including prevention in relevant strategies;
    - Include child injury prevention into specifications for school nursing and health visiting services;
    - Monitor and evaluate data and feedback to relevant partners to support actions to reduce unintentional injuries in children and young people;
    - Focus on home safety issues with relevant multi-agency partners;
    - Programmes are appropriately targeted and dependent on need;
    - Continue to consult with children, young people and their parents when programmes are developed;
    - Support the development of clinical protocols across agencies to ensure quality of care for children and young people involved in accidental injury;

- Explore how to promote safety education in areas that target parents and carers.

2.0 Background

Unintentional injury is a leading cause of death amongst children and young people aged 1to14 years, second only to cancer. In 2007 it led to 220 deaths, in those aged 0 to14 years in England and Wales the majority involved a road injury. Other causes included choking, suffocation or strangulation, smoke, fire and flames and drowning[1]. In addition, unintentional injuries leave many thousands permanently disabled or disfigured.

Every year, 1 million children under the age of 15 are taken to accident and emergency (A&E) units after injuries occur in the home. Many more are treated at home or by their GP. In the UK, injuries that occur in and around the home are the most common cause of death in children over the age of one.[2]

Everyday a child spends in hospital due to an accident costs the NHS £233. This rises to £750 a day for a bed in a specialist burns unit; £1,770 a day for a bed in intensive care; and £2,500 a day for a bed in a burns center intensive care unit. It can cost up to £250,000 to treat one severe bath water scald, and the British Burn Association estimates that, in one year, children who have suffered serious bathwater scalds generate lifetime treatment costs for the NHS of £6.7 million[3].

National Institute for Health and Clinical Excellence (NICE) guidance refers to the term 'unintentional injuries' rather than accidents as 'most injuries and their precipitating events are predictable and preventable. The term accident implies an unpredictable and therefore unavoidable event'[4] .
NICE guidance also identifies several factors which make some children more vulnerable than others. These include the child's age, whether they are disabled, have a learning difficulty, the family income and their home. Of particular concern is the fact that children and young people from lower socioeconomic groups are far more likely to be affected by unintentional injuries. Children and young people of parents classified as never having worked or long-term unemployed were identified to be13.1 times more likely to die from an unintentional injury than the offspring of managers/professionals[5].

Injuries occur as a result of the interaction between the child and his or her physical and social environment and are often preventable.

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[1] ONS (2008), Child Mortality Statistics. www.ons.gov.uk
[2] Health National Report (2007) 'Better safe than sorry'
[3] CAPT (2011) Advocating Child Safety, www.capt.org.uk.
[4] NICE (2010) Strategies to prevent unintentional injuries among the under-15s
[5] Roberts and Power (1996). Does the decline in child injury mortality vary by social class? A comparison of class specific mortality in 1981 and 1991. *BMJ 1996;313:784.*
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All children are exposed to hazards as part of their everyday lives as they play, travel around, and even (at times) when they are asleep.

The World Health Organization (WHO)[6] identified three levels of prevention: primary, secondary and tertiary. 'Primary prevention aims to prevent the injury event in the first place through, for example, stair gates to prevent falls or drink–driving legislation to reduce the risk of road accidents. Secondary prevention seeks to reduce the risk of injury once an event has occurred. A smoke alarm will not prevent a fire but may enable occupants to escape a building before they are overcome by smoke or burned. Tertiary prevention aims to minimize the consequences of an injury, for example, by providing first aid and emergency trauma care.

NICE[4] focuses on strategies, regulation, enforcement, surveillance and workforce development in relation to preventing unintentional injuries in the home, on the road and during outdoor play and leisure: '*It is for commissioners and providers of health services, local authority children's services, local authorities and their strategic partnerships, local highway authorities, local safeguarding children boards, police, fire and rescue services, policy makers, professional bodies, providers of play and leisure facilities, and schools. It is also for other public, private, voluntary and community organizations and services which have a direct or indirect role in preventing unintentional injuries among children and young people aged under 15'(page)*.

The Child Accident Prevention Trust (CAPT), highlight findings from the Accident Prevention Amongst Children Review which found that partnership work is a major driver for success in reducing death and serious injury from preventable childhood accidents. They state that 'creative partnership projects that pool resources and share opportunities can make a real difference at a local level[7]'. These finding are backed up by the Health National Report "Better Safe than Sorry" which found that '*partnerships are the key to the delivery of strategies aimed at preventing unintentional injury and require cooperation at local level[3]'*.

The Health National Report[3] also made the following recommendations for multi-agency working to reduce the number of children killed in accidents in England:

- Develop joint strategic plans and action plans aimed at preventing unintentional injury, ensuring regular review and monitoring of outcomes. These plans should ensure that resources are directed towards sustainable evidence based strategies, that avoid duplication of work and that they are directed at reducing inequalities;
- Regularly review and develop a clear understanding of the rates and types of unintentional injury in their local area to enable actions and resources to be directed accordingly;

[6] WHO (2008), World report on child injury prevention. http://whqlibdoc.who.int/publications/2008/9789241563574_eng.pdf. accessed 29/9/13

[7] CAPT (2011) Advocating Child Safety, www.capt.org.uk.

- Determine what sources of local data are available and, where possible, record and share data across the NHS and local government;
- Influence Local Strategic Partnerships to strengthen the focus on unintentional injury in local communities;
- Use local children's trust arrangements, such as children and young people strategic partnerships or LSCBs as a vehicle to oversee and ensure delivery of prevention strategies, and
- Familiarise themselves and local practitioners with the evidence base detailing what works and target strategies for preventing unintentional injury accordingly.

The effectiveness of this strategy is thus dependent upon cross agency agreement and a commitment to action. In turn the strategy will provide a framework for action and an opportunity to develop a common understanding of unintentional child injury inequalities within County Durham. Through integration into the planning systems of the Health and Wellbeing Board (HWB) and Local Safeguarding Children's Boards (LSCB) appropriate resources can then be allocated to tackle unintentional injuries among children on a knowledge led basis.

The strategy will contribute to the achievement of priorities for the Altogether Better for Children and Young People, Altogether Healthier, Altogether Safer and Altogether Greener. There are identified links with the safer and stronger communities' action plan and the safeguarding children's board.

3.0 Aims and Objectives

This strategy will:

- Highlight the extent of unintentional injury among children and young people in County Durham, indicating where inequalities exist in the county and compared to regional and England;
- Outline national and local priorities for action and relevant targets;
- Map current service provision;
- Provide recommendations for further action in order to reduce unintentional injuries in children and young people by benchmarking against recommendations from NICE guidance; and
- Suggest any actions which could further reduce inequalities in County Durham.

The Accidental Injury Task Force identified a number of areas of particular concern and highlighted interventions which were well tried or most promising

and offered the potential to achieve the biggest reduction in accidental deaths and injuries[8,9].

On the road there is good evidence for:

- 20mph zones (leading to injury reduction and behavior change);
- Cycle helmet education campaigns (leading to behavior change);
- Child restraint legislation (leading to behavior change and injury reduction);
- Area wide urban safety measures (leading to injury reduction);
- Education aimed at parents about pedestrian injuries (leading to behavior change);
- Cycle training (leading to behavior change);
- Cycle Helmet legislation (leading to injury reduction);
- Child restraint education campaigns (leading to behavior change) and
- Seat belt education campaigns (leading to behavior change)

Significant fatalities and injuries occur in or near the home. These may occur through suffocation and ingestion of foreign bodies, fire and flames, drowning and submersion, falls or poisoning. There is good evidence for:

- Smoke detector programmes (leading to injury reduction and behavior change);
- Home risk assessments, safety checks and escape plans(leading to injury reduction);
- Prevention of poisoning - child resistant packaging (leading to injury reduction);
- General safety devices (leading to injury reduction);
- Window bars (leading to injury reduction);
- Parent education on hazard reduction (leading to behavior change) and
- Targeting deprived groups, particularly children in privately rented and temporary accommodation and households in which people smoke.

To maximize safety for outdoor play there is evidence for:

- Increasing the number of children undertaking training and wearing cycle helmets;
- Producing guidelines for safety in children's sports and
- Strengthening risk and safety education in schools.

[8] Local Government National Report (2007) , 'changing lanes', www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/20070226changinglanesreport.pdf

[9] Towner E (2002) The prevention of Childhood Injury, Background paper prepared for the Accidental Injury Prevention Task Force

4.0 Scope

This strategy applies to all children and young people 0 to 19years living within the boundaries of Durham County Council.

Specifically the strategy focuses on preventing and reducing unintentional injuries in the home, outdoor play area, water and on the road.

4.1 Targets

Domains 1 and 2 of the Public Health outcomes framework[10] have outcome indicators that are specific to child injury:

Domain 1: 1.1 Children in poverty
1.10 Killed and seriously injured casualties on England's roads
1.15 Statutory homelessness
1.16 Utilisation of outdoor play for exercise/health reasons

Domain 2: 2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s

5.0 Detail of the strategy

The proposed governance and accountability arrangement for delivering this strategy is outlined in appendix 1.

5.1 Understanding the Local Picture

Data available for childhood injury is variable. Comprehensive data exist for road traffic accidents and fires via the police and fire service. Hospital admissions are reported by the Health and Social Care Information Centre (HSCIC) but there is very limited data on Accidents and Emergency (A&E) attendances.

5.1.1 Age Profile

There were 135,953 children and young people aged 0 to 16 years living in County Durham UA in 2010. The following table shows the numbers of children and young people in age bands and how this compares to the region and England.

Table1: 0 to 16 years population as a percentage of the total population

	% of the population aged 0 to 4 years in 2010	% of the population aged 5 to 10 years in 2010	% of the population aged 11 to 16 years in 2010
County Durham UA	5.5	6.2	7.1
North East	5.7	6.3	7.0
England	6.3	6.7	7.1

Source: Office for National Statistics

[10] DH(2012) Improving Outcomes and supporting transparency

County Durham has a similar proportion of under 5 year olds compared to the region but lower than England. Proportion of 5 to 10 year olds and 11 to 16 years olds is similar to the region and England.

5.1.2 Unintentional injuries

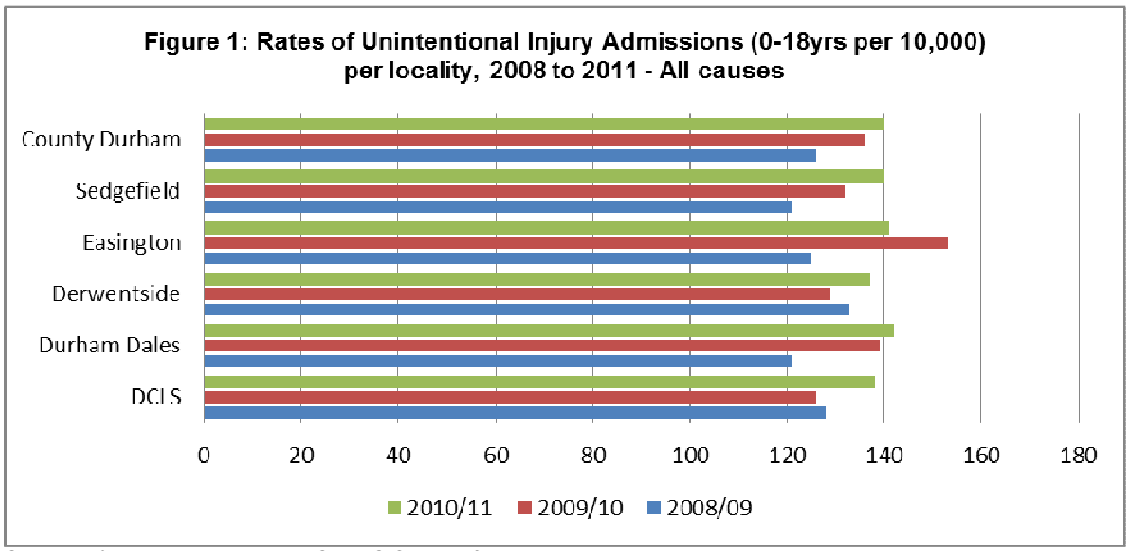
Table 2[11] compares the admissions to hospital due to unintentional injury in County Durham, region and England. It is observed that, in 2010 to 2011, County Durham had a higher rate of hospital admissions from unintentional injuries compared to the region and England.

Table 2: Hospital admissions for unintentional injuries: rate per 10,000 population

	Infants under 5 hospital admissions due to injury cause (2010-2011)	Children 5-17 hospital admissions due to injury cause (2010-2011)	Children under 18 hospital admissions due to injury cause (2010-2011)
County Durham UA	212.59	175.31	185.72
North East	199.62	157.79	169.71
England	143.16	116.34	124.27

Source: Hospital Episode Statistics (HES). The NHS Information Centre for health and social care

Figure 1 below provides a snapshot of hospital admissions attributed to unintentional injuries from all causes for the 0 to 18 year olds by locality. Admission rates gradually increased between 2008 and 2011 in all localities and in County Durham as a whole, except in Easington, where there was a reduction between 2009/10 and 2010/11.



Source: A&E admissions data-HES (NHS CDD performance team)

[11] Child and Maternal Health Intelligence Network.

Table 3 below compares the rate of admissions for transport and non-transport injuries within the same time frame. Non-transport causes mostly accounted for these admissions with no significant differences in rates across the different localities.

Table 3: Rates/10,000 of Unintentional injury admissions (0-18yrs)

	Non-transport			*Transport*		
	2008/09	*2009/10*	*2010/11*	*2008/09*	*2009/10*	*2010/11*
DCLS	111	107	115	17	19	22
Durham Dales	104	120	116	17	19	26
Derwentside	117	107	113	15	22	23
Easington	103	128	119	21	24	22
Sedgefield	103	115	117	17	16	21

Source: A&E admissions data-HES (NHS CDD performance team)

Table 4, provides a breakdown of the types of injury causes per locality and by age group. It is observed that, the highest cause of injury in children in County Durham resulted from non- transport causes and were mostly due to falls in the 0 to 5year olds. Evidence[1] shows that most falls in 0 to 5year olds occur in the home and 6 to15year olds at outdoor play and leisure centres.

Injuries from transport causes happened in the 6-18year olds but predominately in the 6-15year olds. For the 6-15year olds, the injuries were a result of 'pedal cyclist injured in transport accident' and in the 16-18year olds, from 'car occupant injured in transport accident'.

Table 4: Total Number of Hospital Admissions caused by Unintentional Injuriesby Age and Type (2008-2011)								
	County Durham			Easington	Sedgefield	Dales	DCLS	Derwentside
Age group	1 - 5	6 - 15	16 - 18					
Non-transport accidents Total	1436	1659	515	754	678	617	950	611
Falls	704	887	183	381	349	317	452	279
Exposure to inanimate mechanical forces	318	354	172	183	135	152	232	145
Exposure to animate mechanical forces	43	175	52	43	56	49	98	69
Accidental poisoning by and exposure to noxious substances	116	16	7	58	52	38	52	39
Accidental exposure to other and unspecified factors	101	143		54	57	33	79	60
Contact with heat and hot substances	28			6	11		21	12
Overexertion, travel and privation			5	6		5	7	
Exposure to smoke, fire and flames								
Other accidental threats to breathing								
Exposure to electric current, radiation and extreme ambient air temperature and pressure								
Contact with venomous animals and plants								
Transport Accidents Total	35	413	160	143	111	112	166	109
Pedal cyclist injured in transport accident		250	5	74	52	53	79	55
Pedestrian injured in transport accident		54		27	25	6	22	5
Car occupant injured in transport accident			28	5		8	27	10
Motorcycle rider injured in transport accident		6	29	17	11	7	21	9
Other land transport accidents		21		6		18	17	5
Injury of undetermined intent Total								
Contact with sharp object, undetermined intent								
Poisoning								
NOTE: Numbers <5 have been suppressed								

Source: A&E admissions data-HES (NHS CDD performance team)

5.1.3 Falls

The following table shows the number of hospital admissions for falls in County Durham during 2008/09 to 2010/11, compared to the region and England. The rate of falls of all types was higher in County Durham than the region and England averages and the region was higher than the England average.

Table 5: Hospital admissions for falls: rate per 100,000 population

	Hospital admissions for all falls (0 to 4 years) (2008-2010)	Hospital admissions for all falls (5 to 16 years) (2008-2010)	Hospital admissions for all falls (17 to 24 years) (2008-2010)	Hospital admissions for falls from height (0 to 4 years) (2008-2010)	Hospital admissions for falls from height (5 to 16 years) (2008-2010)	Hospital admissions for falls from height (17 to 24 years) (2008-2010)
County Durham	842.74	530.67	346.46	219.69	133.52	92.82
North East	821.53	525.45	322.11	196.22	113.32	78.08
England	571.06	414.37	235.70	127.42	77.90	58.57

Source: Hospital Episode Statistics (HES). The NHS Information Centre for health and social care

5.1.4 Burns

Table 6 shows the number of hospital admissions for burns in County Durham during the period 2006/7 to 2010/11 compared to the region and England. Admission rates for burns in the under 5year olds in County Durham was lower than the region and England. Admission rates were similar to England for the 5year olds and over but lower than the region.

Table 6: Hospital admissions for burns and scalds: rate per 10,000 population

	Admissions for burns in children aged 0 to 4 years (2006-2010)	Admissions for burns in children aged 5 to 16 years (2006-2010)	Admissions for burns in young people aged 17 to 24 years (2006-2010)
County Durham	10.18	1.89	2.58
North East	11.06	2.15	3.35
England	12.10	1.85	2.07

Source: Hospital Episode Statistics (HES). The NHS Information Centre for health and social care

Experimental data from A&E[11]show where people have been diagnosed with 'burns and scalds'. In County Durham, it was observed that:

- 45.87 per 100,000 children aged 0 to 16 years attended A&E for burns and scalds during 2008/09 and 2010/11; and
- 53.80 per 100,000 young people aged 17 to 24 years attended A&E for burns and scalds during 2008/09 and 2010/11.

5.1.5 Exposure to smoke, fire and flames

The following table shows the number of hospital admissions for exposure to smoke, fire and flames in County Durham from 2007/08 to 2010/11. Due to the small numbers, data have been expressed at a Fire and Rescue Service (FRS) level. Please note Durham FRS is displayed below. Admission rates in County Durham for the 0 to 16year olds were lower than the region but higher than England. Admission rates in the over 16year olds were similar to the region but higher than England.

Table 7: Hospital admissions due to exposure to smoke, fire and flames injuries: rate per 100,000 population

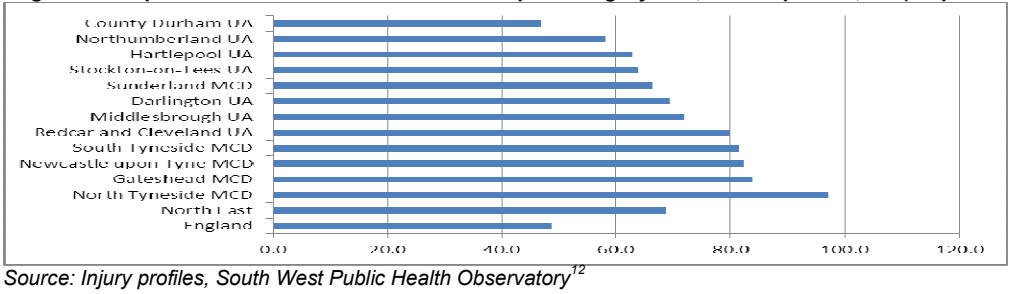
	Hospital admissions for smoke, fire and flames (0 to 16 year olds)	Hospital admissions for smoke, fire and flames (17 to 24 year olds)
County Durham	5.73	10.69
North East	6.08	10.41
England	4.24	6.66

Source: Hospital Episode Statistics (HES). The NHS Information Centre for health and social care

5.1.6 Poisoning

As shown in figure 2 below, County Durham has the lowest number of admissions from unintentional poisoning in the region but similar to national average.

Figure 2: Hospital admissions due to unintentional poisoning injuries, 2010/11per 100,000 (All persons)



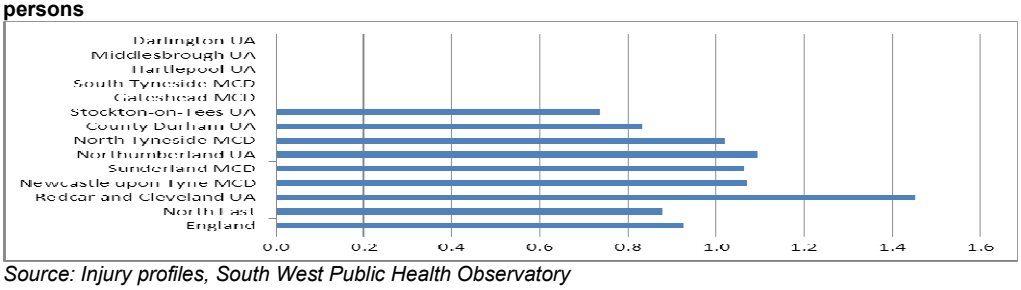
Source: Injury profiles, South West Public Health Observatory[12]

[12] SWPHO, Hospital admissions due to injury, age 0-17. http://www.swpho.nhs.uk/resource/item.aspx?RID=60389

5.1.7 Drowning or submersion

Figure 3 shows that the admission rates from injuries due to drowning in County Durham are similar to both the regional and England averages.

Figure 3: Hospital admissions due to drowning or submersion, 2006/07-2010/11 (combined) per 100,000 –All persons

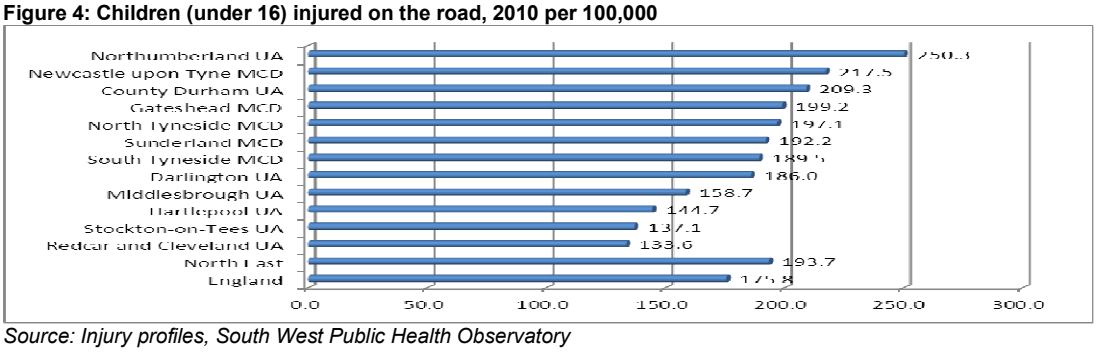


Source: Injury profiles, South West Public Health Observatory

5.1.8 Road injuries

Figure 4 shows road injuries recorded by the police in County Durham UA during 2010 for children and young people compared to the rest of the region and England. County Durham has higher rates of hospital admissions (209.3) per 100,000 due to under 16 injuries on the road than the regional (193.7) and England (175.8) average.

Figure 4: Children (under 16) injured on the road, 2010 per 100,000



Source: Injury profiles, South West Public Health Observatory

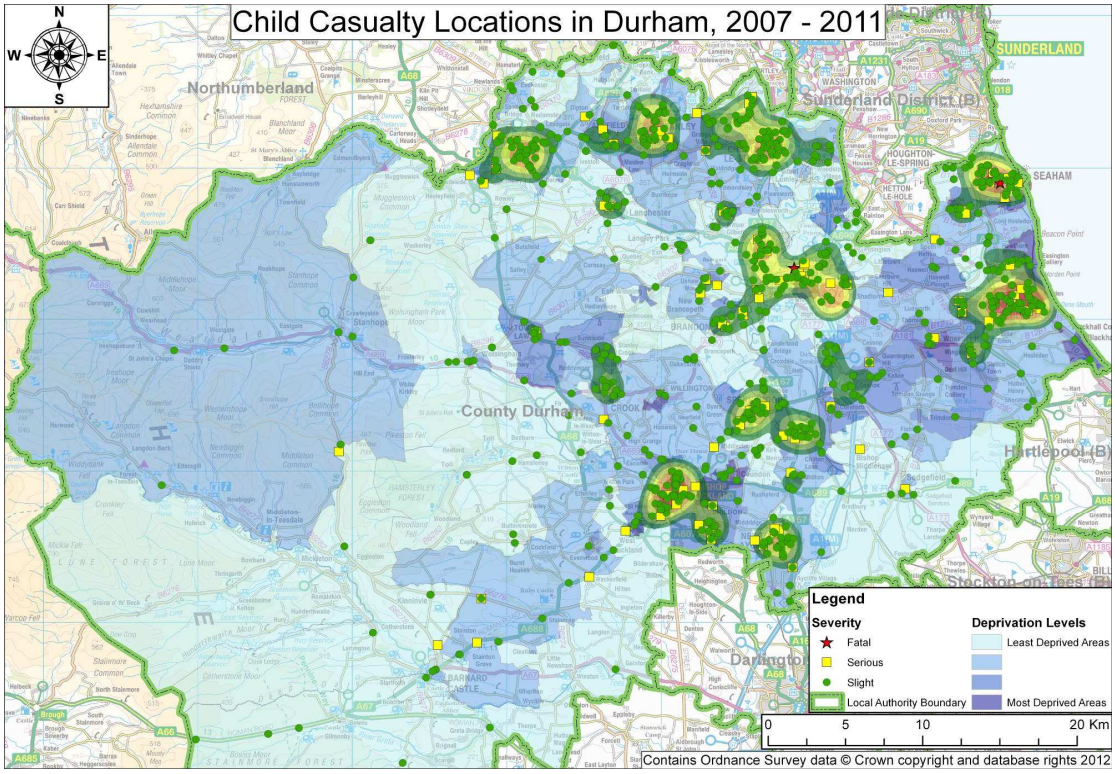
It is important to note that not all road casualties are reported to police.
A&E data shows when people have attended due to a road traffic accident as follows:

- 194.95 per 100,000 children aged 0 to 16 years from County Durham attended A&E as a result of a road traffic accident during 2008/09 and 2010/11.
- 821.21 per 100,000 young people aged 17 to 24 years from County Durham UA attended A&E as a result of a road traffic accident during 2008/09 and 2010/11.

A report by the North East regional road safety resource team[13] provided a breakdown of analysis of child casualties and shows that:

[13] Slater P, Shield C (2012), Analysis of Child Casualties in Durham 2007-2011, North East Regional Road Safety Resource

- County Durham has particularly high numbers of child pedestrians injured in collisions and much worse than England average;
- The majority of child casualties in County Durham occurred in those aged 11 to 15 years;
- There is a gradual decline in casualties for the 11-15year olds but an opposite trend for the 0-5year olds in County Durham;
- For child pedal cyclist casualties, four local authorities (Durham, Northumberland, Newcastle and Sunderland) perform worse than England average, which may indicate an area for improvement and
- Most child casualties occur in the urban centres of County Durham as depicted on the map below, with Seaham and Peterlee having particularly high numbers. Also, as these areas tend to be more deprived, there may be an association between higher numbers of child casualties and higher levels of deprivation.



5.2 Economic costs

Injury has a wide and long-term impact on health including stress, physical disability, social impairment and lower educational attainment and employment prospects. As well as wider heath care costs, there are social care costs, social security costs and productivity losses.[14]

[14] PHE (2014). Reducing unintentional injuries on the road among children and young people under 25years

The Department for Transport calculates the potential value of prevention of casualties from road traffic collisions. The costs take into account the expense to the emergency services, medical care and the loss of future economic output of the casualty. These are shown in table 8 below and calculated using 2009 costs. The estimates allow us to put a monetary figure on the cost of child casualties, and to speculate potential savings if the child casualties had been prevented.

Table 8: Yearly Value of Prevention of Child Casualties in Durham

Severity	2007	2008	2009	2010	2011	Total
Fatal	£1,585,510	£0	£0	£0	£1,585,510	£3,171,020
Serious	£3,563,200	£5,522,960	£3,741,360	£3,206,880	£4,275,840	£20,310,240
Slight	£2,596,860	£2,775,480	£3,009,060	£2,294,580	£2,418,240	£13,094,220
Total	£7,745,570	£8,298,440	£6,750,420	£5,501,460	£8,279,590	£36,575,480

It is estimated that if all of the collisions that caused these casualties had been prevented, this would have saved the County Durham economy over £36.5 million in the five year period.

5.3 Map of Current Activity

During the process of developing this strategy, consultation with partners identified that, a wide range of agencies provided services locally for unintentional injury prevention in children and young people and that there were many examples of good practice and innovation. The majority of the programmes delivered were for safety on the roads and included education in schools, early intervention schemes for young drivers, cyclists and bike safety. Other programmes include road engineering and enforcement campaigns. The fire and rescue team also provide safety carousels and home safety checks. Other agencies also deliver schemes for play and recreation and water safety. There was very limited activity for home safety. A full detail of the current activity is outlined in appendix 2.

5.4 Stakeholder consultation

Consultation on the views of children and young people[15] was carried out by young people with support from investing in children, to find out the knowledge and perceptions on fire safety, water safety, road safety, safety at school, safety while playing out and safety at home. Children and Young people reported that they were well informed on road and fire safety but had limited knowledge of water safety. Parents and other family members and school staff were identified to play significant role in the provision of such information. Feedback from children and young people were mixed depending on where they received safety messages and from whom. They specifically thought that safety messages needed to 'get in their heads', highlighting the following:

- "Safety messages need to be repeated (eg every year) to remind children and young people, using age appropriate language and real life examples and

[15] Davison S, Gaut N, Knox Z, Vasey R (2012). A report about children and young people's views and understanding of the various messages that they receive around safety and injury prevention. Investing in Children, County Durham.

- Safety messages need to be interactive and engaging, such as through posters, the radio, the internet, and films and TV adverts that make them think about the consequences."[11](page 2)

6.0 Strategic action plan

Using the NICE self-assessment tool for the public health guidance on preventing unintentional injuries to benchmark against current practice, a strategic action plan (appendix 3) has been developed from the summary of findings to help progress identified gaps locally and to ensure evidence based practice is embedded in the approach to prevent injuries in children in County Durham. The plan will be reviewed bi-annually by a multi-agency strategic group led by public health. The main areas identified for action are detailed in Appendix 3.

7.0 Conclusion

It is concluded that:

- The types of preventable injury in CYP are age related. The major cause of injury in the 0 -15 is due to falls. Most injuries in the 1- 5year olds occur in the home whereas in the 6-15year olds is due to outdoor play. Transport accidents occur in the 6-18year olds of which injuries in the 6-15year olds is related to pedal cycling whilst that in the 16-18year olds are due to car occupant or motorcycle rider. Interventions can therefore be targeted for maximum output;
- Gaps exist in data available to plan and monitor injury prevention programs locally. The South West Public Health Observatory (SWPHO) has started developing injury profiles to help benchmark against other local authorities, however, the data relates mostly to hospital admissions with limited information on A&E attendances and does not capture data from minor injury or walk-in centers which therefore gives an incomplete picture of the issue. Locally, the North East Regional Road Safety Resource provide quality data to monitor road injuries but this is not available for other types of injuries;
- There is a lot of local activity and good practice to prevent injury in children but at varying levels dependent on the type of injury. For example, road safety prevention is very well advanced and coordinated but very little for water and home safety.
- Not all the relevant current local authority policies have identified prevention of unintentional injury in CYP as a priority;
- Robust partnership arrangements should be in place to coordinate delivery of injury prevention in CYP locally; and
- Clear protocols and pathways for clinical teams to ensure continuity of care for CYP involved in preventable injuries will be delivered. The

knowledge base on injury prevention of some professionals who work with CYP will be further explored.

8.0 Recommendations:

It is recommended that the Director of Public Health has oversight responsibility for implementation of this strategy and to ensure that progress is reported to the Children, Young People and Families' partnership and to the Local Safeguarding Children's Board.

Strategic recommendations include to:

- A local injury prevention strategy group should be developed with relevant partners to lead on implementing the strategic action plan (appendix 3). The strategy group to report to the Children and Families Partnership with links to the Local Safeguarding Children's Board through the Director of Public Health;
- Include child injury prevention in all relevant strategies and take steps to raise the profile of child injury prevention across all partner agencies; and
- Agree local child injury prevention targets which should include both process and outcome measures. The NICE assessment tool and Public Health Outcomes Framework should be used to monitor progress for success.

Specific recommendations include to:

- Continuously monitor, evaluate available data and feedback to relevant partners to ensure appropriate steps are taken to reduce unintentional injuries in children and young people;
- Prioritize home safety and work closely with multi-agency partners to address gaps;
- Ensure that programs are appropriately targeted and dependent on need;
- Explore how to promote safety education in areas that targets parents/carers;
- Promote regular consultation with CYP to ensure programs are tailored to their needs; and
- Support the development of relevant clinical protocols across agencies to ensure quality of care for CYP involved in accidental injury.

Appendix 1: Governance and Accountability Arrangements

The Terms of Reference for the Children and Young People's Unintentional Injury Prevention Strategy Group are outlined below:

Aim: To ensure a strategic and coordinated approach to reducing unintentional injury in children and young people in County Durham.

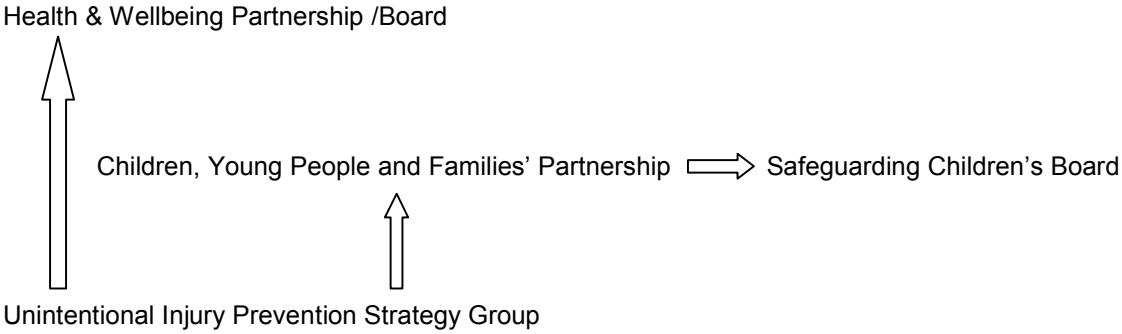
Objectives:

- To review progress on implementation of the recommended actions from the strategy for reducing unintentional injuries in children and young people.
- To make appropriate recommendations to the Local Safeguarding Children Board and Health & Wellbeing board.
- To secure implementation of the strategy through effective performance management and a structured approach to audit and evaluation.

Membership:

Role
Public Health representative
Consultant Pediatrician
Schools representative
One point service Representative
Health Improvement Service Representative
Stronger families service representative
Health Visitor and School Nursing representative
Investors in Children representative
Fire & Rescue Services Representative
Police Service Representative
Health & Safety Representative
Road Safety Representative
Sport & Leisure representative
Youth Services Representative
Play & Urban Games representative
Safer Communities Representative
Voluntary sector representative
Children and Young people representative
Children's commissioning representative
Social services representative
Clinical commissioning group representative

Reporting Mechanism:



Appendix 2: Map of current activity

Priority Area	Current Activities/Initiatives	Lead Organization	Gaps Identified
Fire safety	Carousels (Primary Schools)	Fire &Rescue	
Road safety	Wise drive Die drive Young drive Bike-Wise Annual Event Bike Wise Motorcycle Training, Excelerate Young Driver Training Motorcycles MiniBike Club Community speed watch (speed management strategy) Speed awareness course – occupational road risk course/advice (private company) Driver improvement scheme Enforcement campaigns, insurance / drink/ drug drive, speed vehicles safely School crossing patrol service, Wait a second (motor cycle), Sage Safer Driving with Age scheme (older driver) Bikeability – primary and secondary schools level 1, 2 and 3 Pedestrian training-primary school Junior road safety officers scheme, primary school Road Safety related projects in schools, Good egg –child in car safety County Durham and Darlington causality reduction forum Road safety Engineering Publicity campaigns Local and Regional Publicity Campaigns Respect (motorcycles_ - College and 6th form road shows (driving) Driving for business SAFED (Safe and Fuel Efficient Driving) courses Star accreditation – scheme where schools have to deliver on sustainable travel including road safety to achieve recognition.	Police/F&R Police Police/DCC Police DCC Police Police Police/DCC Police/DCC Police/DCC DCC/Police DCC DCC DCC DCC DCC DCC DBC/DCC/Police/F&R DCC Police/F&R DCC DCC DCC DCC	Low power Motor cycles scooters Drunk/drink impaired pedestrians 20mph zones / safer routes outside of parks / play areas Pedestrian / road awareness for secondary school pupils – use of mobile phone / mp3 whilst cross, etc. Safety on buses independent from training. No ‘push along scooter training’ Evaluation of road safety schemes for impact.
Play & Recreation	Police Alcohol Public order initiatives Summer Nights / Winter Nights Initiatives youth safety Behaviour. Safe at play projects	Police Groundworks	Are safe and suitable places for play effectively advertised to cyp?
Home Safety	Health visitor 0-5 Ante-natal information (pink & fluffy) Home fire safety checks eg smoke alarms, cooking safety, electrical safety and candle safety. Home safety assessment and equipment for vulnerable families	One Point service CDDFT F&R One point service	Opportunistic advice from health care professionals in hospital Gap – home end of safe at home. FARM / agriculture safety rural areas. Gaps info leaflets in hospital Support with safety equipment for children in need Day safety, Detailed risk assessments conducted in areas of disadvantage. Content of antenatal & parenting programmes Re preparing the home. Parenting and programmes only for children flagged to social services Birth-5, download, previously books What resources e.g. dvd are given to new parents re home safety
Water safety	Get Hodies on fishing (x over water safety, play and rec) Epilepsy Action	Police	Loss of free swimming lessons
0-19 settings	EDDY People Initiative- working with young locals to reach groups Youth workers outreach programmes Healthy Star Settings Model programme	Police DCC CDDFT (HIS)	Anti – bullying projects – peaceful playground scheme

Appendix 3: Strategic Action plan

Action Required	Lead agency	Timescale
Partnership working		
Develop local injury prevention strategy group with relevant partners to lead on implementing the NICE action plan	Public Health, CCGs, Social services	March 2015
Support the development of relevant clinical protocols across agencies to ensure quality of care for CYP involved in accidental injury	GPs, School nursing, Health visiting, A&E	March 2016
Support children's centres to raise awareness to parents during National Child safety week by displaying CAPT posters, providing child safety information and having safety related activities	One Point service	Annually (in June)
Explore how to promote safety education in areas that target parents/carers;	All partners	March 2017
Home safety		
Develop local agreement with housing associations/landlords to install permanent safety equipment is installed and maintained in relevant social and rented dwellings	DCC Children's commissioning, Housing	Dec 2017
Encourage home safety risk assessments and advice to at risk families	Health visiting, FNP, Fire&Rescue	Ongoing
Consider providing training on home safety to staff who work with CYP	Fire & Rescue, One point service	March 2016
Explore development of a local scheme to support vulnerable/at risk families to install safety equipment in homes when required	Stronger families One Point service	Ongoing
Outdoor including road safety		
Encourage the implementation of 20mph in lived in areas and schools vicinity in neighbourhoods with high risk for collisions	Road safety partnership	Dec 2017
Develop consultation/evaluation process with local children and young people and their parents, particularly those from disadvantaged communities, about their road use and their opinions about the risks involved to ascertain impact of interventions implemented.	Road safety team	Ongoing
Encourage injury prevention education in schools as part of PSHE	School nursing, Education	Ongoing
Data Monitoring and Evaluation		
Collate and share injury profiles including A&E attendances with relevant partners to help plan and evaluate injury prevention programmes	Public Health	Ongoing

Appendix 4: List of Acronyms

A&E	Accidents and Emergency
CAPT	Child Accidents Prevention Trust
CDD	County Durham and Darlington
CDDFT	County Durham and Darlington NHS Foundation Trust
CYP	Children and Young People
DBC	Darlington Borough Council
DCC	Durham County Council
DCLS	Durham and Chester-le-street
F&R	Fire and Rescue
HES	Hospital Episode Statistics
HWB	Health & Wellbeing board
KSI	Killed or Seriously Injured
LA	Local authority
LSCB	Local safeguarding children's board
MCD	Metropolitan district
NHS CDD	NHS County Durham and Darlington
NICE	National Institute for Health and Clinical Excellence
PHOF	Public Health Outcomes Framework
SWPHO	South West Public Health Observatory
UA	Unitary Authority
UK	United Kingdom
WHO	World Health Organization

Health & Wellbeing Board

5 November 2014

Healthy Weight Strategic Framework for County Durham

Report of Anna Lynch, Director of Public Health County Durham, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to present the Healthy Weight Strategic Framework for County Durham to the Health & Wellbeing Board for agreement.

Background

2. The Joint Strategic Health Needs Assessment[1], the Director of Public Health annual report[2] and the Joint Health and Wellbeing strategy[3] for County Durham have identified overweight and obesity in children, young people and adults as a priority health and social risk area that needs to be addressed. Obesity strategies for children and young people and for adults in County Durham were developed in 2004. Following the review of obesity in primary aged children by the Children and Young People's overview and scrutiny group, it was recommended[4] that the obesity strategy should be reviewed.

3. Over 75% of children in County Durham are a healthy weight when they start school. However throughout the life course, development of excess weight (overweight and obesity) increase to an extent that less than 25% of adults are a healthy weight.

4. In 2011/12, approximately 2000 residents of County Durham across all ages were admitted to hospital with either a primary or secondary diagnosis of obesity[5], most of which could have been prevented.

5. The County Durham Healthy Weight Strategic Framework has been developed by the County Durham Healthy Weight Alliance (HWA) as a local response to 'Healthy Lives, Healthy People: A Call to Action on Obesity in England[6]'. This was developed as a policy priority to tackle the emerging rise in overweight and obesity observed over the past few decades.

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[1] JSNA (2012), http://content.durham.gov.uk/PDFRepository/JSNA-2012-Interactive-Version.pdf. Accessed 8/1/14
[2] NHS County Durham and Darlington, *Back to the Future: annual report of the Director of Public Health,* http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14
[3] County Durham Joint Health and Wellbeing strategy (2013-2017), http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14
[4] Joint Children & Young People's and Adults Wellbeing and Health report (2012), Obesity in primary aged children, http://content.durham.gov.uk/PDFRepository/OS_ObesityinchildrenNov2012.pdf. Accessed 8/1/14
[5] HES, Statistics on obesity, physical activity and diet- England 2013. http://www.hscic.gov.uk/searchcatalogue?productid=11194&topics=2%2fPublic+health%2fLifestyle%2fDiet&sort=Relevance&size=10&page=1#top, Accessed 30/1/14
[6] DH (2010), Healthy Lives, Healthy People :A call to action on obesity in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf. Accessed 13/1/14

6. The Call to Action provides insight into future trends and consequences of obesity. It is estimated that nearly a quarter of people in England are already obese.

7. This could result in a doubling of direct healthcare costs, and an increase in the wider costs to society and business, reaching a possible £49.9 billion by 2050.

8. There are significant social costs associated with the treatment of obesity and its consequences, as well as costs to the wider economy arising from chronic ill health. Sickness absence attributable to obesity in England is estimated at 15.5 -16 million days per year.

9. The Healthy Weight Framework is aligned to priority actions in the County Durham Joint Health and Wellbeing plan, sustainable communities' strategy, cardiovascular disease (CVD) delivery framework, Sustainable food strategy, physical activity strategy, school food action plan for County Durham, Children, Young People and Families Partnership Plan, North Durham CCG commissioning intentions and Durham Dales, Easington and Sedgefield CCG commissioning intentions.

Aims and Objectives

10. The aim of the strategic framework, is to develop and promote evidence based multi-agency working and strengthen local capacity and capability to achieve a sustained upward trend in healthy weight for children, young people and for adults in County Durham by 2020.

11. The objectives are:

    - To develop a supportive built and natural environment such as walking, cycling and access to healthy food and nutrition so that it is less inhibiting to healthy lifestyles;
    - Provide information and practical support available to individuals to make healthier choices;
    - Provide effective programmes and services to help individuals and families achieve and maintain a healthy weight: and
    - Develop a workforce which is competent, confident and effective in promoting healthy weight.

Scope

12. Interventions will be designed across the life course for children, young people and families and for adults and will be targeted according to the specific needs of communities to ensure proportionate distribution of resources. Interventions progressed will be:

    - **Universal** -create positive environments and activities which actively promote and encourage a healthy weight in County Durham. This involves transport, the built environment, parks, open space and access to affordable healthy food. Most interventions at this level will be achieved through provision by the voluntary and community sector, Independent sector, parish councils, children's centres, schools, Area Action Partnerships (AAPs), leisure and culture, businesses, sustainable transport etc. and also through policy and planning. It also includes opportunistic screening of height and

weight by general practitioners (GP), brief intervention and advice and sign posting to relevant activities and programmes;

- **Targeted** – interventions that support individuals, families and communities most at risk of developing overweight and obesity to intervene early. Provision of these interventions will occur mainly through public health commissioning as part of the wellbeing model, breastfeeding and parenting programmes and other children and young people services; and

- **Specialist** – services for children, young people and adults to ensure support to those who need additional help to achieve a healthy weight, including maternity services. These interventions are provided through mainly hospital based services commissioned by Clinical Commissioning Groups or NHS England e.g., bariatric surgery, dietetics, psychology and paediatric services.

The challenge

13. Data from the National Child Measurement Programme (NCMP), shows that in County Durham, very few children (0.6% at reception and 0.8% at year 6) are underweight, compared to those who are either overweight or obese (21.9% at reception and 35.4% at year 6).

14. Interventions to promote healthy weight in children will therefore be targeted more at reducing overweight and obesity and reducing the inequality gap between reception and year 6.

15. Incomplete data exist for adult obesity via the Quality Outcomes Framework (QOF). However, Public Health England estimates that about 28.6% of adults aged 16 years and above are obese in County Durham. Overweight and obese prevalence has been identified to be higher in the most deprived areas of the county.

What we will do

16. A self-assessment was conducted against the recommendations from the NICE guidance (PH42), 'obesity: working with local communities'[7]. There have been consultations with stakeholders including: Clinical Commissioning groups, Voluntary and Community sector, Area Action Partnership Co-ordinators, Scrutiny committee, School nursing and Health visiting service, health watch, Headteachers, Local access forum, Children and Young people, One Point staff, Schools, CDDFT staff, Town and Council forum, local businesses and other relevant agencies between November 2013 to June 2014. Following these a series of strategic actions have been developed. The high level strategic actions include:

    - Explore opportunities for education and training across the life course to promote healthy diet and nutrition;
    - Support the development of A5 (takeaway foods) planning guidance;
    - Explore ways to improve access to the natural environment to increase participation in physical activity;

[7] NICE PH42 (2012), Obesity-working with local communities. http://publications.nice.org.uk/obesity-working-with-local-communities-ph42. Accessed 13/1/14

- Maximise available opportunities to become physically active;
- Consider using a consistent approach to marketing using Change4life branding;
- Develop and implement a model for community engagement; and
- Develop a performance and reporting process for the HWA in order to make relevant data available to all partners and facilitate evaluation and inform commissioning.

17. These actions will be delivered through four multi-agency subgroups of the healthy weight alliance, namely:

    - Food and Health;
    - Physical activity;
    - Social marketing, Engagement and Communications; and
    - Capacity Building, Monitoring, Evaluation and Intelligence.

18. The subgroups will engage with agencies and other community partners to ensure that there is coordinated delivery across the county.

19. Each of these subgroups will produce a detailed delivery plan to be implemented and will report to the HWA. The Food and Health and Physical activity subgroups will in addition report to the Food Partnership and the Sports and Physical Activity Partnership respectively. The HWA will report to the Health and Wellbeing Board through the Director of Public Health annually.

Consultation

20. A series of consultations on the framework with various agencies including Clinical Commissioning groups, Voluntary and Community sector, Area Action Partnerships, Overview & Scrutiny committee, School nursing and Health visiting service, health watch, Headteachers, Local access forum, Children and Young people, One Point staff, Schools, CDDFT staff, Town and Council forum, local businesses and other relevant agencies were carried out between November 2013 to June 2014. Feedback from these sessions have been considered in the development of the framework.

Recommendations

21. The Health & Wellbeing Board is requested to:

- Agree the Healthy Weight Strategic Framework for County Durham
- Note the alignment of the Healthy Weight Strategic Framework to a range of existing strategies between Durham County Council and partner organisations
- Note the need for collaborative working with all relevant partners required for implementation of the strategic framework
- Note the tiered approach to delivery required across the life course; and
- Note the scale of the challenge and potential impact if action to tackle obesity is not progressed
- Note this is long-term approach and actions are programmes over the six year time frame

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Appendix 1: Implications

Finance
The public health grant funds some current commissioned interventions which will be integrated into a new wellbeing approach, based on communities.

Staffing
There are no implications identified for staffing

Risk
Non delivery of the framework poses a risk to achieving some of the performance indicators from the public health outcomes framework, mainly breastfeeding, excess weight in children and in adults and utilisation of outdoor space for physical activity. There is a financial risk to clinical commissioning groups resulting from hospital admissions for obesity and obesity related long term conditions.

Equality and Diversity / Public Sector Equality Duty
Within the delivery of the framework there will be an opportunity to address underlying causes of unhealthy weight e.g., equity, poverty and social justice

Accommodation
There are no new implications for accommodation, although some interventions may need to be delivered at existing premises such us community centres and children's centres.

Crime and Disorder
There are no implications for crime and disorder

Human Rights
There are no implications for human rights

Consultation
A series of consultations on the framework with various agencies including Clinical Commissioning groups, Voluntary and Community sector, Area Action Partnerships, Scrutiny committee, School nursing and Health visiting service, health watch, Headteachers, Local access forum, Children and Young people, One Point staff, Schools, CDDFT staff, Town and Council forum, local businesses and other relevant agencies were carried out between November 2013 to June 2014. Feedback from these sessions have been considered in the development of the framework.

Procurement
No implications

Disability Issues
There are no identified implications for disability issues

Legal Implications
There are no legal implications identified

DRAFT

Healthy Weight Strategic Framework

for County Durham

2014 – 2020

Esther Mireku September 2014

Reader Information	
Title	Healthy Weight Strategic Framework For County Durham -2014-2020
Department	Public Health
Author	Esther Mireku- Public Health Portfolio lead, Durham County Council (DCC)
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Description	This document analyses need, current services and multi-agency working to promote the proportion of healthy weight in children and adults in County Durham and makes recommendations for future commissioning and delivery arrangements.
Superseded documents	N/A
Contact details	esther.mireku@durham.gov.uk
Related information	County Durham CVD delivery framework Count Durham Sustainable Food Strategy County Durham Physical Activity Strategy School Food action plan for County Durham County Durham Joint Health and Wellbeing strategy County Durham Children and Families plan County Durham sustainable communities strategy North Durham CCG commissioning intentions DDES CCG commissioning intentions

Contents

1. Summary

Context

Over 75% of children in County Durham are a healthy weight when they start school however throughout the life course development of excess weight (overweight and obesity) increase to an extent that below 25% of adults are a healthy weight. Underweight in children remains below 1% however there is insufficient information for estimates in adults. Interventions to promote healthy weight will therefore have to be targeted more at reducing excess weight and reducing the inequality gap across the life course through proportionate distribution of resources. In 2011/12, approximately 2000 residents of County Durham across all ages were admitted to hospital with either a primary or secondary diagnosis of obesity[1], most of which could have been prevented.

The World Health Organization (WHO) global Strategy on Diet, Physical Activity and Health[2] provided recommendations for the promotion of healthy weight and prevention of non-communicable diseases. In 2011, the British government proposed that a new way of looking at the issue was needed to make a step-change towards a healthier weight for everyone. Two new national ambitions were set:

- Achieve a sustained downward trend in the level of excess weight in children by 2020 and
- Achieve a downward trend in the level of excess weight averaged across all adults by 2020.

The Joint Strategic Health Needs Assessment (JSNA)[3], the Director of Public Health annual report[4] and the Joint Health and Wellbeing strategy[5] for County Durham identified excess weight in children, young people and adults as a priority health and social risk area that needed to be addressed.

This strategic framework is aligned to priority actions in the County Durham Joint Health and Wellbeing plan, Sustainable communities' strategy, Cardiovascular disease (CVD) delivery framework, Sustainable Food Strategy, Physical Activity Strategy,
School Food plan, Children, Young People and Families Partnership plan, North Durham Clinical Commissioning Group (CCG) commissioning intentions and Durham Dales, Easington and Sedgefield (DDES) CCG commissioning intentions.

The strategic framework has been developed through the County Durham Healthy Weight Alliance (HWA), a multi-agency group working to systematically promote healthy weight in County Durham.

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[1] HES, Statistics on obesity, physical activity and diet- England 2013. http://www.hscic.gov.uk/searchcatalogue?productid=11194&topics=2%2fPublic+health%2fLifestyle%2fDiet&sort=Relevance&size=10&page=1#top, Accessed 30/1/14

[2] WHO(), Global strategy on Diet, Physical Activity and Health, http://www.who.int/dietphysicalactivity/en/ Accessed 15/1/14

[3] JSNA (2012), http://content.durham.gov.uk/PDFRepository/JSNA-2012-Interactive-Version.pdf. Accessed 8/1/14

[4] NHS County Durham and Darlington, *Back to the Future: annual report of the Director of Public Health,* http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14

[5] County Durham Joint Health and Wellbeing strategy (2013-2017), http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14

Aims and Objectives

The aim of the strategic framework is to:

Develop and promote evidence based multi-agency working and strengthen local capacity and capability to achieve a sustained upward trend in healthy weight for children and for all adults in County Durham by 2020.

The objectives are:

- To develop a supportive built and natural environment so that it is less inhibiting of healthy lifestyles such as walking, cycling and access to healthy food and nutrition;
- Provide information and practical support needed for individuals to make healthier choices;
- Provide effective programmes and services to help individuals and families achieve and maintain a healthy weight; and
- Develop a workforce which is competent, confident and effective in promoting healthy weight.

Scope

This strategic framework relates to children, young people and families, and adults within the boundaries of Durham County Council and covers the whole life course (pregnancy to death). Interventions progressed will be:

- **Universal** - create positive environments and activities which actively promote and encourage a healthy weight in County Durham. This involves transport, the built environment, parks, open space and access to affordable healthy food. Most interventions at this level will be achieved through provision by the voluntary and community sector (CVS), Independent sector, parish councils, children's centres, schools, Area Action Partnerships (AAPs), leisure and culture, businesses, sustainable transport etc. and also through influencing policy. It also includes opportunistic screening of height and weight by general practitioners (GP), brief intervention, advice and sign posting to relevant activities and programmes;
- **Targeted** – interventions that support individuals, families and communities most at risk of developing overweight and obesity to intervene early. Provision of these interventions will occur mainly through public health commissioning as part of the wellbeing for Life model, breastfeeding and parenting programmes;
- **Specialist** – services to ensure support to those who need additional support to achieve a healthy weight. These interventions will be provided through primary care/hospital based services commissioned by Clinical Commissioning Groups. E.g. bariatric surgery, dietetics, psychology, paediatrics

What we will do

Stakeholders in County Durham have completed a self- assessment against the NICE guidance PH42 (Obesity: working with local communities), which resulted in prioritising of strategic actions. The high level strategic actions include:

- Provide interventions, education and training opportunities across the life course to promote healthy diet and nutrition;
- Support and progress implementation of A5 (takeaway foods) planning guidance;
- Improve access to the natural environment to increase participation in physical activity;
- Maximise opportunities available to become physically active;
- Adopt a consistent approach to marketing using Change4life branding;
- Develop and implement a model for community engagement; and
- Develop a performance and reporting process for the HWA in order to make relevant data available to all partners and facilitate evaluation and inform commissioning.

These actions will be progressed through four multi agency subgroups of the healthy weight alliance who will engage with agencies and community partners to ensure there is coordinated delivery. The subgroups will report to the HWA. The Food and Health and Physical activity subgroups will in addition report to the Food Partnership and the Sports and Physical Activity Partnership respectively. The HWA will report to the Health and wellbeing board through the Director of Public Health.

How we will know if we have been successful

Implementation of the strategic actions identified through this strategic framework will contribute to achieving improvements in some of the indicators from the Public Health Outcomes Framework (page 19 of this framework). These indicators will be tracked and monitored throughout the lifetime of the strategic framework.

Summary of Conclusion and Recommendations

Partners across the county and members of the population must be engaged in order to effectively address healthy weight. Actions taken should focus on:

- Building capacity and capability to promote physical activity and healthy diets;
- Tackling the obesogenic environment;
- Adopt Change4life branding;
- Investing in prevention, targeted and specialist support through proportionate resource distribution aligned to existing programmes and activities; and
- Embedding evaluation to demonstrate impact and value for money.

2. Setting the context

Lifestyle and behavior choices are important factors in influencing weight status. In County Durham, over 75% of children are a healthy weight when they start school however throughout the life course development of excess weight (overweight and obesity) increase to an extent that less than25% of adults are a healthy weight. The issues relating to underweight are not explored in this framework as less than 1% of children are considered underweight and there is currently insufficient information for estimates in adults.

In 2011/12, approximately 2000 residents of County Durham across all ages were admitted to hospital with either a primary or secondary diagnosis of obesity[1], most of which could have been prevented.

Unhealthy diets and physical inactivity are major risk factors for excess weight as well as a number of chronic health conditions including cardiovascular disease, diabetes, some cancers and high blood pressure and has implications for social care and mental wellbeing.

In May 2004, the World Health Organisation (WHO) produced a global Strategy on Diet, Physical Activity and Health[6]. This strategy provided recommendations on the promotion of healthy diets and regular physical activity for the promotion of healthy weight and prevention of non-communicable diseases.

In 2011, the British government proposed that a new way of looking at the issue was needed to make a step-change towards a healthier weight for everyone. Two new national ambitions were set:

- Achieve a sustained downward trend in the level of excess weight in children by 2020 and
- Achieve a downward trend in the level of excess weight averaged across all adults by 2020.

The Joint Strategic Health Needs Assessment[7], the Director of Public Health annual report[8] and the Joint Health and Wellbeing strategy[9] for County Durham have identified excess weight in children, young people and adults as a priority health and social risk area that needs to be addressed.

This strategic framework has been written as a high-level overview of current issues around healthy weight and has a focus on what will follow to achieve sustainable change in County Durham. It draws on the main themes from '*Healthy Lives, Healthy People: A Call to action on Obesity in England*[10]*'* , *Joined up clinical pathways:*

[6] WHO(), Global strategy on Diet, Physical Activity and Health, http://www.who.int/dietphysicalactivity/en/ Accessed 15/1/14
[7] JSNA (2012), http://content.durham.gov.uk/PDFRepository/JSNA-2012-Interactive-Version.pdf. Accessed 8/1/14
[8] NHS County Durham and Darlington, *Back to the Future: annual report of the Director of Public Health,* http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14
[9] County Durham Joint Health and Wellbeing strategy (2013-2017), http://content.durham.gov.uk/PDFRepository/Public-Health-Annual-Report-2011-2012.pdf. Accessed 8/1/14
[10] DH (2010), Healthy Lives, Healthy People: A call to action on obesity in England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213720/dh_130487.pdf. Accessed 24/9/13

Report of the working group[11] and the National Institute for Health and Care Excellence (NICE) guidance PH42, '*Obesity: working with local communities'* [12] as a clear vision for where action should be taken.

The strategic framework is aligned to priority actions in the County Durham Joint Health and Wellbeing plan, Sustainable communities' strategy, Cardiovascular disease (CVD) delivery framework, Sustainable Food Strategy, Physical Activity Strategy, School Food action plan for County Durham, Children, Young People and Families Partnership plan, North Durham CCG commissioning intentions and DDES CCG commissioning intentions.

The strategic framework seeks to build on existing partnerships and to establish clear links with local services and activities in line with national, regional and local priorities and the evidence base of what works and to help a wide range of partners to see their role in tackling this important priority. It has been developed through the County Durham Healthy Weight Alliance, a multi-agency partnership working to systematically promote healthy weight in County Durham. Its role and way of working will be reviewed as part of the action plan.

The document has been based on dialogue between local partners and consultation with stakeholders.

3. Aims and Objectives

The aim of the strategic framework is to:

- Develop and promote evidence based multi-agency working and strengthen local capacity and capability to achieve a sustained upward trend in healthy weight for children and for all adults in County Durham by 2020.

The objectives are:

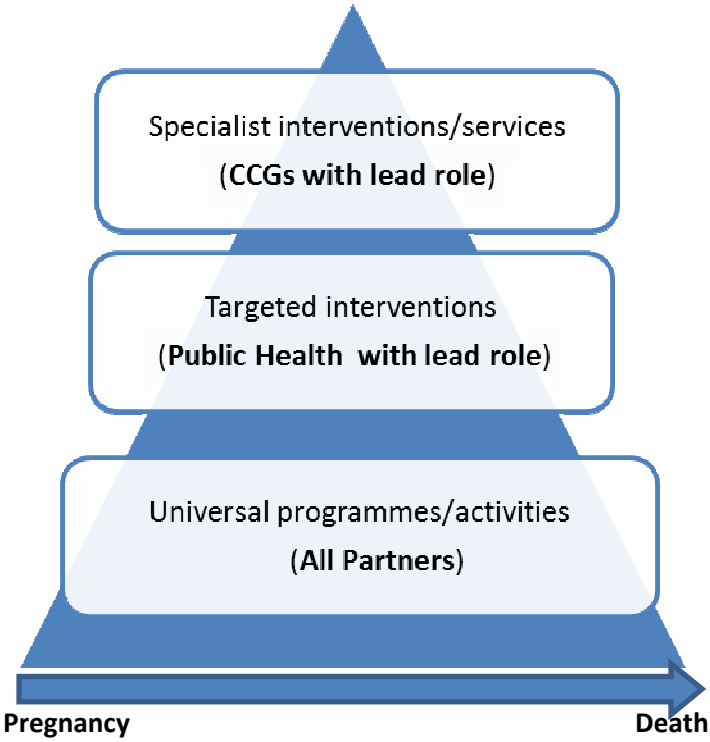
- To develop a supportive built and natural environment so that it is less inhibiting of healthy lifestyles such as walking, cycling and access to healthy food and nutrition;
- Provide information and practical support needed for individuals to make healthier choices;
- Provide effective programmes and services to help individuals and families achieve and maintain a healthy weight: and
- Develop a workforce which is competent, confident and effective in promoting healthy weight.

[11] NHS England (2014), *joined up clinical pathways:* Report of the working group. http://www.england.nhs.uk/wp-content/uploads/2014/03/owg-join-clinc-path.pdf. Accessed 22/8/14

[12] NICE PH42 (2012), Obesity-working with local communities. http://publications.nice.org.uk/obesity-working-with-local-communities-ph42. Accessed 2/10/13.

4. Scope

This strategic framework relates to children, young people and families, and adults living within the boundaries of Durham County Council and covers the whole life course (pregnancy to death) as shown in the diagram below. Interventions progressed will be:



- **Universal** - create positive environments and activities which actively promote and encourage a healthy weight in County Durham. This involves transport, the built environment, parks, open space and access to affordable healthy food. Most interventions at this level will be achieved through provision by the voluntary and community sector, Independent sector, parish councils, children's centres, schools, Area Action Partnerships (AAPs), leisure and culture, businesses, sustainable transport etc. and also through influencing policy and planning. It also includes opportunistic screening of height and weight by general practitioners (GP), brief intervention, advice and sign posting to relevant activities and programmes;
- **Targeted** – interventions that support individuals, families and communities most at risk of developing overweight and obesity to intervene early. Provision of these interventions will occur mainly through public health commissioning as part of the wellbeing model, breastfeeding and parenting programmes; and
- **Specialist** – services for children, young people and adults to ensure support to those who need additional support to achieve a healthy weight, including maternity services. These interventions will be provided through hospital based services commissioned by Clinical Commissioning Groups. e.g. bariatric surgery, dietician, psychology and paediatrician.

5. What is the problem?

The fundamental cause of unhealthy weight is an energy imbalance between calories consumed and calories expended. 'Changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and lack of supportive policies and legislation in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing and education'[13].

5.1 Definition of 'healthy weight'

The term 'healthy weight' is used to describe when an individual's body weight is appropriate for their height and benefits their health. Body weights above (overweight) or below (underweight) the healthy weight range produce adverse effects on health and wellbeing. 'Excess weight' refers to a combination of overweight and obesity.

The recommended measure of underweight, healthy weight, overweight and obesity in children and adults is the body mass index (BMI). BMI is calculated by dividing body weight (kilograms) by height (metres) squared. In children this is adjusted for a child's age and gender. The National Childhood Measurement Programme (NCMP) uses BMI reference charts to classify children which take into account children's weight and height for their age and sex.

Table 1 outlines the classification of BMI in children and adults respectively.

Table 1: BMI classification

Classification	BMI centile range- children	BMI range-Adults (kg/m^2)
Underweight (children may be healthy at this BMI centile)	Below 2nd BMI centile	<18.5
Healthy weight	Between 2nd and 90th BMI centiles	18.5 – 24.9
Overweight	Between 91st and 97th BMI centiles	25.0 – 29.9
Very overweight/Obese (clinically obese)	At or above 98th BMI centile	30.0 – 39.9
Morbidly Obese		>40

Source: NCMP guidance 2013/14[14], NICE 2006[15]

5.2 Healthy weight in Children – the challenge

Information gathered through the NCMP[16], table 2 below, show that, in County Durham, there are fewer children who are underweight at both reception (4-5 year olds) and year 6 (10-11 year olds) compared to England average.

[13] WHO, Obesity and overweight, http://www.who.int/mediacentre/factsheets/fs311/en/index.html. Accessed 30/1/14
[14] NCMP operational guidance for 2013/14. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251651/NCMP-guidance-October-2013.pdf. Accessed 21/10/13
[15] NICE (2006) CG43. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. http://guidance.nice.org.uk/CG43. Accessed 23/10/13
[16] NCMP, http://www.hscic.gov.uk/catalogue/PUB13115/nati-chil-meas-prog-eng-2012-2013-tab.xls. Accessed 23/1/14

There are however, more children who have excess weight at year 6 but similar at reception compared to England average. Proportions of children who are underweight in County Durham are very low compared to those who have excess weight.

Figure 1 below shows that, the proportion of children in County Durham who have a healthy weight reduces by about 14% from reception to year 6.

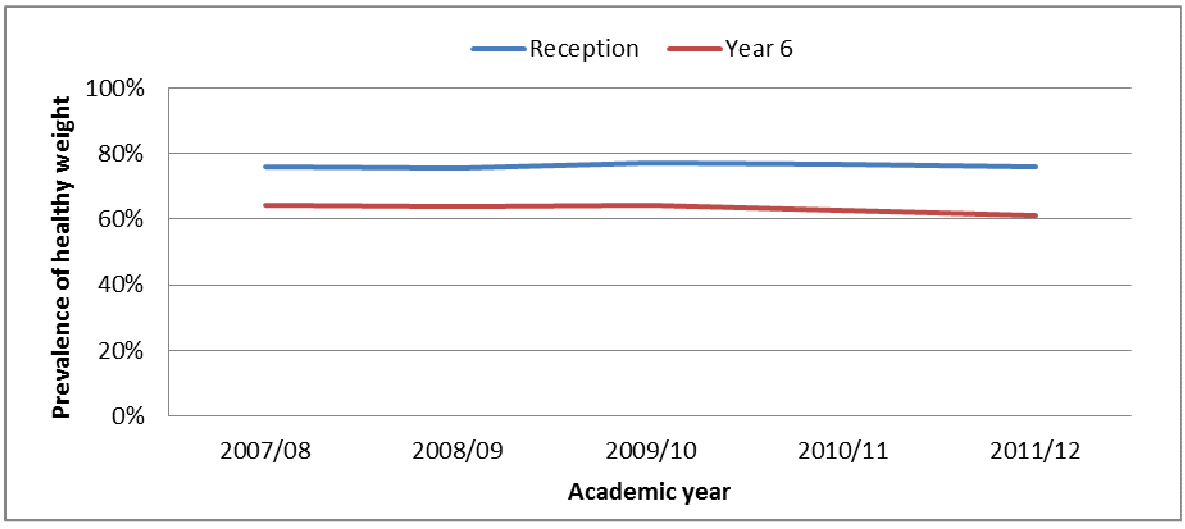
Interventions to increase healthy weight in children in County Durham will therefore need to place a greater emphasis on reducing excess weight and to bridge the gap between reception and year 6.

Table 2: Prevalence of underweight, healthy weight, overweight and obesity in children at reception and year 6 in County Durham (2012/13)

	Reception		Year 6	
	County Durham	England	County Durham	England
Underweight	0.6%	0.9%	0.8%	1.3%
Healthy weight	77.5%	76.9%	63.2%	65.4%
Overweight	12.8%	13.0%	14.4%	14.9%
Very overweight/ Obese	9.1%	9.3%	21.0%	18.9%
Excess weight (overweight plus very overweight)	21.9%	22.3%	35.4%	33.8%

Source: NCMP, www.hscic.gov.uk

Figure 1: Prevalence of healthy weight children, reception and year 6, County Durham, 2007/08 to 2012/13



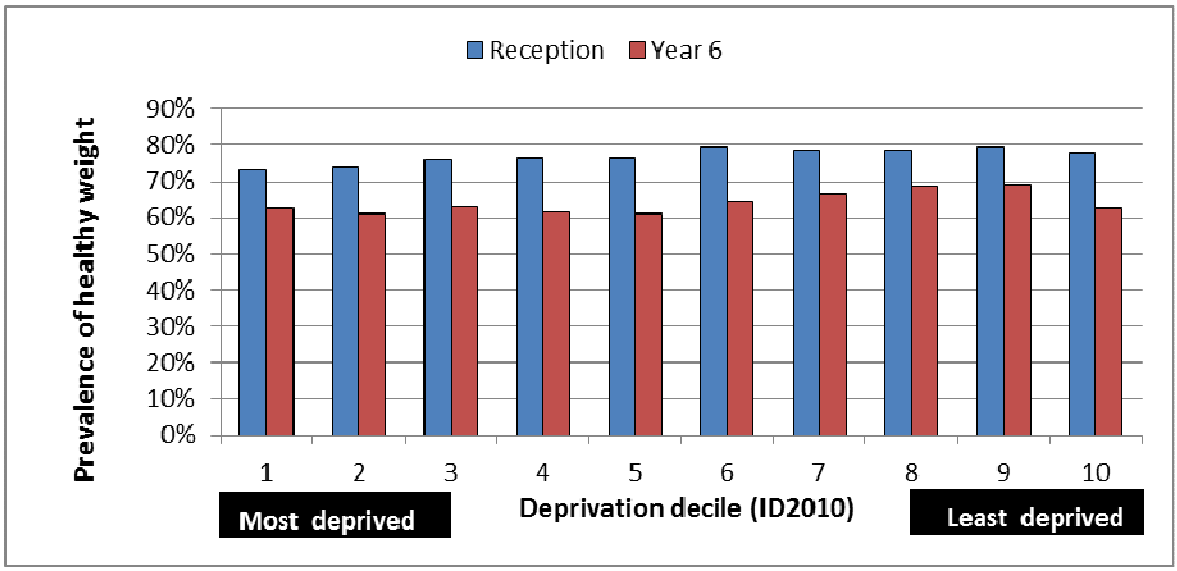
Source: NCMP,www.hscic.gov.uk

Other data from the NCMP have shown that, excess weight in children affects more boys than girls and is higher in children with learning disabilities.

There is a direct relationship between deprivation and achievement of healthy weight in children. From figure 2 below, it is observed that at reception age, there are fewer children who are of a healthy weight in the most deprived families compared to the least deprived/most affluent families.

At year 6, the difference is insignificant and it is also observed that, children from the lowest (1st) and highest (10th) deprivation deciles have the same prevalence of healthy weight. This trend needs to be considered when targeting interventions to reduce inequalities for healthy weight in children in County Durham and to ensure proportionate distribution of resources.

Figure 2: Prevalence of healthy weight children in County Durham at reception and year 6 (2008-11) compared to level of deprivation



Source: NCMP, HSCIC.

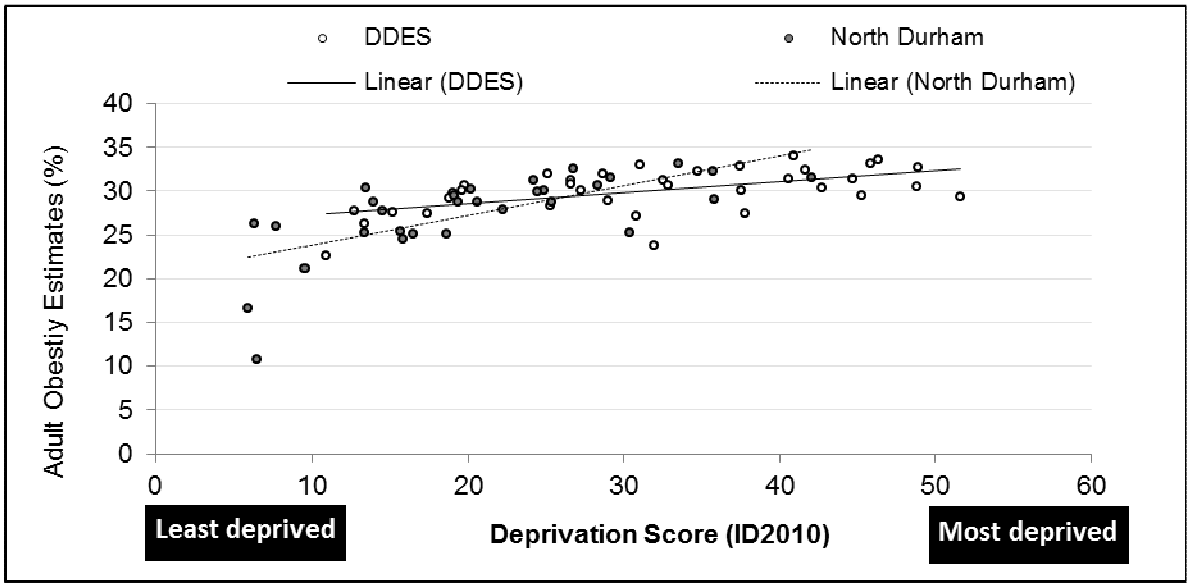
5.3 Healthy Weight in Adults – the challenge

Public Health England (PHE) estimate that 28.6% of the adult population in County Durham aged 16 and over was obese based on modelled estimates[17]. There is some limited data available at a local level via the national Quality Outcomes Framework (QOF) however this data only includes the BMI of those individuals who visit their GP practice and is therefore reflective of prevalence at the population level.

The National Obesity Observatory (NOO) has shown that obesity varies by household income, with greater prevalence associated with lower household income. Figure 3 shows that the relationship between adult obesity estimates and deprivation is strong in North Durham (cc=0.7) and moderate in Durham Dales, Easington and Sedgefield (DDES) (cc=0.5) Clinical Commissioning Group (CCG) areas. Interventions in the DDES area should therefore not be targeted based on deprivation alone, but should consider obesity prevalence in addition, to ensure proportionate distribution of resources.

[17] PHE, Health profiles, http://www.apho.org.uk/resource/view.aspx?RID=50215&SPEAR. Accessed 30/1/14

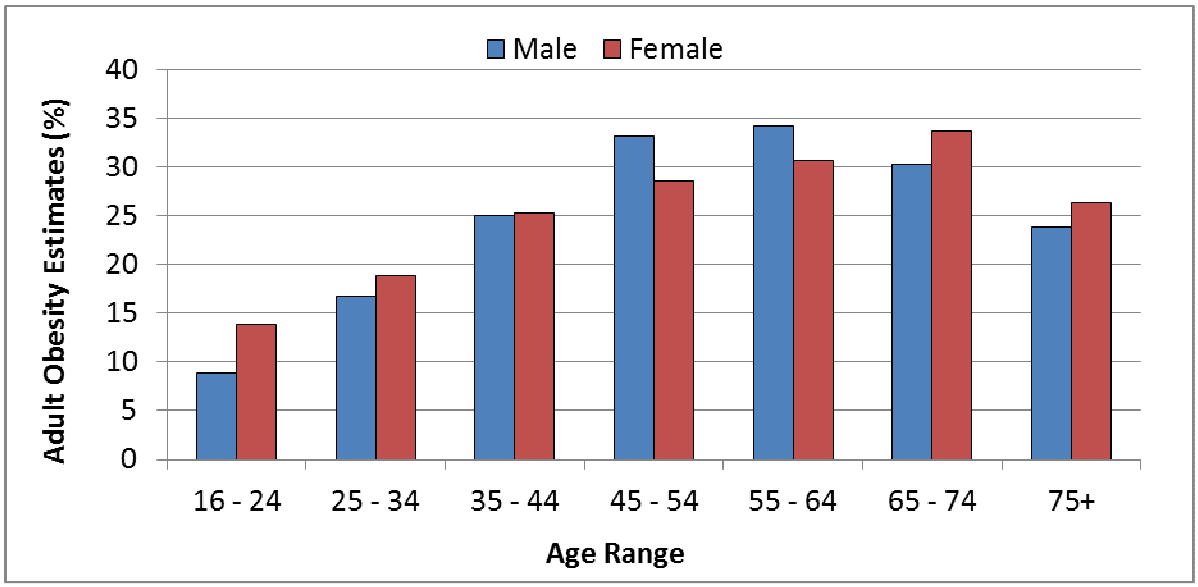
Figure 3: Relationship between middle super output area adult obesity estimates and deprivation, DDES and North Durham CCGs.



Source: Quality Outcomes Framework 2012/13 (QOF), HSCIC.

In addition there is greater prevalence in the older segments of the population although not so different between the sexes (except perhaps at the lowest extreme) as demonstrated in figure 4.

Figure 4: Adult Obesity prevalence by age and sex Health Survey for England 2008-2010



Source: National Obesity Observatory (NOO), Public Health England (PHE)

Obesity in pregnancy (or maternal obesity) increases the risks to health for the mother and child during and after pregnancy and obesity has been described as the biggest challenge facing maternity services today with an 8% increase in maternal obesity in England since 1989 (CMACE 2010). In County Durham the level of maternal obesity is estimated to be around 22% based on booking data from local maternity services. There is good evidence to suggest that women are more motivated to make a lifestyle change when they are pregnant therefore it is important that opportunities to support healthier lifestyle choices are available at key points in life.

5.4 Physical Activity

Physical activity is one of the key lifestyle factors impacting on achieving a healthy weight and reducing development of non-communicable diseases such as diabetes mellitus, hypertension, cancer and cardiovascular diseases as well as improving mental wellbeing. In County Durham 52.2% of the Adult population achieve the Chief Medical Officer (CMO) recommendation of 150 minutes per week compared to the England average of 56%[16].

Physical activity levels for children in County Durham are significantly higher than the English average. 56.7% of children in years 1 to 13 spend at least 3 hours per week on high quality PE and school sport compared to 55.1% nationally[18]. In order to sustain and to improve further this level of participation, it is important to encourage greater use of the natural environment and ensure green spaces, cycle ways and footpaths are well maintained.

5.5 Food and Nutrition

An unhealthy diet is one of the major risk factors for a range of chronic diseases, including cardiovascular diseases, cancer, diabetes and other conditions linked to excess weight. Specific recommendations for a healthy diet include: eating more fruit, vegetables, legumes, nuts and grains; cutting down on salt, sugar and fats. It is also advisable to choose unsaturated fats, instead of saturated fats and towards the elimination of trans-fatty acids[19]. Improving dietary habits is a societal, not just an individual problem. Therefore it demands a population-based, multisectoral, multi-disciplinary, and culturally relevant approach.

5.6 Economic costs

There are significant social and health costs associated with the treatment of obesity and its consequences, as well as costs to the wider economy arising from chronic ill health. Sickness absence attributable to obesity in England is estimated at 15.5 -16 million days per year.

[18] Child and Maternal Health Network, *Child Health Profile 2013.* *http://atlas.chimat.org.uk/IAS/dataviews/report?reportId=201&viewId=305&geoReportId=3567&geoId=4&geoSubsetId=. Accessed 30/1/14*

[19] WHO, diet, http://www.who.int/topics/diet/en/. Accessed 30/1/14

Estimates of the direct costs to the NHS for treating overweight and obesity, and related morbidity in England, have ranged from £479.3 million in 1998 to £4.2 billion in 2007. Estimates of the indirect costs (those costs arising from the impact of obesity on the wider economy such as loss of productivity) over the same time period ranged between £2.6 billion and £15.8 billion. Modelled projections suggest that indirect costs could be as much as £27 billion by 2015. In 2006/07, obesity and obesity-related illness was estimated to have cost £148 million in inpatient stays in England[20].

6. What we need to do – an evidence based approach

Achieving a higher proportion of healthy weight in the population is a complex social and public health issue that requires coordinated multi-agency working. Evidence[2], [21] shows that interventions aimed solely at individuals are inadequate and simply increasing numbers of small scale interventions will not reverse the current trend. Effective action promoting healthy weight at a population level whilst targeting the obesogenic environment, coupled with providing opportunities to improve nutrition and physical activity in individuals is recommended. There are several NICE guidance documents associated specifically with healthy weight all of which highlight the need for wide partnership action. The recommendations apply to individuals and organisations across the public, private, community and voluntary sector. For the purposes of this strategic framework, the NICE guidance PH42, Obesity: working with local communities[11] has been used as the gold standard for promoting healthy weight in County Durham.

A self-assessment against NICE guidance PH42 was completed, NICE obesity ph42 self assessment CD.xls, to assess the current state and identify strategic actions that will need to be undertaken to ensure that there is:

- Strategic leadership and support at all levels;
- Coordination of local action;
- Improved communication;
- Community involvement and engagement;
- Integrated commissioning;
- Involvement of businesses and social enterprises operating in County Durham;
- Learning and sharing of good practice;
- Monitoring and evaluation of programmes including cost effectiveness; and
- Workforce training and capability.

There will be an annual review of the NICE action plan to take account of any emerging issues or guidance that can help to strengthen local delivery.

[20] NOO. Economics of Obesity. http://www.noo.org.uk/NOO_about_obesity/economics. Accessed 24/10/13

[21] The School Food Plan, http://www.schoolfoodplan.com/wp-content/uploads/2013/07/School_Food_Plan_2013.pdf

7. Stakeholder consultation

In developing this strategic framework, consultations have been undertaken using local existing partnerships and mechanisms to include contributions from key stakeholders. This has included the Area Action Partnerships (AAPs), Healthwatch, Durham voice, membership of the healthy weight alliance, Clinical Commissioning Groups (CCGs), parish councils, schools, local access forum, health networks, Durham businesses, carer's groups, care home providers, nurseries, County Durham and Darlington NHS Foundation Trust (CDDFT) and market engagement events with third sector organisations. Themes drawn from these consultations include:

- Ensure the language is simple and messages are clear to support all organisations and stakeholders to progress in 'Making Every Contact Count' (MECC)[22];
- Agree a common message relating to the healthy weight agenda;
- Co-ordinate delivery and implement integrated commissioning and integrated provision across all sectors;
- Need to place a greater focus on universally proportionate provision;
- It is important to promote local innovation and to provide opportunities for partners to learn and share from good practice;
- Use existing local structures to access hard to reach groups;
- Use expertise out there and groups that already exist to support communities;
- Keen to see outcomes where we can actually make a difference; and
- Ensure that healthy weight is considered in all policy and strategy development.

8. Strategic Actions

A strategic action plan (Table 3 below) has been developed following contributions from stakeholder consultations and the self-assessment against the NICE guidance. These actions have been grouped and will be addressed as short term (within one year), medium term (within two to three years) and long term (within four to six years) by the delivery subgroups identified in section 9.0 of this framework. Each of the subgroups will produce a detailed delivery plan that will include process and outcome measures to address the strategic actions. These will be multi-agency plans with partners leading on the relevant areas as described under section 4.0 of this framework. Partners are encouraged to maximise inward investments and resource to avoid duplication and promote coordinated delivery.

Actions agreed will need to consider proportionate distribution of resources in line with the findings from the evidence (sections 5.2 and 5.3 of this framework) and ensure that whereas there is a need to consider interventions to reduce underweight, a greater emphasis is placed on reducing excess weight. In addition, interventions will have to be proportionately aimed at reducing gaps in inequalities along the life course and at geographic levels, taking into consideration the impact on deprivation.

[22] Making Every Contact Count (MECC) encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices.

Table 3: Strategic Action Plan

Strategic Actions	Mar 2016	Mar 2018	Mar 2020	Lead Agency
Food and Health				
Explore opportunities for education and training across the life course (birth to death) – Including breastfeeding, weaning, food growing clubs/allotments, classroom education, cooking clubs, farmers markets, school meals, food banks, etc.	√	√	√	Food partnership, Schools, School nursing, Health visiting, DCC education and public health, CCGs, CDDFT dietetics, AAPs, VCS, Parish Councils, children's centres
Support local businesses to recognise and acknowledge social responsibilities to • Employees health choices • Residents via award/accreditation scheme for businesses	√	√	√	DCC environmental health and public health, Local businesses, Parish Councils
Support the development of A5 (takeaway foods) and street trading planning guidance currently going through County Durham Plan through advocacy and lobbying.	√	√		DCC planning, Parish councils
Explore using procurement processes to specify dietetically appropriate food choices, including low salt and low fat products in settings such as schools, care homes, hospitals, leisure centres and canteens and to include vending machines		√	√	DCC procurement, Food partnership
Physical Activity				
Increase awareness of the benefits of being physically active across the life course	√	√	√	PH, VCS, Independent sector, CCGs, schools. Parish Councils
Maximise affordable opportunities available to become physically active	√	√	√	PH, CCG, AAPs, Culture & leisure, schools, VCS, Independent sector
Explore ways to mprove access to physical activity and encourage greater use of the natural environment			√	DCC planning, neighbourhoods and sustainable transport, AAPs, Parish Councils
Build on community assets and protect existing natural environments/resources, within communities to harness the energy & resource at local level	√	√		DCC planning, AAPs, VCS, Independent sector. Parish Councils
Social Marketing, Engagement and communication				
Consider a consistent approach to marketing using Change4life branding for all healthy weight initiatives in County Durham	√			Public Health, PHE, All providers/partners
Develop a shared communications plan for partners. This will inform partners of ongoing activities in order to improve accessibility and maximise opportunities for clients across the county	√			Public Health
Develop and implement a model for community engagement and to include advocacy		√	√	Public Health
Explore ways to identify the needs and preferences of the population in relation to healthy weight provision. This will include a process to collate current information from providers and or a population level research if required	√			Public Health
Develop and adopt a unified offer of interventions to CCGs to aid the referral process into the community		√	√	Public Health
Join in with national campaigns on the healthy weight agenda and to include advocacy and lobbying	√	√	√	All partners
Capacity Building, Monitoring, Evaluation and Intelligence				
Develop a checklist of indicators that have an influence on behaviours which impact on healthy weight, to be considered when writing strategy/policy	√			Public Health
Develop a performance and reporting process for the HWA in order to make relevant data available to all partners	√			DCC performance, public health
Promote the standard evaluation framework and other resources from the obesity learning centre to all partners	√			Public Health, PHE
Develop and complete an equity audit/needs assessment of healthy weight provision	√	√	√	Public Health
Develop and adopt a framework for assessing value for money (VFM) for the HWA		√	√	Public Health, PHE, Durham Univ.
Design and roll out a capacity building model for the HWA- Training should address the barriers some professionals feel they face, opportunities for sharing good practice, and monitoring and evaluation.		√	√	Public Health
Programmes/Services to help individuals and families achieve and maintain a healthy weight				
Targeted interventions	√	√	√	Public Health
Specialist interventions/services	√	√	√	CCGs

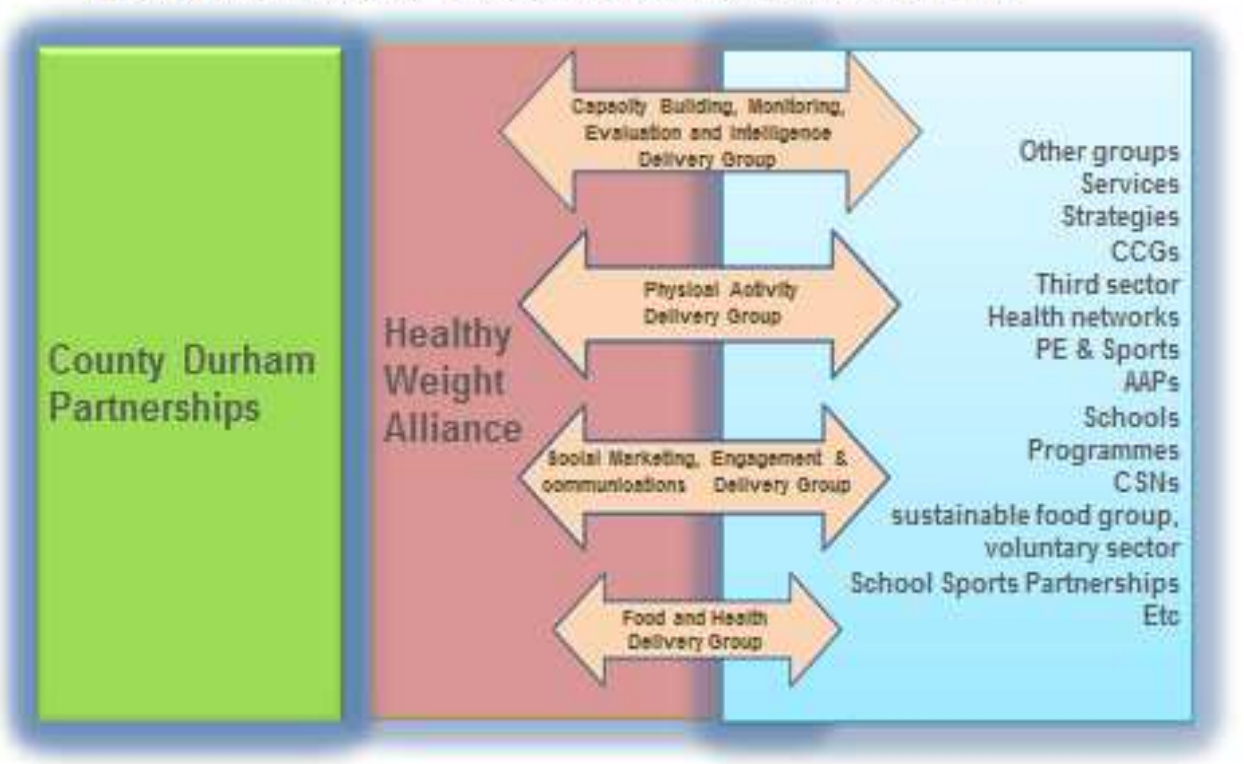
9. How will we know if the framework is making a difference? – Monitoring and evaluation

The actions identified from the NICE self-assessment and stakeholder consultations will be addressed through four delivery subgroups of the healthy weight alliance namely:

- Food and Health (F&H)
- Physical activity (PA)
- Social marketing, Engagement and communications (SME&C)
- Capacity Building, Monitoring, Evaluation and Intelligence (CBME&I)

These subgroups will develop links (figure 5 below) with other existing groups, services, programmes or organisations that are progressing similar objectives or activities in order to ensure that there is a coordinated approach across the county and a shared responsibility for promoting healthy weight.

Figure 5: From Strategy to action via local delivery mechanisms



Each of the delivery groups will report progress directly to the healthy weight alliance bi-annually. The Food and Health, and the physical activity groups will in addition report to the Food Partnership and the Sports and Physical Activity Partnership respectively. Evaluation of programmes should include both qualitative and quantitative measures. The healthy weight alliance will in turn report to the health and wellbeing board through the Director of Public Health.

Delivery of the strategic framework will contribute to achieving improvements in the indicators from the Public Health Outcomes Framework (PHOF)[23] listed below. These indicators will be tracked and monitored throughout the lifetime of this strategic framework. There will be direct impact on:

- 1.16 Utilisation of outdoor space for exercise/health reasons;
- 2.02i Breastfeeding initiation;
- 2.02ii Breastfeeding prevalence at 6-8weeks after birth;
- 2.06i Excess weight in 4-5year olds
- 2.06ii Excess weight in 10 -11year olds;
- 2.13i Percentage of physically active adults;
- 2.13ii Percentage of physically inactive adults;
- 2.23 Self-reported wellbeing;

There will be indirect impact on:

- 0.1 Healthy life expectancy at birth;
- 0.2 Inequality in life expectancy at birth:
- 1.09 Sickness absence;
- 2.01 Low birth weight of term babies;
- 2.17 Recorded diabetes;
- 4.01 Infant mortality;
- 4.03 Mortality rate from causes considered preventable;
- 4.04i Under 75 mortality rate from all cardiovascular diseases;
- 4.04ii Under 75 mortality rate from cardiovascular diseases considered preventable;
- 4.05i Under 75 mortality rate from cancer; and
- 4.05ii Under 75 mortality rate from cancer considered preventable.

10. Conclusions

Strong leadership and interventions at industrial scale is required to tackle the issue of healthy weight in County Durham. The challenge to address healthy weight must engage all relevant partners across the county and members of the population. Interventions/actions taken should focus on:

- Making healthy weight a priority for all;

[23] DH (2013), Public Health Outcomes Framework 2013-2016 and technical updates, https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency. Accessed 10/12/13

- Promoting healthy behaviours;
- Tackling the obesogenic environment;
- Investing in prevention, targeted and specialist support through proportionate distribution of resources and aligned to existing programmes and activities; and
- Embedding evaluation to demonstrate impact and value for money.

11. Recommendations

It is recommended that:

- The healthy weight alliance should lead on the delivery of the healthy weight strategic framework. The alliance should report to the Health and Wellbeing board through the Director of Public Health;
- A needs assessment or equity audit for healthy weight in County Durham should be undertaken to understand current service provision against needs in order to tailor programmes for proportionate distribution and to provide insight for providers to plan delivery;
- The delivery subgroups should ensure that their delivery plans are aligned to interventions by external partners to facilitate integrated and coordinated delivery for healthy weight;
- The healthy weight alliance should adopt change4life branding for all healthy weight initiatives in County Durham and build on the baseline registration data;
- The healthy weight alliance should promote evidence based delivery and use the standard evaluation framework to assess impact/ outcome of programmes;
- Commissioners of healthy weight programmes should assess value for money and to ensure proportionate distribution to reduce inequalities;
- Universal programmes designed for promoting healthy weight should build on current local structures/programmes to enhance community engagement;
- The healthy weight alliance should work with key partners to develop an environment that promotes physical activity as part of daily life;
- Ensure a range of weight management interventions are available in workplaces;
- Implement a range of multi-component family and adult interventions for healthy weight. Tailored advice/support for different groups should be available, especially for those population groups at risk of developing obesity and those at a life stage when there is an increased risk of weight gain;
- Ensure all relevant staff groups have the capacity and knowledge to provide appropriate advice/brief intervention on healthy weight;
- Equip children, young people, families and adults with knowledge on food and diet and cooking skills to consume a healthy balanced diet; and
- Ensure strategic policy developments consider impact on healthy weight.

Appendix 2: List of Acronyms

AAP	Area Action Partnership
BHAW	Better health at work
BMI	Body mass index
C4L	Change4life
CCG	Clinical commissioning group
CDS	County Durham Sport
CDDFT	County Durham and Darlington NHS Foundation Trust
CPAL	Changing the physical activity landscape: commissioned programme which delivered physical activity for adults aged 40-74 at risk of CVD
CPD	Continuous professional development
CVD	Cardiovascular disease
DCC	Durham County Council
DDES	Durham Dales, Easington and Sedgefield
DPH	Director of Public Health
FISCH	Family Initiative Supporting Children's Health
HV	Health visiting
HWB	Health and Wellbeing
HSE	Health Survey England
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
M4L	Move4life
MECC	Making Ever Contact Count- Encourages conversations based on behaviour change methodologies (ranging from brief advice, to more advanced behaviour change techniques), empowering healthier lifestyle choices
NCMP	National Child Measurement Programme – A national surveillance programme that measures the height, weight and BMI of children at reception and year 6 annually.
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NOO	National Obesity Observatory
PH	Public Health
PHE	Public Health England
QOF	Quality Outcomes Framework
SEF	Standard Evaluation Framework
SN	School Nursing
VCS	Voluntary and Community Sector
WHO	World Health Organization

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Health and Wellbeing Board

5 November 2014

County Durham Interim Child and Adolescent Mental Health Services Strategy 2014/16

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

Purpose of the Report

1. The purpose of this report is to present the County Durham Interim Child and Adolescent Mental Health Services (CAMHS) Joint Strategy 2014/16 and to seek ratification from the County Durham Health and Wellbeing Board.

Background

2. In the paper to the Mental Health Partnership Board on 12 June 2014, on the child and adolescent joint commissioning arrangement, it was proposed that a short-term child and adolescent mental health strategy be developed as an interim measure, whilst more detailed work is undertaken to develop a three-year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan commencing in 2016.

3. The interim CAMHS strategy supersedes the previous strategy dated 2007/10.

4. Strategy development has been informed by national policy, the Joint Strategic Needs Assessment (JSNA) and draws on previous reviews and feedback from children and young people.

5. The strategy builds on the extensive work that has been achieved in County Durham and provides direction over the forth coming year, in order for children and young people to continue to have improved mental health and emotional wellbeing.

6. The strategy aligns to the County Durham Joint Health and Wellbeing Strategy, specifically in regard to improving the mental and physical wellbeing of the population (objective 4).

7. The objectives within this strategy correspond with those identified within the County Durham Implementation Plan of the 'No Health without Mental Health' National Strategy; also those within the County Durham Children, Young People and Families Plan 2014/17.

Discussion, implications and risks

8. The aim of the strategy is to provide direction and a coordinated approach across partner agencies to improve the mental health and wellbeing of children and young people in County Durham.

9. The strategy refers to the four-tiered framework used to describe CAMHS in relation to how a child or young person accesses services that contribute to mental health and emotional wellbeing. However, the main focus of the interim strategy is Tiers 2 and 3, which include specialist support provided by practitioners in community and primary care settings (Tier 2) and multi-agency teams for those with more severe, complex disorders (Tier 3). The full pathway will be considered in the wider Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

10. As well as providing an overview of National directives, the strategy provides some local context including prevalence rate where data is available.

11. A key priority area within the strategy is reducing self-harm. Self-harm and suicide rates in County Durham are significantly higher than the national rates; admission rates to hospital due to self-harm for 0-17 year olds in 2011/12 (228 per 100,000) was significantly higher than the England average (116 per 100,000) (County Durham Joint Strategic Needs Assessment 2013).

12. Priority actions identified in the strategy aim to support the six objectives of the No Health Without Mental Health Strategy, in the context of children and young people:

    - More children and young people will have good mental health, including those in vulnerable groups such as looked after children
    - More children and young people with mental health problems will recover
    - More children and young people with mental health problems will have good physical health
    - More children and young people and their family/carers will have a positive experience of care and support
    - Fewer children and young people will suffer avoidable harm
    - Fewer children and young people will experience stigma and discrimination

13. Section 12 of the strategy and Appendix 2 detail the action plan which has been developed with relevant stakeholders. The main focus is on re-affirming partnership and governance arrangements; refreshing the local needs assessment; consulting and engaging with children, young people and families and reviewing current services to inform the longer term plan.

14. A range of stakeholders have been consulted during the course of strategy development. It is acknowledged that wider engagement with children and young people and their family/carers will be undertaken as part of the health needs assessment and development of the three-year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

15. A joint commissioning plan for actions requiring investment will support implementation of this strategy. This will include CCGs commissioning intentions for 2014/15 and 2015/16 once approved. The commissioning plan will also take into consideration local authority commissioning priorities. Any action/intervention requiring investment, where there is not a funding pre-commitment, will need to be considered by the relevant commissioning organisation(s) as part of their cyclic prioritisation process.

Recommendations

16. The Health and Wellbeing Board is recommended to:

- Note the content of this report
- Ratify the County Durham Child and Adolescent Interim Joint Strategy 2014-16.

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Tel: 0191 374 4109
Tricia Reed Commissioning Policy and Planning Officer Strategic Commissioning Children and Public Health Durham County Council – Tel: 0300 269095

Appendix 1: Implications

Finance
Any action/intervention where there is not a funding pre-commitment will need to be considered by the relevant commissioning organisation(s) as part of their cyclic prioritisation process.

Staffing
There is assumption that many actions within the strategy will be implemented within existing staffing resource.

Risk
Risks related to initiatives detailed within action plan to be captured via project specific risk logs; risks to be escalated within individual organisations and within mental health partnership structure as agreed.

Equality and Diversity / Public Sector Equality Duty
Equality analysis will accompany this strategy.

Accommodation
None

Crime and Disorder
None

Human Rights
None

Consultation
A range of stakeholders have been consulted during the course of strategy development. It is acknowledged that wider engagement with children and young people and their family/carers will be undertaken as part of the health needs assessment and development of the three-year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

Procurement
None

Disability Issues
None

Legal Implications
None

North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group

County Durham

Child and Adolescent Mental Health Services

Interim Joint Strategy

2014 - 2016

24 October 2014

Developed on behalf of County Durham Mental Health Partnership Board

Child and Adolescent Mental Health Services
Interim Joint Strategy for County Durham 2014/16

Vision Statement

Our vision is to improve the mental health and wellbeing of children and young people in County Durham and reduce health inequalities. Children and young people and their families across County Durham will be supported to reach and maximise their potential and when faced with difficulties will have access to effective, high quality mental health services.

This statement is based on the vision within the Health and Wellbeing Board which is '*Improve the health and wellbeing of the people of County Durham and reduce health inequalities'. It also supports* the County Durham Children and Families Partnership vision which is to *'All children, young people and families believe, achieve and succeed'.*

Child and Adolescent Mental Health Services
Interim Joint Strategy for County Durham 2014/16

Contents

Child and Adolescent Mental Health Services
Interim Joint Strategy for County Durham 2014/16

1, Introduction

This Children and Adolescent Mental Health Services (CAMHS) Joint Strategy for County Durham has been developed by local Clinical Commissioning Groups and Durham County Council as an interim measure whilst a more detailed piece of work is undertaken to develop a three year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan 2016/18.

This interim CAMHS strategy supersedes the previous strategy dated 2007/10.

Strategy development has been informed by national policy, the Joint Strategic Needs Assessment (JSNA) and draws on previous reviews and feedback from children, young people, parents and carers.

The strategy builds on the extensive work that has been achieved in County Durham and provides direction over the forth coming year, in order for children and young people to continue to have improved mental health and emotional wellbeing.

The strategy aligns to the County Durham Joint Health and Wellbeing Strategy, specifically in regard to improving the mental and physical wellbeing of the population (objective 4). The objectives within this strategy correspond with those identified within the County Durham Implementation Plan of the 'No Health without Mental Health' National Strategy[1].

> *'By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does'.*
>
> (No Health, Without Mental Health: A Cross-Government Mental Health Outcomes Strategy, Department of Health, 2011)

2. Overall purpose

This strategy has been developed to:

- Provide strategic direction in the interim whilst further work is undertaken on longer-term priorities, based on the needs of the local population.
- Provide a cohesive approach across the partner agencies, in regard to improving the mental health and wellbeing of children and young people in County Durham.
- Ensure any work taken forward is centred on the child and family and is outcome focused.

[1] HM Government: *No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages* (2011). https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

3. What is CAMHS?

The term CAMHS is used as a broad concept embracing all services that contribute to the mental health and emotional wellbeing and care of children and young people, whether provided by health, education, social services or other agencies.

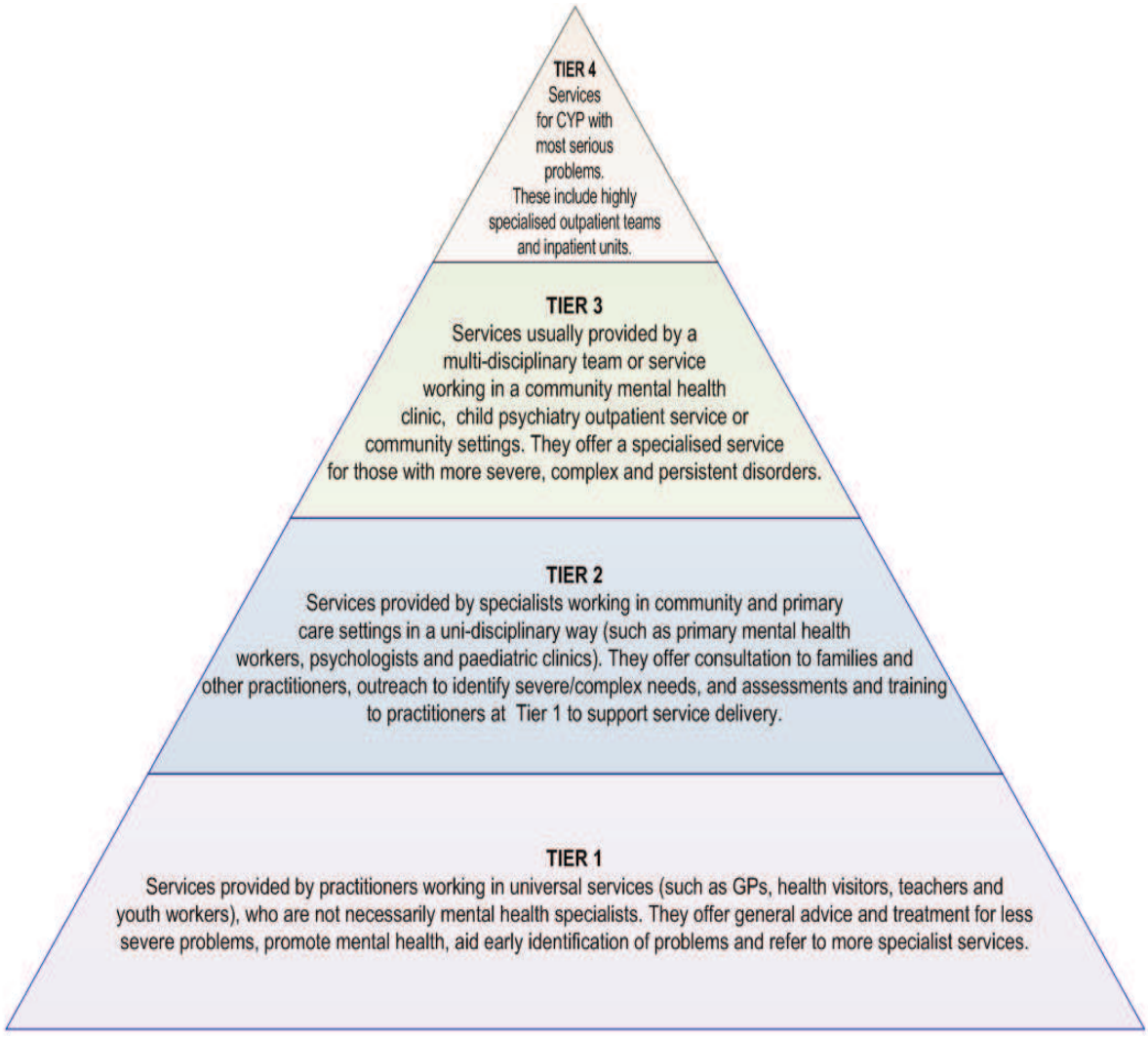
The national Joint Commissioning Panel for Mental Health[2] advised that comprehensive mental health services for children and young people should:

- cover all ages (pre-birth to 18)
- address all emotional, behavioural and mental health disorders
- provide for children and young people with intellectual disabilities
- work across all interfaces – education, social care, youth justice, paediatrics and child health (including acute care, community child health, primary care, substance misuse and adult mental health)
- address all levels of severity from prevention and early intervention through to intervention for children and young people with severe and complex problems
- support other agencies/professionals working with children and young people
- be prepared to focus on relationships and systems surrounding the child or young person, rather than taking an individual approach; this supports the 'think family' approach
- work through networks, collaboration and pathways with other agencies.

The structure of CAMHS is often explained in terms of how a child or young person accesses the service, with four 'tiers' of service provision or levels of need. See model overleaf.

In regard to the scope of this strategy, focus is predominately on Tiers 2 and 3. Although some reference is made to Tier 1 and 4, it should be noted that this strategy does not cover these levels inclusively. The full pathway (Tiers 1 to 4), will be considered in the wider Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

[2] Joint Commissioning Panel for Mental Health: *Guidance for commissioners of child and adolescent mental health services* (2013) www.jcpmh.info



CAMHS Four-tiered Framework

4. Governance

The Children and Young People's Mental Health and Emotional Wellbeing Group will have responsibility for the development of the longer-term Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan. CAMHS will be incorporated into this plan.

Oversight of this CAMHS strategy is provided by the County Durham Health and Wellbeing Board; implementation is through the No Health without Mental Health Implementation Group which reports to the Mental Health Partnership Board.

As the strategy specifically relates to children, there is a requirement to report to the Children and Families Partnership. It has been agreed that issues such as self-harm by young people will be dealt with jointly by the Health and Wellbeing Board and the Children and Families Partnership.

5. Policy context

There is a need to ensure that CAMHS provision in County Durham is commissioned against the relevant national standards and guidance and fits with current and emerging local policies and plans.

5.1 National context

National directives over recent years have focussed on improving outcomes for children and young people by encouraging services to work together to protect them from harm, ensure they are healthy and to help them achieve what they want in life.

No Health without Mental Health[3]

The publication of No Health without Mental Health: A cross government mental health strategy for people of all ages, published in February 2011, drew together the wider principles that the government has laid down for its health reforms, including patient-centred care and locally determined priorities and delivery.

In regard to improving outcomes for children and families, No Health without Mental Health (2011) emphasises the crucial importance of early intervention in emerging emotional and mental health problems for children and young people.
The strategy takes a life course approach, recognising that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much can be done to protect and promote wellbeing and resilience through early years, into adulthood and then on into a healthy old age.

The strategy sets out high level objectives to improve the mental health and wellbeing of the population. These are detailed below, alongside how these are described for children and young people within the report of the Children and Young People's Health Outcomes Forum [4].

[3] HM Government: *No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages* (2011). https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[4] Children and Young Peoples Outcome Forum: *Report of the Children and Young Peoples Outcome Forum – Mental Health Sub-Group* (2012) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216853/CYP-Mental-Health.pdf

Health Without Mental Health Objectives	Objectives Translated for Children and Young People
More people will have good mental health	More children and young people will have good mental health • More children and young people of all ages and backgrounds will have better wellbeing and good mental health; and • Fewer children and young people will develop mental health problems by starting well, developing well, learning well, working and living well.
More people with mental health problems will recover	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 people with mental health problems will have good physical health	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 • Fewer children and young people with mental health problems will be at risk of premature morbidity and mortality in adult life. There will be improvements in the mental health and wellbeing of children and young people with serious physical illness and long-term conditions.
More people will have a positive experience of care and support	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. Where in-patient care is required this should be in an age appropriate setting and in the least restrictive environment.
Fewer people will suffer avoidable harm	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 with particular reference to medication treatment/side-effects, age-appropriate in-patient care and reducing the risk of self/harm suicide.
Fewer people will experience stigma and discrimination	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.

Health and Social Care Act (2012)[5]

The Health and Social Care Act (2012) shifted responsibility for commissioning of local services from Primary Care Trusts to CCGs led by General Practitioners. Clinical Commissioning Groups (CCGs) became responsible for commissioning CAMHS services, where appropriate in partnership with other agencies. NHS England was given responsibility for commissioning Tier 4 and other highly specialised services. Top tier local authorities became responsible for commissioning services that improve public mental health, including for children and young people.

In terms of joint working, the Act also introduced Health and Wellbeing Boards as a forum where key figures from the health and social care system work together to improve the health and social care of the local population and reduce health inequalities. As a result patients and public should experience joined up working between health and local authorities.

Children and Families Act (2014)[6]

Aimed at improving services available to vulnerable children and to support families, the Act includes provision across a number of different areas of children's services, which will contribute to the achievement of mental health outcomes. This includes transformation of the system for children and young people with special educational needs and disabilities; providing children, young people and their parents with greater control and choice in decisions and ensuring needs are properly met.

Key reforms include:

- Replacing old statements with a new birth-to-25 education, health and care plan (EHCP).
- Offering families personal budgets.
- Improving cooperation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together.
- Giving young carers similar rights to assessment as other carers have under the Care Act.

Care Act (2014)[7]

The Care Act 2014 brings together a number of existing laws and introduces new duties to local authorities to ensure that wellbeing, dignity and choice are at the heart of health and social care and introduces changes to how care is charged for, who has to contribute, and how much people will have to pay towards their care. The majority of the Care Act will come into force in April 2015.

[5] HM Government: Health and Social Care Act (2012) http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

[6] HM Government: Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/pdfs/ukpga_20140006_en.pdf

[7] HM Government: Care Act (2014) http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf

The programme of reform includes support for people moving from children's to adult care and support services. The Act says that if a child, young carer or an adult caring for a child is likely to have needs when they, or the child they care for, turns 18, the local authority must assess them if it considers there is 'significant benefit' to the individual in doing so. This is regardless of whether the child or individual currently receives any services. Part of this process will be giving the right information, advice and planning well in advance, depending on the individual's circumstances so there is no gap in service. Transition assessments must also take into account other health and social care assessments within the family and could also potentially become part of a child or young person's EHCP.

Think Family

Children and young people's emotional wellbeing and mental health concerns are frequently associated with their relationships. The Government's reports into the future direction of public services highlight the importance of family-focused interventions to better support individual and family resilience and happiness, and social well-being, for example, the 'Think Family' reports from the Cabinet Office Social Exclusion Task Force.

The Think Family agenda is relevant to all six objectives within No Health without Mental Health (2011) as it:

- Stresses the need to intervene early, and tackle stigma, where mental health problems arise in children; to break the intergenerational cycle of them growing up with mental health problems which then affect their own parenting.
- Focuses on early intervention with adults with mental health problems.
- Calls for whole-family assessments and care plans to promote family and individual recovery.
- Recognises the crucial, detailed information other family members, including children, have about a person's mental ill health, and the importance, therefore, of listening to all family members when planning a person's care and support.
- Cites the improved outcomes that whole-family approaches can achieve.

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report July 2014[8]

This report outlines findings of the first stage review, to assess and understand the current CAMHS Tier 4 services, with a particular focus on a factual assessment of current provision and commissioning issues.

Recommendations that require immediate implementation include:

- Procure additional Tier 4 beds in parts of the country where there is insufficient capacity.
- Ensure that all admissions to inpatient services are appropriate for the individual child.
- Increase the number of case managers to enable timely and effective discharge planning and support back to local services.

[8] NHS England: *Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report* (2014) http://www.england.nhs.uk/wp-content/uploads/2014/07/camhs-tier-4-rep.pdf

The report also makes reference to new commissioning arrangements posing a challenge where a young person's journey (care pathway) moves across and between organisations and commissioning responsibility. Also the significant role played by local authorities in the CAMHS pathway needs to be recognised and included in collaborative arrangements.

Payment by Results

Payment by Results (PbR) or tariff-based care is already in place in the acute sector, and is moving into adult mental health services. The Department of Health has indicated PbR will be central to the future commissioning of CAMHS.

Work is underway to define currencies for CAMHS to ensure that the particular complexity of CAMHS is reflected in the clusters and pathways which underpin currency development for the future.

National CAMHS Secondary Uses Data Set (Information Standards Board 1072)[9]

A key driver to achieving better outcomes is the National CAMHS Secondary Uses Data Set. This will be used in all organisations providing specialist CAMHS services commissioned or provided by the NHS to capture key information at each stage of the care pathway e.g. demographics, referrals, care planning, encounters with healthcare professionals, inpatient stays, diagnosis, interventions, outcome measures and discharges.

The data set will support implementation of payment by activity.

Children and Young People's Improving Access to Psychological Therapies (IAPT)

Children and Young People's IAPT is a service transformation programme delivered by NHS England that aims to improve existing CAMHS working in the community.

The programme works to transform services provided by the NHS and partners from local authority and third sector that together form local area CAMHS Partnerships. It is different to adult IAPT as it does not create standalone services.

5.2 Local context

County Durham Joint Health and Wellbeing Strategy 2014-17[10]

The Joint Health and Wellbeing Strategy, informed by the Joint Strategic Health Assessment (2013) and the Annual Report of the Director of Public Health, is based on the broad vision to 'improve the health and wellbeing of the people of County Durham and reduce health inequalities'.

Within the strategy, the strategic objectives relevant to the CAMHS strategy are:

[9] Health and Social Care Information Centre: Child and Adolescent Mental Health Services Data Set http://www.hscic.gov.uk/CAMHS

[10] County Durham Joint Health and Wellbeing Strategy 2014-17
http://content.durham.gov.uk/PDFRepository/County-Durham-Joint-Health-and-Wellbeing-Strategy-2014-2017.pdf

- Objective 1: Children and young people make healthy choices and have the best start in life.
- Objective 4: Improve the mental and physical wellbeing of the population.

The Health and Wellbeing Strategy objectives are underpinned by a range of strategic actions, many of which have a direct or indirect impact on children and young people's mental health and wellbeing, for example:

- Work together to reduce incidents of self-harm by young people.
- Support children and young people to take part in positive activities which are appropriate for their age and reduce negative and sexual health risk-taking behaviours.
- Work in partnership to increase awareness and provide education to young people and their parents on the risks of alcohol and ensure that adequate control on the sale of alcohol is in place and effective treatment services are available.
- Continue to improve the emotional wellbeing of children and young people and provide effective, high quality mental health services to those who need it.
- Increased physical activity and participation in sport and leisure.
- Identify priority groups such as young carers and looked after children.
- Implement birth to 25 Education, Health and Care (EHC) assessments/plans for children with special educational needs as part of Special Education Needs and Disability (SEND) reforms.
- Safeguard children whose circumstances make them vulnerable and protect them from avoidable harm.
- Provide protection and support to improve outcomes for victims of domestic abuse and their children.

Children, Young People and Families Plan 2014-17[11]

The Children, Young People and Families Plan 2014-2017 is the single overarching, multi-agency plan for the delivery of priorities for children and young people in County Durham. The plan draws on a vast range of evidence including the Joint Strategic Needs Assessment, performance data, policy drivers, legislation and the ongoing engagement with children, young people, parents, carers and partner agencies.

The Children, Young People and Families Plan will focus on the following three outcomes:

[11] County Durham Children and Families Plan 2014-17
http://durhamvoice.org.uk/documents/10830April/CYPFP2014-17.pdf

- Children and young people realise and maximise their potential.
- Children and young people make healthy choices and have the best start in life.
- A Think Family Approach is embedded in our support for families.

'Children and young people make healthy choices and have the best start in life' is a shared objective included in the Joint Health and Wellbeing Strategy and the Children, Young People and Families Plan.

The delivery plan details a number of specific actions to reduce incidents of self-harm in younger people and improve the emotional wellbeing and resilience of children.

County Durham Public Mental Health Strategy 2013-2017[12]

This strategy outlines the implications for public mental health. In line with *No Health without Mental Health*, it is for people of all ages, including children and young people. The vision is for 'individuals, families and communities within County Durham to be supported to achieve their optimum mental wellbeing'. This is to be achieved by promoting mental health, preventing mental ill-health, reducing stigma and discrimination, early identification and intervention for those at risk and supporting recovery from mental health.

The strategy contains an action plan which details specific interventions to improve mental health and wellbeing of children and young people including:

- 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
- Interventions with young people to address high-risk behaviour in school, including prevention.

DRAFT No Health without Mental Health County Durham Implementation Plan 2014-17[13]

[12] County Durham Public Mental health Strategy 2013-17
http://democracy.durham.gov.uk/documents/s35630/Item%208b%20-%20Public%20Mental%20Health%20Strategy.pdf

This document sets out how mental health services, covering all ages, will be developed and improved over the next 3 years. It outlines local priorities, to achieve positive outcomes in line with the requirements and objectives of the national strategy. The implementation plan has been developed in partnership with a wide range of organisations, people that use mental health services and carers.

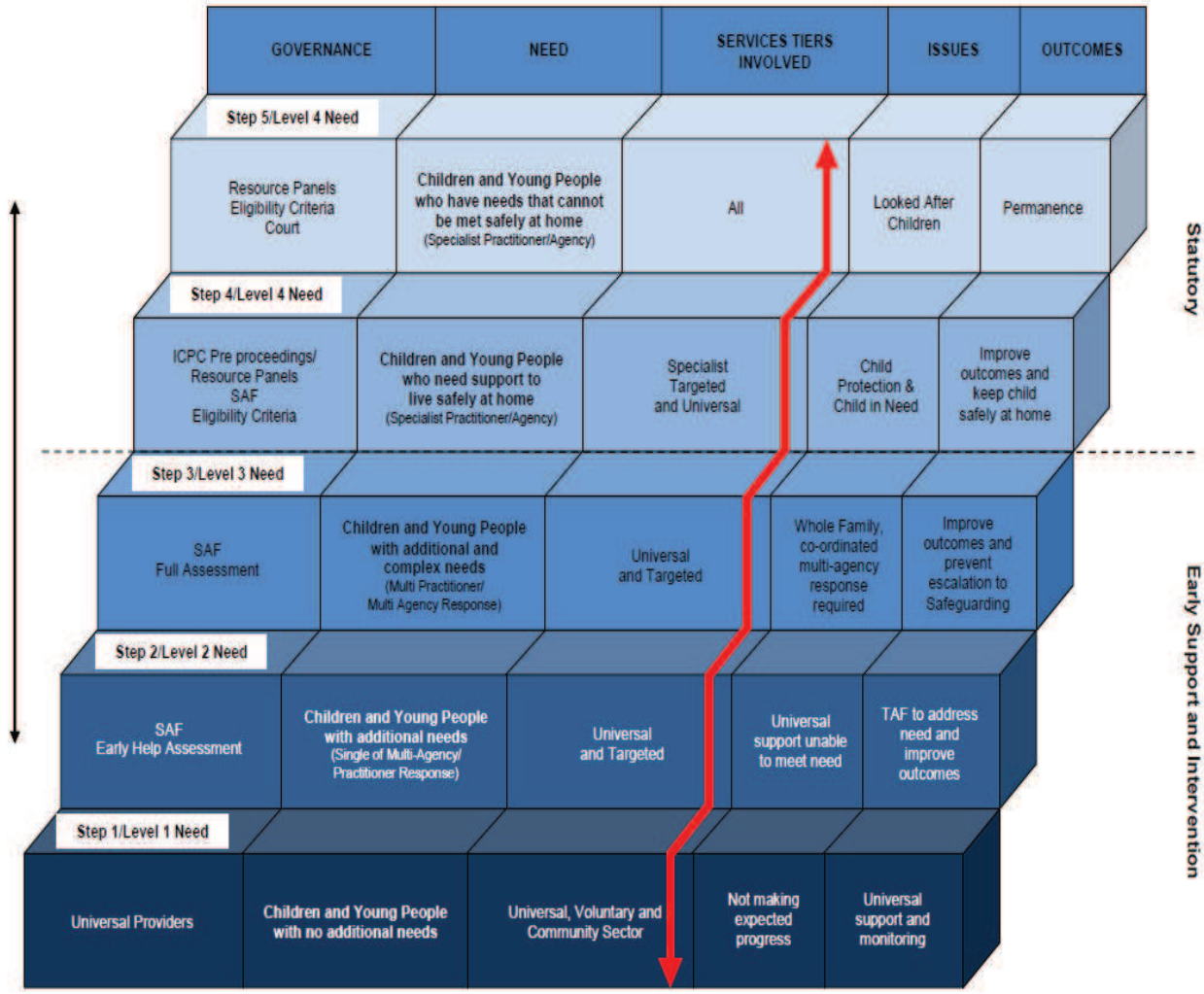
Early Help Strategy for Children, Young People and Families in County Durham (2014)[14]

This strategy outlines partners' commitments and a shared vision to collectively deliver early help and timely intervention to children, young people and their families to improve their outcomes and reduce cost to our services and communities.

The Think Family Partnership has developed an agreed local understanding of levels of need using a staircase concept, with the lowest need represented as the bottom step and the highest level of need on the top step. The Durham Staircase and Continuum of Need (below) illustrates the integrated services pathway model and is designed to reflect the fact that the needs of children, young people and families exist along a continuum and needs may change over time.

[13] Draft No Health without Mental Health County Durham Implementation Plan 2014-17
http://www.northdurhamccg.nhs.uk/wp-content/uploads/2013/07/CD-MH-Implementation-Plan-Draft-v7.pdf
[14] Durham Local Safeguarding Children's Board: Early Help Strategy for Children, Young People and Families in County 2014
http://www.durham-lscb.gov.uk/documents/Publications/2014/Early%20Help%20Strategy%20-%20Final.pdf

The Durham Staircase and Continuum of Need



The four-tiered framework used to describe CAMHS could be applied to the staircase model e.g.

Tier 1 - Level 1: Universal provision for children and young people with no additional needs

Tier 2 - Level 2: Early intervention and targeted single agency/practitioner response

Tier 3 - Level 3: Early intervention and targeted multi-practitioner/agency response; and
- Level 4: Specialist practitioner/agency response

Tier 4 - Level 5: Highly specialist services for children and young people with needs that cannot be managed safely at home.

Children and young people using services at the higher levels should be able to access services at the lower levels as appropriate, e.g. universal services should be available to all children and young people regardless of the severity of mental health need.

Children and Young People's and Adults Wellbeing and Health Overview and Scrutiny Committees' Joint Working Group Report January 2013[15]

The review focused on support offered to children and young people with mental health issues. Key recommendations within the report included:

- To continue to work in partnership with providers, children, young people and their families to ensure the best possible outcomes for service users, and to take a Think Family approach to commissioning services.

- To continue with commissioning intentions that enable children and young people to access mental health services via early interventions of universal services. By accessing services at an early stage, actions are taken that will prevent services being required at a later stage when more specialist interventions may be required.

- To continue to evaluate and monitor commissioned services to measure their impact.

- CAMHS and Adult Mental Health Services (AMHS) to continue to follow best practice to ensure that the young people of County Durham receive effective transitions into AMHS through essential planning and delivery of services and stakeholder engagement.

CAMHS Joint Commissioning Arrangement Review

On behalf of CCGs in County Durham and Darlington, North Durham CCG was nominated as the lead commissioner for the mental health services, which include Tier 2 and Tier 3 CAMHS.

A review of historic joint commissioning arrangements was undertaken to gain a full understanding of services covered by the arrangement.

The review undertaken in 2014, highlighted need for:

- Re-affirmed partnership working given recent changes in the commissioning landscape.

- Development of children and young people's mental health and emotional wellbeing strategy or plan.

- A full CAMHS review and refresh of the service specifications.

- Meaningful engagement with children and young people and parents and/or carers when reviewing currently commissioned services and developing future services/pathways.

- Review of performance indicators and outcomes.

[15] Durham County Council: Children & Young People's and Adults Wellbeing & Health Overview and Scrutiny Committees' Joint Working Group Report http://content.durham.gov.uk/PDFRepository/OS_MentalHealthChildrenYoungPeoplev2.pdf

6. Evidence of need

6.1 National picture of need

- Mental health problems most relevant to children and young people include: emotional disorders (e.g. phobia, anxiety, depression); conduct disorders (e.g. severe defiance, and physical and verbal aggression, and persistent vandalism); obsessive compulsive disorder; attention deficit hyperactivity disorder (ADHD); other behavioural problems; tics disorders and Tourette's syndrome; autism spectrum disorders (ASD); substance misuse problems; eating disorders (e.g. anorexia and bulimia nervosa); post-traumatic stress disorder; psychological effects of abuse and neglect; attachment disorders; psychological effects of living with a chronic illness; somatisation disorders; psychosis; emerging borderline personality disorder[16] .

- Mental health problems in children are associated with underachievement in education, bullying, family disruption, disability, offending and anti-social behaviour, placing demands on the family, social and health services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, and the wider community, continuing into adult life and affecting the next generation.

- One in ten children aged between 5-16 years has a mental health problem, and many continue to have problems into adulthood[17].

- Of the one in ten children aged between 5 and 16 years who have a clinically diagnosable mental health problem, about half of these (5.8%) have a conduct disorder, 3.7% an emotional disorder (anxiety, depression) and 1–2% have severe Attention Deficit Hyperactivity Disorder (ADHD) [18].

- Half of those with lifetime mental health problems first experience symptoms by the age of 14[19], and three-quarters before their mid-20s[20].

- Referral rates to Tier 3 CAMHS have increased greatly in recent years, with the number of cases rising by more than 40% between 2003 and 2009/10[21].

- There are around 700,000 people in the UK with autism[22]. Over 40% of children with autism have been bullied at school[23] .

[16] Joint Commissioning Panel for Mental Health: *Guidance for commissioners of child and adolescent mental health services* (2013) www.jcpmh.info
[17] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004. London: Office of National Statistics.
[18] ONS: Mental Health of Children and Adolescents in Great Britain, 2004
[19] Kim-cohen J, Caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* 60: 709–717; Kessler R, Berglund P, Demler o et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-Iv disorders in the national comorbidity survey Replication. *Archives of General Psychiatry* 62: 593–602 (in No Health without Mental Health 2011)
[20] Kessler R and Wang P (2007) The descriptive epidemiology of commonly occurring mental disorders in the united states. Annual Review of Public Health 29: 115–129 (in No Health without Mental Health 2011)
[21] National CAMHS Support Service, 2011
[22] Baird, G et al (2006). Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP). *The Lancet*, 368 (9531), pp210-215
[23] Batten, A et al (2006). Autism and education: the reality for families today. London: The National Autistic Society, p3

- The prevalence of attention deficit hyperactivity disorder (ADHD) varies among studies and is estimated to be around 2.4% of children in the UK[24]. Typically, ADHD is diagnosed in children 3–7 years of age, but it may not be recognized until much later in life and sometimes not until adulthood.

- Nearly 80,000 children and young people suffer from severe depression[25]. The number of young people aged 15-16 with depression nearly doubled between the 1980s and the 2000s[26].

- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm[27]. There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%[28].

- About 1 in 250 females and 1 in 2000 males will experience anorexia nervosa, generally in adolescence or young adulthood and about five times that number will suffer from bulimia nervosa[29].

- Some children are more vulnerable to experiencing mental health problems than others. These include those who have one or more of the following risk factors[30]:

  - from low-income households
  - from families where parents are unemployed or families where parents have low educational attainment
  - who are looked after by the local authority
  - with disabilities (including learning disabilities)
  - who are black and other ethnic minority groups
  - who are lesbian, gay, bisexual or transgender (LGBT)
  - who are in the criminal justice system
  - who have a parent with a mental health problem
  - who are misusing substances
  - who are refugees or asylum seekers
  - who are in gypsy and traveller communities
  - who are being abused.

- Looked after children have come from a variety of traumatic backgrounds and experience many of the risk factors that lead to mental health problems including neglect, violence and sexual abuse. About 60% looked after children in England have been reported to have emotional and mental health problems and a high proportion experience poor health, educational and social outcomes after leaving care[31].

[24] NICE 2013 http://cks.nice.org.uk/attention-deficit-hyperactivity-disorder#!backgroundsub:2
[25] Green, H., McGinnity, A., Meltzer, H., et al. (2005). *Mental health of children and young people in Great Britain 2004* London: Palgrave.
[26] Nuffield Foundation (2013) Social trends and mental health: introducing the main findings. London: Nuffield Foundation
[27] Mental Health Foundation (2006). *Truth hurts: report of the National Inquiry into self-harm among young people.* London: Mental Health Foundation.
[28] YoungMinds (2011) *100,000 children and young people could be hospitalised due to self-harm by 2020 warns YoungMinds*. London: YoungMinds.
[29] NICE*: Clinical Guideline 9 Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders* (2004) **http://www.nice.org.uk/guidance/cg9**
[30] Better Mental Health Outcomes for Children and Young People, 2011
[31] NICE 2010

- Over recent years, there has been an increase in the incidence of mental health concerns for children and young people with complex special education needs (SEN)[32].

- It is reported that 36% of children and young people with learning disabilities will have a mental health problem, compared with 8% of non-disabled children[33].

- Young offenders are thought to be at four-fold increased risk of anxiety and depression, and three-fold increased risk of mental disorder. Young men in custody age 15–17 are at 18-fold increased risk of suicide and women in custody age under 25 are at 40-fold increased risk of suicide[34] .

- The ages 16–18 are a particularly vulnerable time when there is increased susceptibility to mental illness, as well as major physiological, emotional, educational and social change. It is also the age at which the young person already in contact with mental health services will move from child and adolescent services (CAMHS) to adult services (AMHS). Transitions can be problematic if there are gaps in service provision and different structures and systems to navigate[35] .

6.2 Local picture of need

- CHIMAT (Child and Maternal Health Observatory) estimates that in County Durham, the number of children and young people who may experience mental health problems appropriate to a response from CAMHS by tier is:

Tier 1 (universal services)	15,040
Tier 2 (targeted services)	7,020
Tier 3 (specialist intervention services)	1,855
Tier 4 (specialist intervention services)	80

- CAMHS referrals by CCG locality/constituency from April 2012 to March 2013 are tabled below.

CCG Commissioning Locality / Constituency	Number of GP & other referrals to CAMH T2 & T3 Services	Population 0-17 ONS 2011 population estimates	Rate per 10,000 population (aged under 18)
Durham	491	15,664	313.5
Chester-le-Street	462	10,586	436.4
Derwentside	986	18,506	532.8
North Durham CCG sub-total	**1,939**		
Durham Dales	1,430	17,578	813.5
Easington	938	19,662	477.1
Sedgefield	1,256	18,120	693.2
DDES CCG sub-total	**3,624**		
Grand total	**5,563**	**100,119**	**555.6**

Source: Tees Esk and Wear Valleys NHS FT

[32] Allen (2013)

[33] Emerson, E., Hatton, C. (2007). Mental health of children and adolescents with intellectual disabilities in Britain. *British Journal of Psychiatry* 191, pp. 493–499.

[34] Joint Commissioning Panel for Mental Health: Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services (2012) www.jcpmh.info

[35] Joint Commissioning Panel for Mental Health: *Guidance for Commissioners of Transition Services* (2012)

- There were 5,563 referrals to Tier 2 and 3 CAMHS (0-17 years) during 2012/13 at a rate of 555.6 per 10,000. There was variation in referral rates within County Durham, with Durham Dales displaying the highest rate (813.5 per 10,000) and Durham the lowest (313.5 per 10,000).

- There were 607 looked after children on 31 March 2014 and the largest proportion of these children (68.4%) was with foster carers[36]. The average total difficulties score for looked after children in County Durham in 2012-13 is 15.9. This is above both the England (13.8) and North East (13.8) scores. County Durham's total difficulties score has been consistently above both comparator averages since 2009-10, suggesting looked after children in Durham experience more mental health difficulties[37].

- Alcohol-related hospital admission rates for children and young people under 18 (116 per 100,000) are higher than the regional and national rate (96.5 and 55.8 per 100,000 population) (County Durham Joint Strategic Needs Assessment 2013).

- Self-harm and suicide rates in County Durham are significantly higher than the national rates; admission rates to hospital due to self-harm for 0-17 year olds in 2011/12 (228 per 100,000) was significantly higher than the England average (116 per 100,000) (County Durham Joint Strategic Needs Assessment 2013).

- According to the latest available data (January 2012), approximately 31 children in every thousand known to schools in County Durham have learning difficulties. This includes children with moderate, severe or profound multiple learning difficulties.

- There were 2,366 children and young people with statements of Special Education Needs in mainstream and special schools as at January 2013 (County Durham Joint Strategic Needs Assessment 2013.

7. Evidence base

There is a growing evidence base on the range of interventions which are effective in treating mental health disorders, such as psychological therapies and multi-systemic therapy. The earlier action is taken, the more likely it is to be effective.

The CAMHS Evidence Based practice Unit at University College London collates key sources of information, pathways and guidelines and the National Institute for Health and Clinical Excellence (NICE) has produced a number of detailed clinical guidelines for child mental health disorders; see the following table.

[36] Durham County Council: Children's services 4th quarter 2013/14 performance report.
[37] County Durham Joint Strategic Needs Assessment http://content.durham.gov.uk/PDFRepository/FINAL_JSNA_2013.pdf

CG09 Eating Disorders (2004)
CG26 Post-traumatic stress disorder (2005)
CG28 Depression in Children and Young People (2005)
CG31 Obsessive Compulsive Disorder and Body Dysmorphic Disorder (2005)
CG38 Bipolar disorder (2006)
CG45 Antenatal and postnatal mental health (2007)
CG72 Attention Deficit Hyperactivity Disorder (2008)
CG77 Antisocial personality disorder (2009)
CG78 Borderline personality disorder treatment and management (2009)
CG89 When to suspect child maltreatment (2009)
CG111 Nocturnal enuresis- the management of bedwetting in children and young people (2010)
CG113 Anxiety (2011)
CG128 Autism Diagnosis in Children and Young People (2011)
CG133 Self-harm: Longer term management (2011)
CG155 Psychosis and Schizophrenia in Children and Young People (2013)
CG158 Anti-Social Behaviour and Conduct Disorders in Children and Young People (2013)
CG170 Autism (2013)
PH28 Looked After Children and Young People (2010)

Examples of NICE Guidelines

8. Achievements since previous Child and Adolescent Mental Health Strategy

The previous County Durham and Darlington CAMHS Strategy recognised the need to develop local services. Achievements to date are summarised below:

Partnership and involvement

- The CAMHS Strategy Partnership and CAMHS Commissioning Group proved effective in promoting joint working to commission, plan and support the delivery of CAMHS.

- Investing in Children has supported children and young people to contribute to the development of CAMHS. The Emotional Wellbeing Reference Group conducts research by holding 'Agenda Days', adult-free spaces where children and young people can come together to discuss issues and develop agendas. Projects include: tackling the stigma of mental health; 'sorting stuff out' awareness campaign; stress and self-harm; improving access to psychological therapies (IAPT); membership award for teams demonstrating dialogue with children and young people and change as a consequence.

- A joint referral protocol has been developed between Looked After Children Services and CAMHS to ensure that children and young people access the most appropriate service based on their needs. This has resulted in clearer and timelier referrals, closer working relationships and improved information sharing between the two services.

- Durham County Council is developing a Multi-Agency Safeguarding Hub (MASH) in partnership between NHS health services, Police and wider partners working together to safeguard children, young people and vulnerable adults. This is to help professionals, family members or members of the public report a safeguarding concern. The viability of CAMHS being located in the MASH is being considered to streamline pathways.

Targeted services

- Introduction of the emotional health and wellbeing service, which is responsible for promoting emotional health and wellbeing of young people in schools, improving access to psychological therapies and developing capacity of staff within schools to identify and meet the needs of vulnerable young people. The team consists of specialist educational psychologists, specialist mental health advisory teachers, counsellors and support staff.

- Commencement of Primary Mental Health Workers (as outreach from Tier 3 CAMHS) who work with children and young people, either directly or indirectly, by supporting professionals working in universal and targeted services.

- Monitoring and reviewing the mental health needs of children involved in child protection and looked after processes i.e. those with a child protection plan or care plan. As part of the monitoring and reviewing process, Independent Reviewing Officers (IROs) ensure that referrals are made to appropriate mental health services within a timely manner. They also ensure that any mental health services already provided are appropriate and meeting the child's needs, making relevant recommendations with the child protection conference and looked after reviews to progress the child's care plans.

Specialist services

- Increased capacity into specialist CAMHS (Tier 3) multi-disciplinary teams, who provide a range of interventions, linked to clinical pathway development.

- Increased capacity in planned and emergency respite/short break care for children and young people with learning disabilities.

- Full Circle is a specialist targeted service funded by the Local Authority which provides therapeutic mental health interventions for looked after children and young people and those who have been adopted. Full Circle is a team made up of therapeutic workers and a clinical psychologist who works with those who have suffered trauma and abuse which is affecting their daily life.

- Successful application by Tees Esk and Wear Valleys NHS Foundation Trust to be part of the Children and Young People's Improving Access Psychological Therapies (IAPT) national programme. Elements of this programme include collaborative working and partnership, routine outcome monitoring and staff training re evidence based practice.

Transitions

- Improvements in the transitional care pathway between adolescent and adult mental health services. A review of the CAMHS Transition Service 16-17, resulted in replacement of the service by a 0-18 service. CAMHS focus on all transitions in a child/young person's life which impacts upon their mental health including transitions to post 18 services. A transitional plan or post 18 discharge plan is produced with the involvement of the young person. Work begins on plans 6-months in advance.

- The Early Intervention in Psychosis Service, which is commissioned as part of adults' services, provides assessment and a range of interventions for young people aged 14-35, who are having unusual or distressing experiences. Depending upon the severity and impact, these experiences can indicate that a young person has or is at risk of developing psychosis. The earlier this is picked up and addressed the better the outcomes and the recovery for the young person, and the service can support young people through the transition to adulthood and adult services if needed.

- There are a variety of specialist services and teams who provide support and advice for children with special educational needs (SEN), including educational psychology, and educational support services and these can help young people making the transition to adult services.

- An interagency transition steering group has been established to ensure transition protocol is reviewed and implemented so that young people (aged 14-25) with additional needs have a planned, coordinated and positive progression from childhood to adulthood.

Workforce development

- Staff working with children and young people with mental health needs across universal, targeted and specialist services have had the opportunity to develop their skills and competencies through access to a programme of learning and development.

Information for children and young people

- A regional newsletter, Mental Health North East has been developed, by young people (aged 12-22 years) who have 'lived experience' of mental health distress. The newsletter is aimed at young people suffering from distress or in contract with friends and relatives suffering from distress. These young people are increasingly utilising social media as a method of communicating with their peers. Editions have covered a number of issues including eating disorders, bullying and self-harm. The newsletter has been supported by the North Durham CCG Mental Health Clinical Lead.

9. Consultation and engagement

We consult and engage with young people on their views on health and wellbeing. The information below indicates some of their issues.

Self-harming was raised as a major issue for young people. The majority felt that within their local area and school self-harming has become a problem and more and more young people do it. Some young people said they would be confident enough to offer support to a friend who was self-harming however the majority said they couldn't.

The group recommended the following to reduce self-harm:

- Lessons/sessions in local schools ran by CAMHS professionals raising awareness of the issues and how they can support each other and seek help.

- Drop in sessions in schools with mental health professionals for children and young people to access.

- More publicity around the issues of self-harming/mental health.

The young people made the link between physical and mental health and highlighted the importance of a good diet and access to gyms etc.
Consultations also took place with a group of young people, all of whom have a disability.

The group were asked if they think mental health services (like CAMHS) are important.

- They felt this was very important because if people don't get support they may harm themselves or others, and because it affects all areas of your life, school, home friendships and relationships.

- They think it's one of the most important services because good help can change people's lives. They felt services should be easier to access and get help from.

- The group felt that they shouldn't need to go through long referrals, that they should be able to just walk-in and get help.

- An issue highlighted by the group was that health services need to be more inclusive for people with disabilities, not separate and far away in one specific area of the county, but with everyone else's services.

10. Overview of current commissioned services

Although not an exhaustive list, the table below details services commissioned for children and young people with emotional and mental health difficulties. The list excludes universal services.

Whilst the local authority provides a range of services for children who are in need, and their families/carers, there is acknowledgement that the needs of vulnerable children and young people are not always met by mainstream commissioned services. This strategy recognises that for some, services need to be commissioned on an individual basis to meet identified needs via continuing care.

Local authority services	• Full Circle (Integrated children's mental health service working with looked after children, children in need, adopted children, and children experiencing post-trauma through neglect and abuse)
CCG commissioned services	• Emotional Health and Psychological Wellbeing Service (Service promoting emotional health and wellbeing of young people in schools; improving access to psychological therapies across universal, targeted and specialist settings) • Primary Mental Health Workers – Core • Primary Mental Health Workers - Learning Disability (LD) • CAMHS – Core • CAMHS – Learning Disability (LD) • CAMHS – Out of Hours Response (Consultant Psychiatrist) • CAMHS – Community Forensics • CAMHS – Eating Disorder Community Service • Pathways – Attention Deficit, Autism Spectrum Disorder • Paediatric Liaison (acute trust) • Learning Disability Challenging Behaviour • Intermediate Care/Respite • Early Intervention in Psychosis (NB age range 14-35)
Regionally commissioned services (NHS England)	• Assessment and Treatment – Mental Health inpatient • Assessment and Treatment – Learning Disability inpatient • Eating disorders in-patient • Psychiatric intensive care units • Medium Secure • Low Secure
National Transformation Programme (DH)	• Children & Young People's Improving Access to Psychological Therapies (CYP IAPT) (aims to improve existing CAMHS working in the community; different to Adult IAPT as it does not create standalone services)

Summary of commissioned services

11. Emerging local issues and priorities

Based on the current information available, the following local priorities have been identified:

- Given the change in the commissioning landscape; there is a need to re-affirm partnership and governance arrangements.

- Development of a fully informed 3-year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan (across Tiers 1-4). This will include a refreshed mental health needs assessment.

- Mapping of perinatal maternal mental health and establishing a standardised pathway that all partners adhere to. However, it is beyond the scope of this strategy, but will be taken forward as part of wider 3-year plan.

- Ongoing development of the front end of emotional wellbeing pathway, to be taken forward via the Children and Young People's Mental Health and Emotional Wellbeing and Resilience Plan 2016-18.

- Ensuring services are able to respond to the needs of children and young people who develop mental health problems, to enable them to have the opportunity to recover and have a good quality of life.

- There needs to be improvements in the interfaces between the different services supporting children, young people and families, and full engagement of CAMHS with the single-assessment process.

- There needs to be greater awareness and improved response from services working together to support children and young people whose parents and other family members have mental health problems and/or substance misuse problems.

- Given the national reported increased rates in anxiety, depression and behaviour problems there is a need to understand the current and expected future demand on local CAMHS; to inform pathway development and commissioning decisions.

- Given the prevalence, there is a need to take action to reduce the rate of self-harm and suicides in County Durham. This has already been agreed as a local priority as is referenced in several local policy documents, and is a CCG commissioning intention for 2014/15. More support is needed for professionals and parents as well as children and young people to know how to deal with issues of self-harm and suicide.

- Although national commissioning guidance indicates CAMHS should cover all ages pre-birth to 18; there is a need to understand this in the context of the SEND reforms requiring education and health care plans to cover up to age 25.

- Whilst there is acknowledgement that considerable work has been undertaken to improve transitions, there is recognition that further work is needed to ensure young people's needs are fully met as they make the transition into adulthood.

- Nationally and locally there is an emphasis on outcome based commissioning. CAMHS need to have measurement systems in place and report on the impact and effectiveness of their interventions. This will support the ethos of continuous improvement.

Overarching priorities aligned to objectives with No Health without Mental Health are summarised below.

Objective	Local Priorities
More children and young people will have good mental health, including those in vulnerable groups	• Strategic planning and commissioning organisations will work together effectively to support child and adolescent mental health and wellbeing • Improve mental health in identified priority groups
More children and young people with mental health problems will recover	• High quality targeted and specialist services will be available to those most in need • Improve access to psychological therapies • Service provision will be coordinated and joined-up
More children and young people with mental health problems will have good physical health	• Develop a more integrated response to both mental health and physical health conditions

Objective	Local Priorities
More children and young people and their family/carers will have a positive experience of care and support	• Involve children and young people and their parents/carers in service evaluation and improvement • Improve access • Improve transition to adulthood • Improve support to families/carers
Fewer children and young people will suffer avoidable harm	• Reduce rate of self-harm in children and young people living in County Durham • Effective safeguarding
Fewer children and young people will experience stigma and discrimination	• Tackling stigma and discrimination

Local Priorities

12. SWOT analysis

Strengths	Opportunity
• Commitment to work in partnership • Alignment with Health and Wellbeing strategic objectives; interface with County Durham Implementation Plan of No Health without Mental Health National Strategy	• Development of CYP Mental Health, Emotional Wellbeing and Resilience Plan 2016/18 will provide opportunity to review whole pathway (T1-T4) including health needs assessment and consultation • CAMHS review being taken forward as CCG commissioning intention 2014/15 • ASD strategy development
Weakness	**Threats**
• Limited up-to-date local intelligence, service user profile	• Budget pressures

13. What we need to do

It is acknowledged that work on the six objectives will need to continue in the longer-term and consequently be incorporated in the emerging children and young people's mental health, emotional wellbeing and resilience plan.

Objective 1: More children and young people will have good mental health, including those in vulnerable groups such as children looked after

The importance of strategic planning and effective joint working is recognised, in ensuring a coordinated approach to planning initiatives aimed at promoting good mental health in children and young people. A targeted approach to those deemed at highest risk of developing poor mental health is required.

There is a need to ensure that more children and young people of all ages and backgrounds have better wellbeing and good mental health through a focus on prevention and building resilience.

In this regard a number of interventions will be taken forward via the Public Health Mental Health Strategy e.g. promoting importance of effective parenting and addressing bullying in school and community environments.

Within the scope of this strategy we will:

- Ensure a co-ordinated and coherent delivery and commissioning system by embedding effective partnership approaches and governance.

- Gain a more complete picture of local need by refreshing the County Durham Health Needs Assessment; identifying vulnerable and hard to reach groups, such as those in the criminal justice system.

- Consult and engage with children and young people and their families/carers and other key stakeholders (including education) to develop a 3-year children and young people's mental health, emotional wellbeing and resilience plan, to ensure the needs of the local population are being met.

- Ensure that children with complex needs, including mental health issues, are given full and equal access whilst being assessed under the new Children's and Family Act responsibilities and where appropriate are able to take advantages of opportunities offered by personal health budgets in all settings including those children in special schools.

- Continue to provide nurturing attachment training as part of the fostering and adoption training programme.

- Ensure timely support is available for children with additional needs and disabilities.

- Support a preventative approach for Looked After Children through the Looked After Children Reduction Strategy and adoption reforms, incorporating pre-birth initiatives.

- Continue to identify and support young carers and provide early help to families with additional needs coordinated through One Point.

- Ensure information and education is available for children, young people and their parents/carers on substance misuse and support children and young people to take part in positive activities which are appropriate for their age and reduce risk-taking behaviours.

Objective 2: More children and young people with mental health problems will recover

By commissioning high quality child and adolescent mental health services we will ensure that children and young people who develop mental health problems have the opportunity to recover and have a good quality of life. Service provision will be well co-ordinated and joined-up. The need for continuous improvement approach to pathway development, taking into account national evidence base (NICE) is recognised.

We will:

- Undertake a full review of CCG commissioned CAMHS services to ensure provision is evidence based and meets local needs. The review will take into consideration information requirements (e.g. referrals by source) and post 16 service provisions.

- Increase utilisation of out-reach work i.e. clinics within children's centres and general practices, as identified with the Children, Young People and Families Plan 2014/17.

- Continue to improve access to and recovery rate from psychological therapies for children and young people, increasing capacity to deliver evidenced-based interventions and linking to the Children and Young Peoples Improving Access to Psychological Therapies (IAPT) national project.

- Monitor / review the joint referral protocol between Full Circle and CAMHS and amend accordingly.

- Monitor performance data so that mental health outcomes at a population level can be demonstrated. To enable this, a local performance dashboard will be developed. In the longer term, the dashboard will be taken from the national CAMHS data set, which is still in development.

- Review pathways including: attention deficit and hyperactivity disorder; autistic spectrum disorder; eating disorder; challenging behaviour; and others in line with the mental health trust children and young people services pathway programme 2013-15.

- Engage with NHS England to understand the recommendations of the Tier 4 service review, in a local context. This will likely include review of the discharge pathway from Tier 4 services.

- Ensure support/signposting is available in schools for people suffering from mental health issues.

Objective 3: More children and young people with mental health problems will have good physical health

Promoting good physical health and addressing co-morbid physical and mental health will help ensure fewer children and young people will be at risk dying prematurely.

We will:

- Ensure that children and young people with a mental health problem are supported to make healthier lifestyle choices, including prevention of substance misuse, obesity.

- Review psychological support for children and young people with a disability or long-term condition e.g. diabetes, obesity and chronic fatigue.

Objective 4: More children and young people and their family/carers will have a positive experience of care and support

The importance of children and young people and their families/carers being able to access the right service, at the right time, delivered by the most appropriate professional(s) to meet their needs is acknowledged. Timely access and choice will contribute to children and young people and their family/carers having a positive experience. Service user and carer views and experiences will need to inform future service developments.

We will:

- Ensure that the experiences of children and young people and their family and carers are accessing CAMHS are captured, and where appropriate, intelligence informs service development.

- Review information on what support services are available.

- Develop open access and drop in clinics for CAMHS.

- Work towards establishment of a single point of referral and extended service provision; increasing choice of places to be seen. It is recognised that this is a longer term aspiration and will be dependent on funding availability.

- Explore better use of technology within CAMHS, e.g. Skype, texting appointment reminders, to connect to children and young people, in line with action in the Children, Young People and Families Plan 2016/18.

- Continue to adopt a whole family approach to assessment and care planning. Increase engagement of CAMHS in the single-assessment process, SEN reforms and interagency working to improve transitions for children and young people with mental health problems and children with disabilities, including those with learning disabilities

- Ensure a continued planned approach to the transition to adulthood, taking into account individual housing, education and employment needs, including the implementation of a transitions programme, which is being led by a transition steering group with representatives from Children and Adults services and Health.

- Implement a local CAMHS Commissioning for Quality and Innovation (CQUIN) scheme, specifically to improve the support to families who have a child or young person with mental health difficulties open to the Mental Health Trust, including parents and other siblings. It is anticipated that this will contribute to a positive experience of care and supports the 'Think Family' ethos.

- Provide training to professionals and develop a range of marketing materials to raise awareness of young carers, again in line with action in the Children, Young People and Families Plan 2016/18.

Objective 5: Fewer children and young people will suffer avoidable harm

This objective aligns to local agreed priorities of making children and young people more resilient and ensuring they are safeguarded and protected from harm.

We will:

- Work together to reduce incidents of self-harm by children and young people, increasing the availability of information e.g. recognising the signs and how to access help.

- Develop the knowledge and skills of school based staff to recognise and respond to signs of self-harm.

- Pilot a CAMHS crisis liaison /deliberate self-harm service; providing greater support out of hours to children in crisis and in danger of self-harm. It is anticipated that this will prevent children inappropriately accessing Tier 4 services and maintain them in the community. The service will work closely with the current primary mental health targeted CAMHS teams and specialist Tier 3 teams within County Durham and Darlington.

- Review the pathway for paediatric self-harm admissions.

- Continue to work in collaboration with other agencies, such as specialist substance misuse service, to ensure a seamless pathway of care for children and young people mental health problems and drug and alcohol dependence.

- Ensure all local authority commissioned and grant aided voluntary sector organisations work to safe standards of practice by implementing the 'Never Do Nothing' standards, to ensure the safeguarding of children and young people accessing their services.

- Continue to develop a Multi-Agency Safeguard Hub (MASH) to support the reporting of Safeguarding issues and consider the interface with CAMHS.

- Continue to work together to safeguard children and young people including those who are Vulnerable, Exploited, Missing, Trafficked (VEMT).

Objective 6: Fewer children and young people will experience stigma and discrimination

By raising general awareness of emotional mental health in children and young people, it is hoped that negative attitudes and behaviours decrease.

We will:

- Support National campaigns to challenge mental health stigma and discrimination.

- Support local opportunities to raise awareness of mental distress in children and young people e.g. newsletters.

13. Investment

Like many areas, County Durham priorities have to be delivered in the face of reductions in public spending. Services need to be responsive, easily accessible and delivered in a way that supports children and families to take responsibility for their own achievements and an outcome focussed approach to meeting local need is required. Scarce resources and budgets should be targeted at the most vulnerable and at risk, whilst minimising duplication. Universal measures should be evidence-based and capacity should be maximised through partnership working across agencies and professional boundaries.

The current funding for CAMHS services in Durham is quite complex. Some of the funding is wrapped up within the block contract that each of the CCG's have with Tees, Esk and Wear Valleys NHS FT and because of the nature of the block contract it is difficult to disaggregate the amounts which relate to CAMHS. In addition there is a contract value specifically for CAMHS which is funded and invoiced separately by the mental health trust. Durham County Council contributes to the Emotional Health and Wellbeing Service which is commissioned through the Section 256 route.

A joint commissioning plan for actions requiring investment will support implementation of this strategy. This will include CCGs commissioning intentions for 2014/15 and 2015/16 once approved. The commissioning plan will also take into consideration local authority commissioning priorities. Any action/intervention where there is not a funding pre-commitment will need to be considered by the relevant commissioning organisation(s) as part of their cyclic prioritisation process.

14. Measuring success

Performance indicators will be developed. These will include:

- Emotional and behavioural health of looked after children (average score of Strength and Difficulties Questionnaire)
- Young people aged 10-24 years admitted to hospital as a result of self-harm (rate per 100,000 population)
- Number of new referrals to CAMHS

15. Next steps

This interim strategy identifies actions that set the direction of travel for this year. The action plan for the next 12 months is detailed in **appendix 1**. After this period of time, the action plan will be refreshed, taking into account progress on the boarder work lead by County Durham Public Health.

The all age health needs assessment for mental health for County Durham will be a priority as this will help identify areas that need improvement across the whole pathway (Tier 1-4).

Appendix 1: Action plan 2014/15

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
1. More children and young people will have good mental health					
1.1 Strategic planning and commissioning organisations will work together effectively to support child and adolescent mental health and emotional wellbeing.	Re-affirm partnership and governance arrangements through the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Group, reporting to the Mental Health Partnership Board and Children and Families Partnership	Meetings scheduled and membership identified; agree Terms of Reference and governance/reporting arrangements	CCGs/DCC		July 2014
	Gain a more complete picture of local needs by refreshing the mental health needs assessment, identifying vulnerable groups	Develop a project plan to undertake a County Durham all age mental health and emotional wellbeing Health Needs Assessment and gap analysis (including universal promotion and prevention, early help and vulnerable groups)	CCGs/DCC		September 2015
	Consult and engage with children, young people, parents/carers and other stakeholders to inform future plans	Develop a consultation/engagement plan following appropriate organisational guidelines; build on existing participation mechanisms e.g. Investing in Children, parent forums and Healthwatch; map hard to reach groups and tailor consultation plan accordingly	CCGs/DCC		September 2015
	Develop and ratify the 3-year children and young people's mental health, emotional wellbeing and resilience plan for County Durham. This all- encompassing plan will supersede the interim CAMHS strategy and support the County Durham No Health Without Mental Health Implementation Plan	Analyse the results of the needs assessment, consultation and gap analysis to develop the three year plan (2016-2018) with a focus on prevention and building resilience and targeting interventions for those at highest risk of developing poor mental health	CCGs/DCC		December 2015
1.2 Improve mental health in priority groups within County Durham	As part of mental health needs assessment identify local vulnerable and priority groups		CCGs/DCC		March 2015
	CAMHS to support implementation of SEND code of practice by contributing to EHCPs and SEN support plans when appropriate to do so		CCGs/DCC		September 2014

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	Continue with nurturing attachment training as part of the fostering and adoption training programme		DCC		Ongoing
	Support a preventative approach for LAC through LAC reduction strategy and adoption reforms incorporating pre-birth initiatives	Initial Pre-Birth Stakeholder Group established; temporary psychologist in post	DCC		Ongoing
	Ensure information and education is available on substance misuse and support children and young people to take part in positive activities to reduce risk-taking behaviours		DCC		Ongoing
	Continue to identify and support young carers and provide early help to families with additional needs coordinated through One Point		DCC		Ongoing
	Ensure timely support is available for children with additional needs and disabilities and strengthen the work of primary mental health workers and early intervention within One Point.	Role of IROs/ Full circle capture outcomes?	CCGs/DCC		Ongoing
2. More children and young people with mental health problems will recover					

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
2.1 High quality targeted and specialist services will be available to those most in need	Undertake a review of CCG commissioned CAMHS, capturing accessibility/choice and patient outcomes including patient and carer satisfaction	CCG Commissioning Intention 2014/15; develop project plan to undertake review; report findings and refresh service specifications	CCGs		March 2015
	Explore mechanisms for increasing utilisation of out-reach work i.e. clinics within children centres and general practices	PMHW part of CAMHS review; case for change documentation to be complete	CCGs/TEWV		March 2015
	Ensure support/signposting is available in schools for people suffering from mental health issues		CCGs/DCC		
	Continue to improve access to and recovery rate from psychological therapies for children and young people, increasing capacity to deliver evidenced-based interventions and linking to the CYP IAPT national project	Additional training places made available Explore baseline data on access and recovery rates	TEWV CCGs		Ongoing
	Ongoing monitoring of joint referral protocol between Full Circle and CAMHS and review		DCC		July 2015
	Develop CAMHS performance dashboard for monitoring and reporting purposes	Core data in line with National CAMHS data set yet to be agreed; scoping exercise re CAMHS information requirements (to include referrals by source, service user/carer experience)	CCGs/TEWV		TBC
2.2 Service provision will be well-coordinated and joined-up	Adopt a continuous improvement approach to pathway development/implementation; review progress against CYPS pathway programme specific to County Durham; explore opportunities for integrated approach where appropriate	Review and implement pathways specific to ADHD, ASD, challenging behaviour, eating disorder and other (TBC)	CCGs/TEWV		Ongoing
	Engage with NHS England to review discharge process from Tier 4 to Tier 3	Review discharge pathway from Tier 4 to community services; mapping exercise	NHS England		March 2015

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
3. More children and young people with mental health problems will have good physical health					
3.1 Improve integrated response to co- and multi-morbidity mental health and physical health conditions	Explore further via health needs assessment; specific actions to be incorporate in 3-year plan	Needs assessment and 3-year plan to reference smoking, obesity, alcohol and substance misuse	CCGs/DCC		July 2015
	Children and young people with mental health issues and LTC to be considered as part of integrated pathway development	Link to needs assessment; map psychological support for children with a disability or LTC e.g. diabetes, obesity, chronic fatigue; consider links to pathway development/ IAPT	CCGs/DCC		TBC
4. More children and young people will have a positive experience of care and support					
4.1 Involve children and young people and their parents/carers in service evaluation and improvement	Service satisfaction questionnaire and taken action where appropriate	When evaluating service user and carer experience take into consideration Think Family approach and gather feedback on family involvement in assessment/care planning process	CCGs/TEWV		Ongoing
4.2 Improve access	Information on what support services are available		CCGs/TEWV		Ongoing
	Develop open access and drop in clinics		CCGs/TEWV		March 2015
	Adopt a better use of technology within CAMHS e.g. Skype, texts appointment alerts		CCGs/TEWV		March 2015
	Review web-based tool (previously commissioned by PCT) and make recommendation		CCGs		March 2015

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
4.3 Improve transition to adulthood	Adopt a planned approach to transition to adulthood taking into account individual housing, education and employment needs; establish joint transition team	A transitions steering group has been established, as part of the current adults and children's work stream; developing and implementing a transitions programme, including joint protocol Increase involvement of CAMHS in transitions work around MH and LD and SEN reforms.	DCC		Ongoing
4.4 Contribute to supporting families and carers	Implement local CQUIN scheme, specifically to improve support to families who have a child or young person with mental health difficulties open to the mental health trust	CQUIN applied via contracting process	CCGs/TEWV		March 2015
	Provide training to professionals and develop a range of marketing materials to raise awareness of young carers needs	Action included in CYPFP	DCC		March 2015
5. Fewer children and young people will suffer avoidable harm					
5.1 Reduce rate of self-harm in children and young people	Increasing the availability of information on self-harm e.g. recognising the signs and how to access help		CCGs/DCC		March 2015
	Pilot crisis/deliberate self- harm service	Initiative taken forward as commissioning intention 2014/15; service specification developed; service 'live' since June 2014; pilot interim 6-m report due early 2015	CCGs/TEWV		Ongoing
	Review pathway for paediatric self-harm admissions	Task and finish group to review pathway; paper re place of safety - potential models of care to be developed and presented to safeguard meeting; need to ensure effective engagement with Primary Care / GPs	CCGs/TEWV CDDFT		March 2015
	Develop knowledge and skill of school based staff to recognise and respond to signs of self-harm		DCC		March 2015

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	Promote awareness of self-harm in Primary Care	Practice Safeguarding Children Leads to undertake self-harm session	CCGs		Dec-14
5.2 Effective safeguarding	Implementation of Never Do Nothing initiative	Voluntary and Community Sector to be aware of simple actions they can carry out if they have concerns about a child, suspect that a child is in danger of harm or if there are concerns for a child's safety and welfare	DCC		Ongoing
	Continue to develop a local Multi-Agency Safeguard Hub (MASH)		CCGs/DCC		Ongoing
	Continue to work together to safeguard children and young people including those who are Vulnerable, Exploited, Missing, Trafficked (VEMT)		DCC		Ongoing
6. Fewer children and young people will experience stigma and discrimination					
6.1 Tackling stigma and discrimination	Support National campaigns		All		TBC
	Promote newsletter written by young people with lived experience of mental distress		All		Ongoing

Glossary

Attention deficit hyperactivity disorder (ADHD)
One of the most common childhood disorders which can continue through adolescence and adulthood. Symptoms include difficulty staying focused and paying attention, difficulty controlling behaviour, and hyperactivity or over activity.

Autistic spectrum disorders
Describes a range of conditions including autism, Asperger syndrome, pervasive developmental disorder not otherwise specified (PDD-NOS), childhood disintegrative disorder, and Rett syndrome. These disorders are typically characterized by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests and sometimes cognitive delays.

CAMHS (Child and Adolescent Mental Health Service)
Multidisciplinary teams comprising of psychiatrists, social workers, community psychiatric nurses and psychologists providing support to children and young people with severe mental health problems, both out of hospital and within hospital settings. There are four different levels of services for children and adolescents with mental health problems - these are described as Tiers 1, 2, 3 or 4.

Clinical Commissioning Groups (CCGs)
Groups of GPs responsible for planning and designing local health services in England.

Commissioning
The process for deciding how to use the total resource available in order to improve outcomes for children, young people and their families in the most efficient, effective, equitable and sustainable way.

Commissioning for quality and innovation (CQUIN)
This is a payment framework where a proportion of an NHS provider's income is conditional on quality and innovation. It aims to support the vision set out in "high quality care for all" of an NHS where quality is the organising principle.

Emotional wellbeing
A holistic, subjective state which is present when a range of feelings, among them energy, confidence, openness, enjoyment, happiness, calm, and caring, are combined and balanced.

Health and Wellbeing Boards
The Health and Wellbeing Board focuses on promoting integration and partnership working, and improving democratic accountability of health and social care services.

Inpatient
Essential tertiary level services such as highly specialised out-patient teams and in-patient units.

Joint Strategic Needs Assessment (JSNA)
An assessment that provides an objective analysis of the current and future health and wellbeing needs of local adults and children, bringing together a wide range of quantitative and qualitative data, including user view.

Learning disabilities
If someone has a learning disability, it means that they may find it more difficult to learn, understand and communicate. Learning disabilities are not a "mental illness", but can be caused by illness or problems before or during birth, or that develop during childhood or as the result of an illness.

Looked After Children
Child who is either provided with accommodation by a local authority social services department for a continuous period more than 24 hours, or someone who is subject to a relevant court order under part IV or V of the Children Act 1989. Could refer to children subject to accommodation under an agreed series of short term placements like short breaks, family link placements or respite care. Most looked after children cease to be looked after on reaching their 18th birthday; some are looked after until their 21st birthday under Section 20 (5) of the Children Act.

Mental health problem
A phrase used as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems.

County Durham

Child and Adolescent Mental Health Services

Interim Joint Strategy

2014 - 2016

24 October 2014

Developed on behalf of County Durham Mental Health Partnership Board

39

Health and Wellbeing Board

5 November 2014

Early Help Strategy

Report of Carole Payne, Head of Children's Services, Children and Adults Services, Durham County Council

Purpose of the report

1. The purpose of this report is to introduce the final copy of The Early Help Strategy to the Health and Wellbeing Board (Attached at Appendix 2)

Background

2. The Early Help Strategy sets out our commitment to provide Early Help, Intervention and Prevention in County Durham.

3. Durham's Early Help Strategy is inclusive. It is a strategy for all; for all of our colleagues, for all of our partners and for all of our children, young people and families.

4. The Early Help Strategy shares the vision of the Children, Young People and Families Partnership Plan.

5. The Early Help Strategy has three ambitions:

    - We will work collaboratively - Early Help will be Everyone's business
    - Children, young people and families will get the right help at the right time
    - We will provide help that we know works

The Journey

6. The Early Help Strategy has been subject to much discussion and wide consultation with partners across the County Durham Partnership. These views and feedback has enabled us to be confident that the strategy is consistent with partners' ambitions of ensuring children; young people and adults who are parents and carers get the right support at the earliest opportunity.

7. The Think Family Partnership has worked on the draft Early Help Strategy to ensure their individual services key principles and objectives were reflected.

8. Workshops were held and well attended by colleagues from across partner agencies in Durham.

9. Alongside the consultation workshops senior management meetings, team meetings, reference groups, 1:1s, Community of Learning Groups, partnerships and forums across Durham have hosted Early Help Consultation sessions.

10. An effective Early Help strategy is not static. This strategy and its implementation will be regularly reviewed and developed. The development of the strategy is the beginning of its journey and we hope its shared vision and ambitions and the commitment to 'getting it right' continues in its implementation and governance across our partnerships.

Recommendations

11. The Health and Wellbeing Board are recommended to:

    - Receive regular updates on its implementation and success

Contact: Rachel Hirst-Dean, Think Family Services Strategic Manager, Durham County Council, 03000 268 375

Appendix 1: Implications

Finance
No implications at this stage

Staffing
Workforce Development for all partners

Risk
No implications at this stage

Equality and Diversity / Public Sector Equality Duty
No implications at this stage

Accommodation
No implications at this stage

Crime and Disorder
No implications at this stage

Human Rights
No implications at this stage

Consultation
No implications at this stage

Procurement
No implications at this stage

Disability Issues
No implications at this stage

Legal Implications
No implications at this stage

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Early Help Strategy for Children, Young People and Families in County Durham

Section	Page

Foreword

This strategy sets out our commitment to provide early help, Intervention and Prevention in County Durham.

Thanks to many colleagues and their valuable input The Early Help Strategy has been developed and will be implemented in partnership.

The Early Help Strategy outlines our partnership commitment to deliver early help and timely intervention to children, young people and their families in County Durham. It aims to outline our shared vision and principles, our shared ambitions and objectives and how collectively we can deliver stronger services to support our children, young people and families, improve their outcomes and reduce cost to our services and communities.

Early help is a key message and principle in a broad range of partnership work and has many cross cutting themes and objectives.

An effective early help strategy is not static. This strategy and its implementation will be regularly reviewed and developed.

The Early Help Strategy is for all those who work with or who have an interest in the outcomes of children, young people and their families in County Durham.

Thank you to all of our partners and colleagues who have contributed to the development of this strategy. The strategy has had a vast amount of consultation and a great amount of support has been received throughout.

The writing of the Early Help Strategy is the beginning of its journey and we hope its shared vision and ambitions and the commitment to ‘getting it right’ continues in its implementation and governance across our partnerships.

Consultation

The Early Help Strategy has been developed through discussion and consultation with partners across the County Durham Partnership. The wide range of views and feedback has enabled us to be confident that the strategy is taking us in the right direction and is consistent with our partner's ambitions of ensuring children, young people and adults who are parents and carers get the right support at the earliest opportunity.

The Early Help Strategy is based on a sound evidence base relating to 'what works', with the voices of children, young people and parents at its heart. Their views have been sought through commissioned work through Investing in Children as well as reference groups working with groups of children and parents from within our existing services.

We know that children and young people value

- Trust, openness and honesty
- Being treated with respect
- Support for their parents as well as themselves

There have been two phases of consultation, one before work commenced on the strategy and one after a draft had been produced.

The Think Family Partnership have worked on the draft Early Help Strategy to ensure their services key principles and objectives were reflected. Two further workshops were held and attended by colleagues from across partner agencies in Durham.

Alongside the consultation workshops, senior management meetings, team meetings, reference groups, 1:1s, Community of Learning Groups, partnerships and forums across Durham have all hosted Early help Consultations.

All the feedback, views and amendments have been reflected to ensure that an effective early help offer is the responsibility of all partners and is a responsibility shared with families and their communities.

Introduction

The majority of children and young people in County Durham will grow up and reach their potential in a supportive environment but there are still many who don't.

Some children, young people and their families face additional difficulties and problems, additional help and support needs to be there at the earliest opportunity to stop these problems from escalating and negatively impacting on their future

This help can range from appropriate advice and support, to a single agency response to an issue, through to the need for more coordinated and intensive support, sometimes from specialist services.

In Durham, we are in a positive position to move forward with the Early Help Strategy. Significant progress has already been made in many areas to deliver timely early help and prevention services that work well together and there is a strong commitment set out across Durham's Children, Young people and Families Partnership and Durham's LSCB to genuinely work collaboratively.

We will use this knowledge and commitment as a platform for early help, we will build on what we know works and aim to strengthen joint working and consistency across partners to ensure that we work together to identify needs and provide support to children, young people and their families at the earliest possible stage, improving outcomes and reducing costs

Durham's Early Help Strategy is inclusive. It is a strategy for all, for all of our colleagues, for all of our partners and for all of our children, young people and families.

All agencies in County Durham should be committed to the principle of providing help as early as possible to families.

This document aims to:

1. Outline the vision and ambitions for Durham's Early Help strategy

2. Define what we mean by early help in Durham and why it is important for children, young people and families.

3. Outline the national and local policy directives and evidence driving the implementation of the Early Help Strategy.

4. Articulate the principles that underpin the future development and delivery of services.

5. Describe the role of 'early help' within our integrated delivery model, for supporting children, young people and families and set out clearly what we plan to do and how we intend to work, with an increasing emphasis on high quality services, value for money and the significance of early help.

6. Set out the Implications of the Early Help Strategy, how it differs from current delivery and how partners and services can add value to it across the pathway of need, from universal, right through to specialist services.

7. Describe the importance of effective commissioning across the County Durham Partnership in what services all partners will offer to children, young people and families.

8. Identify key priorities and actions for the implementation of the Early Help Strategy across all our services and our entire workforce.

> "Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years".
>
> **Department for Education (2013) Working Together to Safeguard Children**

Definition of Early help

Children, young people and their families have different levels of need depending on their individual circumstances and quite often these change over time with some families moving between universal, targeted and specialist services.

Children can be helped in three broad ways:

- **Prevention** ➡ So that problems don't arise in the first place
- **Early Intervention** ➡ So that problems are cut off at an early stage
- **Protection/ Targeted intervention / treatment** ➡ So that something is in place for needs or problems that are serious or will endure.

At any or all three stages, there will always be a need for some level of help which requires services to be equipped and able to respond to these changing needs and demands.

Early help is an approach and the need for early help can occur at any point in time. Central to this approach is a focus on increasing independence for families and communities, supporting and building resilience.

It is a way of thinking and working that views children, young people and their families as equal partners with an emphasis on doing 'with' rather than doing 'to'.

For the purpose of this strategy we refer to early help both in the context of the early years of a child's life (including pre natal interventions) and early in the emergence of a problem at any stage in their lives.

We incorporate the concepts of 'protection/treatment', 'early intervention' and 'prevention' and the importance of anticipating problems and taking action to prevent these.

It takes into account the individual needs of the whole family including social, educational, physical and mental health and wider impacts such as social and health inequalities and material disadvantage.

Early help includes universal services that are offered to an entire population to prevent problems from developing and also services that are targeted to particular children, young people and families with existing risk factors or additional needs to reduce the risk of problems developing, or reduce the severity of problems that may have already emerged.

> "intervening early and as soon as possible to tackle problems emerging for children, young people and their families or with a population most at risk of developing problems. Early intervention may occur at any point in a child or young person's life".
>
> **Centre for Excellence and Outcomes -C4EO (2010)**

Vision

At the heart of this strategy are our children young people and their families.

We share the vision of the Children, Young People and Families Partnership Plan that in County Durham.

'All children, young people and families believe, achieve and succeed'

The Early Help Strategy's core objective is to help deliver this vision by ensuring that;

County Durham has an effective and consistent early help offer across its partnership.

Improving the outcomes and life chances for all, particularly our most vulnerable through a collaborative and effective early help offer is the foundation of this piece of work

Under pinning our vision and objective are three main ambitions:

1. **We will work collaboratively- Early help will be everyone's business**

2. **Children, young people and families will get the right help at the right time.**

3. **We will provide help that we know works**

To have an effective and consistent offer of early help across our partnership, we need to work together and share the responsibility. We will learn from the best and deliver high quality preventative help and intervention backed by evidence of success. We will ensure we have seamless, clear and efficient pathways into and through services and have integrated approaches to screening, assessment, planning and service delivery.

If we intervene early with high quality coordinated services we should be able to increase the number of children, young people and families reaching positive outcomes and reduce the number of families requiring higher cost interventions.

Our Ambitions

1 We will work collaboratively - early help will be everyone's business

What?

Early help and prevention are terms often used interchangeably but in reality they overlap. The first ambition of this strategy is to ensure that early help is everyone's business. Which means our entire workforce across the partnership will provide help at the earliest possible opportunity to tackle problems emerging or becoming worse for individual children, young people and their families.

Why?

Together we will make a difference.

Thinking Family and multi agency working go hand in hand. Adults and children's services need to work more closely and effectively together to ensure that when problems faced by the adults in the family are identified and addressed, the implications for their children are also consistently considered and addressed in a holistic way.

Collectively agencies invest greatly in services for children and their families. We have many high quality services and a highly trained and experienced workforce. However, the array of services is complex and not always well coordinated, with different systems and definitions of need.

As a result, some families' problems are allowed to escalate because no agency is willing to take responsibility early enough, leading to high levels of demand on expensive specialist services.

We will need to genuinely work together. Effective collaboration relies upon effective sharing of information between professionals and local agencies. It is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services.

We will work collaboratively - early help will be Everyone's Business

What we need to do:

Develop a shared understanding, responsibility and commitment from all partners of our early help offer

Create a culture across our partnership of early identification and information sharing to ensure joined up work and collaboration

Focus more on pathways and how we will work together to agree our responsibilities and respective roles

We will 'Think Family': all needs of the whole family will be considered, such as employment, education, health, substance misuse and housing.

A workforce and services committed to working collaboratively in addressing unmet need and managing risk at the lowest levels and the earliest opportunity.

Listen effectively and respond to the views of children, young people and their families

Provide effective governance processes and accountability through our existing Children and Families partnership and our Local Safeguarding Children's Board.

Key Strategic Actions to reach this ambition:

1. We need to ensure there are clear pathways to share information and identify families early so we are able to work in genuine collaboration to get the best offer of support at the right time to the right families.

2. We need to embed the Think Family ethos across our partnership so that the well-being of children and young people can be properly addressed by ensuring that the voice and needs of the child are heard and clearly informs our work alongside assisting parents.

Good Practice Journey so Far:

Durham's LSCB protocol for collaborative working to protect vulnerable adults and children 2014 is a good tool to enable practitioners from different service to work together effectively by sharing information

Through our partnerships we are successfully delivering the national Troubled Families Programme, locally known as Stronger Families. To date this programme is working with 1504 families and has turned around 677 which means we have supported 52% of our targeted families to achieve positive outcomes.

2 Children, young people and families will get the right help at the right time

What?

Effective early help will mean identifying:

- the right families
- the right services
- at the right time
- to improve outcomes

Why?

It should never be too late to offer early help.

We know that a small number of families with complex needs are responsible for a disproportionate amount of the workload of many agencies. To improve our offer of early help, we need to join up and coordinate our responses to ensure children, young people and families get the right support and intervention they need to achieve good outcomes and not fall through the gaps often created by service thresholds and remits.

As an authority Durham County Council will be focusing emphasis on targeted services. In an era of decreasing resource, services must be offered first to those who need them, when they need them.

Early help involves all staff adopting a 'Think Family' ethos at all levels of support and intervention and in all services. We know that children's problems do not sit in isolation from their parents, and that parents' problems impact on their children. By making sure that families receive co-ordinated, multi-agency, solution focused help, we can ensure that all family members are able to get the support they need, at the right time.

We know that situations change for families; their lives are not static, and challenging issues can arise at any time. We need our services to be timely and responsive throughout a child's life and to the needs of their families as they either escalate or as their circumstances improve.

Genuine collaboration will allow our children, young people and families to receive a seamless service. Our service boundaries and thresholds should not be a barrier to support. We know from audits and case reviews in Durham that there are still families treated like 'hot potatoes' where no one truly grips the family, often because they are seen as difficult to work with, or reluctant to engage. This then leads to an escalation of need or a 'revolving door' situation where the family re-presents because the original issues have not been resolved.

The Early Help Strategy is reinforced by Durham's LSCB Protocol: Collaborative Working to Protect Vulnerable Adults and Children. Effective service delivery depends upon proficient information sharing; continued collaboration; understanding and mutual respect between agencies and professionals.

The Right Help at the Right Time

What we need to do:

We need to ensure there is seamless escalation and de-escalation between services to ensure families are supported holistically by the right people at the right time.

We need to target resources at those who need it most.

The child or young person must remain at the centre of our work. We will work together to ensure that the child's journey is seamless and positive.

Children, young people and their families will access support through a 'Single Front Door' within County Durham which will screen all requests for help to ensure that appropriate levels of response are provided in every case.

One family, one plan- all agencies will be committed to identifying children and families' unmet needs and identifying early, low level problems emerging for children and their families. There will be no wrong door; all services have a responsibility to provide early help, no matter which service a member of a family first makes contact with, and regardless of whether the issue falls within their immediate area of professional expertise.

We will recognise the important part universal and preventative services play in our early help offer and support services such as schools and health services to offer early, holistic support to the people who need it the most.

Key Strategic Actions to reach this ambition:

1. We will use a single but proportionate assessment model across all levels of need and assessment. Help and assessment will be offered in tandem so that families are not waiting for early help and support.

2. We will, never do nothing. We will use our staircase model to adopt a 'step up-step down', 'Think Family' approach so that families move smoothly between services and a seamless offer of support is received at the right level at the right time.

Good Practice Journey so Far:

Strategic work such as the transformation of children's services is already underway

The single front door and single assessment models are expected to be implemented by January 2014. This work has all been developed in partnership.

3 We will provide help that we know works

What?

Early help must include the concept of building resilience in families so that they are able to meet their own needs are do not become dependent on services, and are able to find their own long term solutions.

We need to harness community resources. This will help to break cycles of dependency and improve outcomes in the long term for families as well as ultimately reducing costs.

Why?

Durham has made significant progress over recent years to build the foundations for providing early help to families through its universal and targeted services. The development of the One Point Service, the Family Pathfinder Service, The Family Nurse Partnership, The Family Intervention Project, Pre Birth service and Stronger Families programme to name but a few, have all played their part in turning around hundreds of our most vulnerable, challenging and challenged families' in County Durham over the years.

Many of these programmes have had had positive Independent evaluations and several have won awards.

According to an independent evaluation of Durham's FIP in 2010, every household supported by the FIP produces cost-savings of between £21,313 and £64,867. A similar evaluation of Family Pathfinder showed that for every £1 invested in service, £2.50 of future cost was avoided.

This would suggest that not only does this style of working have huge cost savings potential, but also that it works, with effective support at the earliest opportunity children, young people and their families are able to thrive and achieve.

We need to work together and ensure we provide the right services at the right time.

Commissioning, accountability and clear partnership governance are all mapped out later in this strategy as key to successfully embedding the early help ethos.

Services use a lot of resource dealing with the consequences of poor parenting; family breakdown and an array of multiple and complex problems. It is important to shift this focus away from solving problems to preventing and reducing problems. Help must be offered in a way that families want to engage with, so that it can make a real and lasting difference to their lives and tackle the root causes to ensure that changes that families make can be sustained.

We will provide help that we know works

What we need to do:

We need to learn from 'what works' and do more of those things that have a sound evidence base rather than activities that do not.

We must coordinate our commissioned services and ensure alignment of budgets and services, for example between Public Health and CAS commissioned services

We must deliver services that deliver positive outcomes and reduce the inequality gap for children young, people and their families

Our work will be solution focused. Families will be offered the help that works for them.

Our workforce will be assertive in the early identification of vulnerable families and will respond flexibly to their needs.

Key Strategic Actions to reach this ambition:

1. We will ensure our commissioning strategies are aligned.

2. We will audit our current activity and reshape what we offer to match the needs of our families to prevent children from experiencing harm, neglect and poor outcomes.

3. Our workforce will offer practical hands on support to families in order to build resilience within our families and achieve sustainable positive change to the families who need it most.

4. We will be outcome focussed. Services will demonstrate and monitor what difference they have made to the lives of the children and families who use them.

Good Practice Journey so Far:

Evidenced based practice in Durham is not a new concept. Much of the development across agencies is based on what we know works. Durham's Stronger Families programme has built on existing partnerships and long standing multiagency partnerships and work.

The Family Intervention Project, Pathfinder, Child in Need Pilot, Pre Birth Pilot and High Impact Families amongst others in Durham all have proven success in supporting families to achieve positive outcomes. Several evaluations of these services highlight them to be cost saving and well-liked by both professionals and the families they support.

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Why does Durham need an early help Strategy?

There has been a continued emphasis across key partners in County Durham to deliver an early help approach to improve outcomes for children and young people and families to reduce their need for intensive, acute or specialist support and prevent harm, not least because of the:

- recognition of the importance and impact of intervening early to achieve positive outcomes for children and young people;
- the high demand for specialist support for children and young people;
- Continued pressure on public sector budgets and spend.

Early help reflects the widespread recognition that it is better to identify risks offer **help early** and **prevent** problems from occurring rather than responding later when risks have heightened and require action from intensive, high cost and statutory services.

For children, young people and families who need additional help, every day matters. The actions taken by professionals to meet the needs of these children as early as possible can be critical to their future.

> "The case for preventative and Early Help Services is clear, both in the sense of offering help to children and families before any problems are apparent and in providing help when low level problems emerge. From the perspective of a child or young person, it is clearly better if they receive help before they have any, or only minor, adverse experiences."
>
> **The Munro Review of Child Protection, 2011**

There is sound evidence both **nationally** and **locally** that early help needs to be a priority when working with children, young people and their families.

National Drivers

Over the last fifteen to twenty years successive governments have continued to build emphasis on the importance of early help. Policy direction has set the way for strategic thinking and funding streams nationwide, The Early Intervention Grant (EIG), The Health Visiting: Call to Action Programme, The Social Mobility Strategy, Supporting Families in the Foundation Years and The Troubled Families Programme to name but a few.

The central importance of early help in enabling children and adults to reach their full potential has been a common theme in five key documents published following the formation of the Coalition Government.

- **Professor Sir Michael Marmot 2010**: Fair Society, Healthy Lives
- **The Rt Hon Frank Field MP 2010**: The Foundation Years: Preventing Poor Children Becoming Poor Adults
- **Graham Allen, MP 2011**: Early Intervention, the next steps
- **Dame Clare Tickell 2010**: Review of the Early Years Foundation Stage
- **Professor Eileen Munro 2011**: Review of Child Protection

All five are united in their call for early intervention and all have independently reached the same conclusions on the importance of providing help early in order to improve outcomes for children and young people, with concerns that range from preventing abuse and neglect to helping parents achieve the aspirations they hold for their children.

The foundations for virtually every aspect of human development – physical, intellectual and emotional are laid in early childhood. What happens during those early years, starting in the womb, has lifelong effects on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational and economic achievement… Later interventions, although important, are considerably less effective if they have not had good early foundations."

Marmot 2010

We have found overwhelming evidence that children's life chances are most heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years that together matter more to children than money, in determining whether their potential is realised in adult life.

Field 2010

"The case for preventative and Early Help Services is clear, both in the sense of offering help to children and families before any problems are apparent and in providing help when low level problems emerge. From the perspective of a child or young person, it is clearly better if they receive help before they have any, or only minor, adverse experiences."

Munro 2011

Building their essential social and emotional capabilities means children are less likely to adopt antisocial or violent behavior throughout life. It means fewer disruptive toddlers, fewer unmanageable school children, fewer young people engaging in crime and antisocial behavior. Early intervention can forestall the physical and mental health problems that commonly perpetuate a cycle of dysfunction.

Allen 2011

The evidence is clear that children's experiences in their early years strongly influence their outcomes in later life, across a range of areas from health and social behaviour to their employment and educational attainment. The most recent neuroscientific evidence highlights the particular importance of the first three years of a child's life. A strong start in the early years increases the probability of positive outcomes in later life; a weak foundation significantly increases the risk of later difficulties.

Tickell 2011

Local Drivers

One of the key drivers in Durham is the aspiration to reduce the number of children in receipt of statutory and specialist services. By having a successful offer of early help we would expect to see this number reduce.

We need a range of agencies to be identifying needs at the earliest opportunity to enable the right support to be offered at the right time and prevent problems from emerging or worsening. Too many of our children and young people live in situations which escalate over time often into chronic neglect. Last year (2013/14) 681 children were subject to child protection plans with neglect listed as a category; which is 61% of all cases.

It is these families in particular where we believe early help can be most effective. By working together to address the needs of the whole family at the earliest opportunity we would hope to see a reduction in the number of these cases.

To understand why early help is important in Durham and to be able effectively to prioritise and target early help responses it is essential to understand the key needs and issues of the local population.

It is also important when shaping our services to recognise that some outcomes such as life expectancy rates are lower in our most deprived areas, highlighting the significance of health inequalities which was the underlining theme throughout the 2010 Marmot review

In Durham we know:

Our Young people compared to national rates have a higher teenage pregnancy and child hood obesity rate and County Durham is ranked 12th worst out of all Local Authorities for alcohol related admissions for people under 18 years old. Their educational attainment has improved generally but the gap between those children in the bottom 20% and their peers remains wider than in other Local Authority areas.

The number of children with a child protection plan and children looked after has risen for several years. However, in County Durham the trend has recently turned downward both for children with a plan and for children looked after. Numbers per 10,000 are lower in County Durham than elsewhere in the region, where numbers continue to rise. (See appendix 1)

62% of children subject to a Child Protection plan in January 2013 had a plan as a result of neglect, which is an increase on previous years. The rate has been increasing since 2009/10. Neglect is a long term, chronic form of harm to children and services offering early help should be able to impact positively on outcomes for this group of children and young people – either in reducing levels of neglect or in reducing delay that many children experience before decisions are made about ‘good enough’ parenting.

Parental issues of domestic abuse, mental health and alcohol misuse continue to be key issues of risk relating to children subject to a child protection plan within County Durham. Unless parents’ issues are identified and supported through the provision of early help, the outcomes for their children will remain poorer than their peers.

There is extensive evidence to show that this group of children often experience poorer outcomes against a range of measures including education; higher prevalence within criminal justice agencies, for example.

County Durham experiences higher levels of deprivation than the national average. Almost 50% of the population live in relatively deprived areas. The Council's approach to financial inclusion has evolved over the past three years. With the ongoing impacts of the roll out of welfare reforms the main aims of the work are to assist residents in maximizing their income – through sustainable employment, as well as reducing household outgoings. The approach but still holds as a key element the principles of education, access to advice along with access to financial products.

> The health of the people of County Durham has improved significantly over recent years but remains worse than the England average. Health inequalities remain persistent and pervasive. Levels of deprivation are higher, and life expectancy is lower, than the England average.
>
> **Annual Report- Director of public Health, County Durham 2012/13**

Almost 8,000 people seek homeless and housing advice in County Durham every year. Homelessness has a detrimental effect on individuals, families and communities and can undermine social cohesion

Tackling the effects of homelessness can be costly to the public purse when compared to the costs associated with proactively seeking to prevent homelessness in the first place. Homelessness can happen to anyone at any time so it is important that services are available to all in housing need, in addition to those at greatest risk due to social or economic influences.

Life expectancy for Men in County Durham is 1.2 years less than the England average. For women it is 1.1 years less than the England average (at birth 2008-10).

With Welfare Reform taking an estimated £150 million out from our economy in 2013/1, vulnerable families are likely to further struggle and the inequality gap is likely to grow.

There are significant inequalities amongst our children, young people and families with almost half of our population living in relatively deprived areas and almost a third living in the most deprived areas of England.

The link between deprivation and poor health outcomes is well documented and the 2012 Marmot indicators (appendix 2/3) show County Durham to have significantly worse:

- Male and female life expectancy than England.
- Inequality in disability-free life expectancy for males and females than England.
- Levels of children achieving a good level of development at age 5 than England.
- Levels of young people not in education, employment or training compared to England.
- Households in receipt of means-tested benefits than England.

The Cost Implications

Early help matters. Not only is it the right thing to do to improve outcomes for children and their families as outcomes are improved and opportunities for change are maximised, but it is also cost effective.

The social cost of failing to act for children and young people who experience multiple disadvantage is significant. They run the risk of living with lower aspirations and failing to reach their potential. This can become inter-generational as these children and young people go on to become parents themselves.

There is good evidence, both nationally and locally, that investment in early help not only improves outcomes for children and families but provides value for money. Incorporating the concept of early help into Durham's invest to save strategies has been a commitment for some time, and this will need to continue to implement an offer of early help effectively.

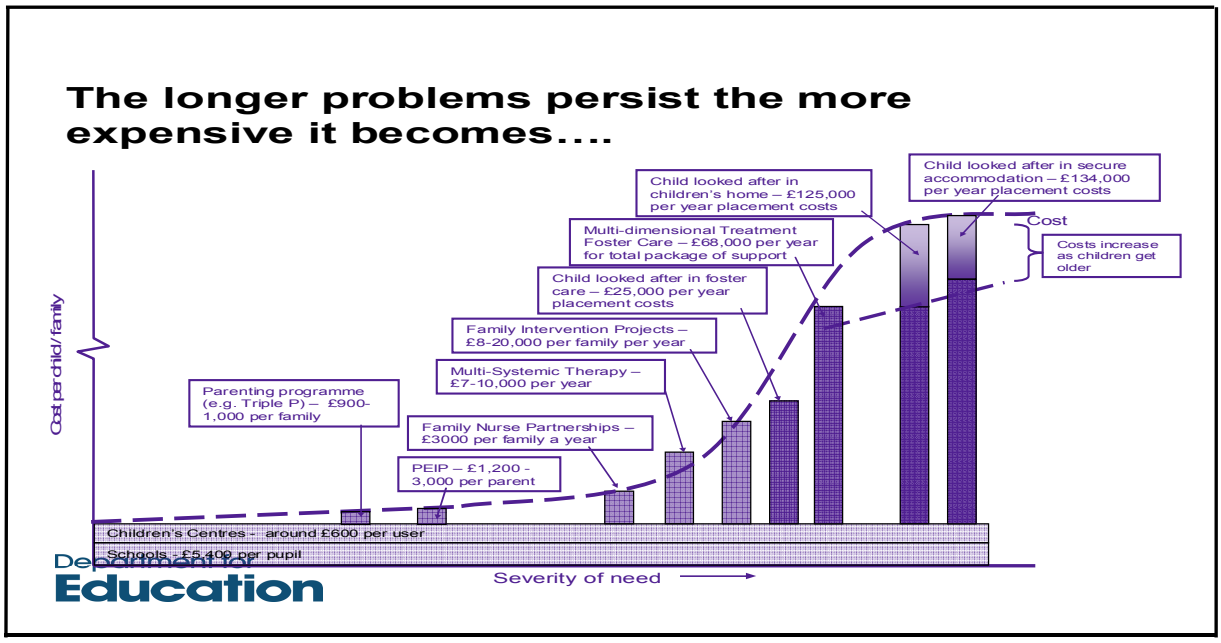
Public spending is at an unprecedented level and we are all under financial pressure. Providing effective early help is paradoxically more challenging, yet more crucial in a time of significantly reduced public spending. During times of austerity and with a squeeze on resources, it is increasingly necessary to ensure that resources are targeted where they will make the greatest difference.

An effective offer of early help has the potential to reduce the need for more costly specialist and statutory interventions. However it is important to note that although helping early may be more cost effective in the long term in the short and perhaps even medium term, in order to transform it will require the refocus of already stretched resources.

It is also important to acknowledge that in the interim of embedding an early help offer costs and demands on resources may be increased by the very awareness raising that will ensure successful implementation. It is also important to note that there will always be some children, young people and families that will need the help and support of specialist and statutory services.

The financial case for delivering early help through coordinated, whole family services in a targeted way is well made through extensive evaluation of both Family Intervention and Family Pathfinder Projects. Further cost benefit evaluation is also beginning to be conducted for the Troubled Families Programme which will add to this evidence base

The Department of Education produced a graph in 2010 illustrating how the costs of intervention rise as the level of need rises and how much could potentially be saved if need and risk was identified in a much more proactive way and interventions were provided to meet that need.



Early help across Durham's Continuum of Need

Early help is a concept relevant to all services from universal right up to specialist services.

Most families will access our Universal Services never needing any additional support. These Universal services are well placed to provide for most families. The interventions and support they offer are vital in preventing many children, young people and families from escalating in to more targeted services.

In Durham, our universal services include children's centres, schools, health visiting and universal health services and some aspects of our One Point Service.

> *For children who need additional help, every day matters. Academic research is consistent in underlining the damage to children from delaying intervention. The actions taken by professionals to meet the needs of these children as early as possible can be critical to their future.*
>
> **Department for Education Working Together to safeguard children (2013)**

Families may also use leisure and play facilities, neighbourhood, community or voluntary sector services.

These universal services greatly support an effective early help approach; prevention services such immunisation programmes, early years advice, health visiting and school nursing and universal and accessible public health information that supports better life style choices all serve to ensure that the huge numbers of children, young people and families they reach get what they need and preventing them from needing further support.

Universal Services are also in a key position to identify situations where a more targeted and assertive approach is required. Targeted services and intervention delivered early will reduce the need for specialist services.

Pro-actively challenging non-engagement, such as missed health appointments, also facilitates early help.

Schools, like other universal services, have a key role in identifying emerging concerns early on, and close working with the school community is critical to the successful delivery of early help to children, young people and their families. Often a child missing school will be the first indication that the family are experiencing problems. Schools play a key role in helping build resilience and stronger networks of support for families in their local communities.

Funding is increasingly devolved to schools to meet the needs of their pupils around careers advice, sex and relationship education, and other areas. Durham County Council will continue to work with schools to ensure that appropriate access to services is maintained, considering the needs of both individual school communities and the wider needs of children and young people across Durham.

Levels of Need

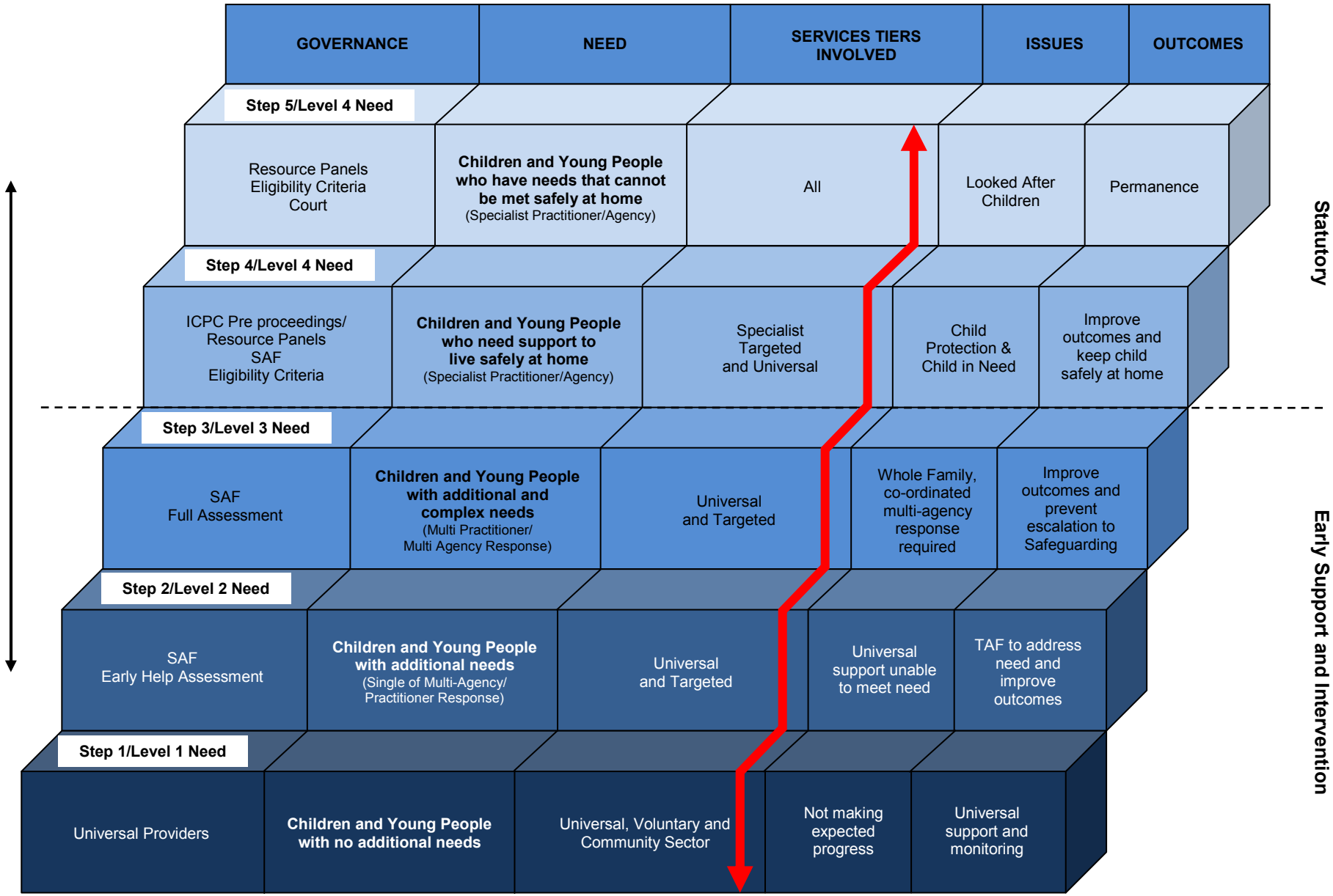
It is also important to have an agreed local understanding of levels of need and what work is facilitated across this.

A useful way to conceptualise need is to think of it as a staircase, with the lowest need represented as the bottom step and the highest level of need on the top step. As need increases the next step up might be taken and as need may decrease a step down can be taken. Regardless of which 'step' children, young people and families are identified they will be supported at the earliest opportunity and continued to be supported by the relevant services as they move up and down the staircase.

The Durham staircase illustrates our integrated services pathway model and is designed to reflect the fact that the needs of children, young people and families exist along a continuum. The model recognises that needs may change over time and is based on the principle that children and young people's welfare and safety is a shared responsibility and should be a seamless positive journey.

The staircase sets out need across 5 levels- 5 steps and is represented on the following page.

The Durham Staircase and Continuum of Need



Level 1- Universal Provision Children with no additional needs

Children and young people who are achieving expected outcomes and have their needs met through universal service provision. Typically, these children/young people are likely to live in a resilient and protective environment. Families will make use of community resources. Universal services remain in place regardless of which level of need a child is experiencing.

Level 2-Early Intervention – Targeted Provision

Children with Additional Needs (single practitioner/agency response)

These are children and young people identified as having an additional need which may affect their health, educational or social development and they would be at risk of not reaching their full potential. At this level the pre CAF checklist can be used to decide whether a common assessment is required and the CAF may be a useful tool to identify need and plan help for the family

Level 3-Early Intervention - Targeted Provision Children with Additional Needs (multi practitioner/agency response)

These are children and families whose needs are not being met due to the range, depth and significance of their needs which makes them very vulnerable and at risk of poor outcomes. A multi agency response is required using either the CAF or whole family assessment tools as in most instances there will be issues for parents which are impacting on the children achieving positive outcomes. These families need a holistic and coordinated approach and more intensive intervention and help. Lead Professionals could come from a range of agencies as the key issue will be the quality of the relationship that exists between practitioner and family to assist them to make change and reduce the likelihood of moving into Level 4 services. Intensive support might come from One Point, Family Pathfinder Service; FIP, YOS

Level 4- Services to keep the child safely at home – (specialist practitioner/agency response)

These are children who's needs and care is significantly compromised and they may be at risk of harm or at risk of becoming accommodated by the Local Authority. These families require intensive support often on a statutory basis. This may include support provided by Children's Social Care such as a social work assessment, support from the Family Pathfinder Service or Family Intervention Project or for example, through the provision of Direct Payments for a disabled child. The assessment and multi agency response is likely to be coordinated by a social worker in most cases and will be holistic (considering the needs of all family members) and multi agency.

Level 5- Need that cannot be managed safely at home

Children and young people who require intensive help and support from a range of specialist services. These children will often need to be accommodated outside of their immediate family or may require admission into hospital. In most cases the multi-agency involvement would be led by Children's Social Care.

In general, children and young people with disabilities will have their needs met through early intervention and targeted services at levels 1, 2 and 3. However, some children with a high level of need related to severe disabilities may require specialist services at levels 4 and 5.

Cross Cutting Themes

This strategy is not a stand-alone document. It cross cuts much of the strategic thinking in Durham. It ties in and is evident in strategies and plans that have been developed by our many services and organisations and is driven and shaped by national changes.

Locally

We will all achieve our strategic vision through sharing and delivering our key priorities both as a Council and through our Partners.

The County Durham Partnership (CDP) is the overarching partnership for County Durham and is supported by five thematic Partnerships, each of which has a specific focus:

- Economic Partnership - 'altogether wealthier' - creating a vibrant economy and putting regeneration and economic development at the heart of all our plans

- Children and Families Partnership - 'altogether better for children and young people' – enabling children and young people to develop, achieve their aspirations and maximise their potential;

- Health and Wellbeing Board - 'altogether healthier' - improving health and wellbeing;

- Safe Durham Partnership - 'altogether safer' - creating a safer and more cohesive county;

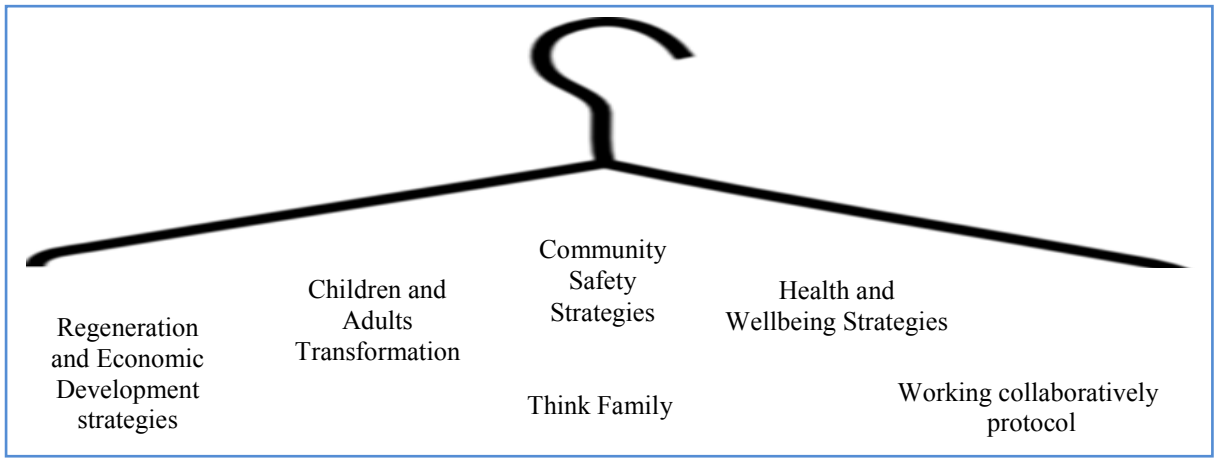
- Environment Partnership - 'altogether greener' - ensuring an attractive and 'liveable' local environment and contributing to tackling global environmental challenges.

It is acknowledged that the foundations for positive outcomes for our children, young people and families relies upon wider needs and social inequalities being addressed for example, employment, health and wellbeing, education, transport, crime and disorder these are best addressed through the Sustainable Community Strategy (SCS) which is the over-arching strategic document of the County Durham Partnership.

Early help will be the golden thread that runs through all of our services, strategies and thematic partnerships for children young people and their families.

The strategy has been designed to provide an overarching ethos for all partners to work together to ensure all their strategies are integrated within a combined early help offer, in order to improve life chances and outcomes for children and their families within County Durham.

Early help will thread through transformational work and strategic direction within Durham's Children and Families Partnership and the County Durham Partnership. It will over arch and guide the vision for much of the development work and key messages that run through our partnership strategies.



What Does Early Help mean for Schools?

Schools are key partners in the delivery of the early help strategy. We are committed to supporting schools to provide access to early help by;

Making information available to schools and families so that they can find out what services there are, where and how they can access them, when they need them;-- FIS and DIG SEND info on school sites

Assessing needs easily – using the early help single assessment to identify where there is a need for the involvement of more than one agency;

Having easy access to targeted and specialist services through First Contact Service so that families can 'step up and step down' between tiers of need quickly as their needs emerge and are dealt with;

Where children and families need coordinated, multi-agency support, a full Single Assessment is undertaken and 'Team Around the Family 'developed to ensure a full and clear picture of the family's needs are known and understood.

This approach will enable stable families to get support quickly and easily.

Team Around Schools will also be developed following learning from their pilot. This service will allow for schools to identify children and young people at an early stage who may need further support from multi agency services.

Nationally

Services for children, young people and families are operating within the context of rapid change. Recent, key national cross cutting themes which may impact on the development of the early help strategy include:

- Transformation of the special educational needs (SEN) system for children and young people including those with disabilities; giving children, young people and their parents greater control and choice in decisions. Including a requirement for local authorities to publish a 'local offer' of support.
- The development of local clinical commissioning groups.
- Changes to public health nursing.
- The appointment of Police and Crime Commissioners and their role in supporting preventive initiatives in the community.
- Working Together to Safeguard Children: A guide to inter-agency working to promote the welfare of children - HM Government (March 2013)
- The introduction of Public Health in to Local authority
- National Troubled Families Programme
- Probation Service Reform

The Early Help Strategy is linked with existing strategies across the County Durham Partnership including the strategies which have a broader application to population risk factors such as Durham's Joint Strategic Needs Assessment, the Joint Health and Well Being strategy, The Safe Durham Partnership Plan, Durham's Homeless Strategy and Durham'sFinancial Inclusion Plan the strategy is underpinned by Durham's Children & Young People and Families Plan

Implications of the Strategy

Current activity

For several years, services and organisations in Durham have worked in partnership to start 'Thinking Family'. There has been significant investment and resourcing such as Children's Centre Investment, Provision of a Family Intervention Project and Pathfinder service, One Point Development and Health Visitor Expansion. Despite this, over the years, there has been a rise in the numbers of Looked after Children, a significant increase in core assessments and an increase in children subject to a Child protection Plan as a result of neglect.

Following a mapping exercise in March 2013, a graph was produced to summarise activity across the continuum of need in Durham (see below chart 1)

From this exercise we know that during 2011/12 3,124 referral (a rate of 309.8 per 10,000 population aged under 18).

The rate of referrals to Children's Care resulted in 'No further action' (NFA) in 2011/12 of 33% which was significantly higher than the England average (15.6%) and the north east average (6.4%). This amounts to 1026 referrals.

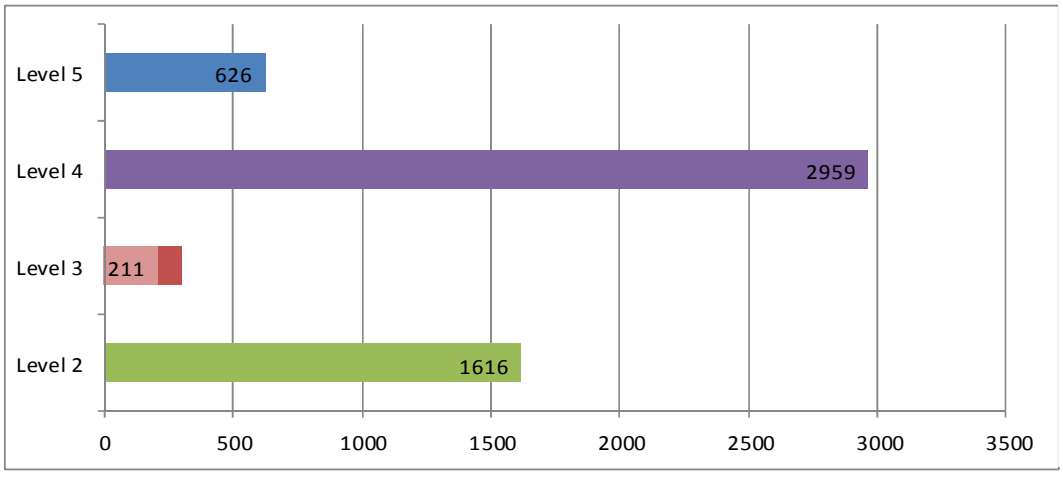
This would suggest that there are high numbers of professionals who are concerned about children and their outcomes and are seeking support for these families but are going to the wrong place to find it. The key presenting issues in relation to significant harm to children remains the 'toxic trio' of parental mental health, drug and alcohol misuse and domestic abuse.

There is evidence that numbers of referrals into early help services from these key adult agencies remains very low. Professionals working with adults who are parents are well placed to identify at an early stage the emerging needs of the children within these families and play a critical role in the early identification and support for families, in line with the Think Family approach.

Looking at the graph below it is clear to see that a disproportionate level of activity is undertaken at the statutory levels and that a significant number of families are by passing the early help levels 2 and 3.

This table illustrates our current activity in Durham and underpins the early help Strategy – we need to get better helping families earlier.

Services Delivered to Children, Young People and their Families through the CAF/CIN Procedures at 31st March 2013.



Pre CAF's and CAF's are recorded on behalf of the whole Children's Trust and therefore the figures above are illustrative of the whole of County Durham Partnership and their involvement in delivering against the CAF/CIN procedures. Please note level 1 is not represented on this chart

If we got it right

To readdress this balance to how we need it to look we need to switch our services from battling with the symptoms of high need and risk rather than tackling cause an earlier stage. In an era of decreasing resources we need to ensure that we target what we have at the families who need it most in the most effective and efficient ways.

Although we know our preventative and universal services are keeping many more families from reaching level two, it would seem in many services Durham that all too often early help is a stage that is missed out.

This strategy is designed to assist in transforming service delivery towards a robust 'early help' offer and change the trajectory of the graph above to begin to represent a smaller number of children at the higher levels of need.

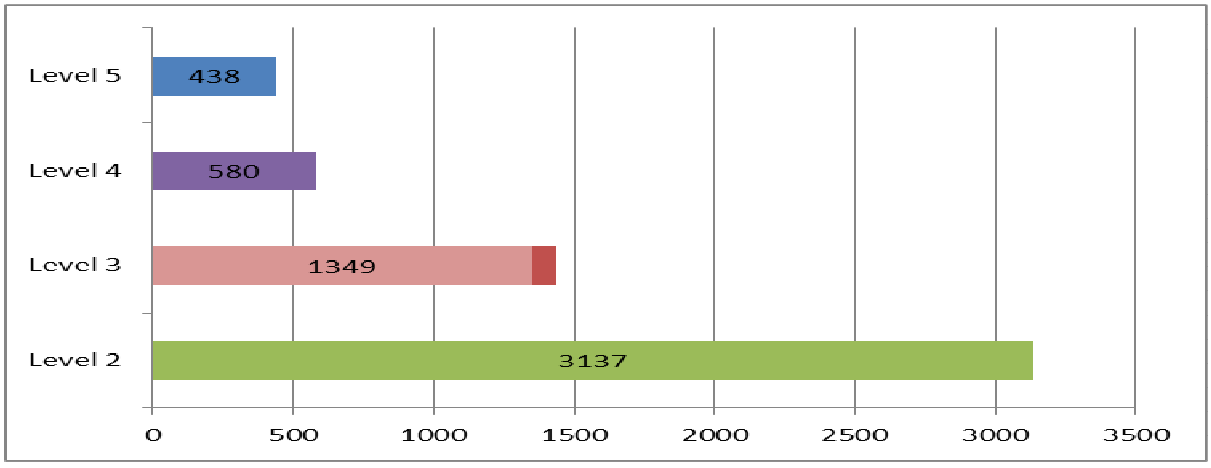
If we successfully supported families better at the earliest opportunity we would expect to see a significant reduction in the numbers of children needing to access high need high cost services and an expansion in those assisted at levels 2 and 3.

The earlier the better, we must support our workforce to assertively identify, help and support our children, young people and families at the earliest opportunity to stop their needs developing and enable them to meet positive outcomes.

The graph below shows how if we deliver early help successfully across all of our partners we would expect a proportionate decrease in families receiving support the higher up the level of need they go with the largest cohort being at level 2 and the smallest at level 5. It should be expected , that numbers reduce, as need increases.

This model would not only have significant cost saving implications but it would mean we have successfully supported more children, young people and families to achieve positive outcomes and prevented them from moving up the continuum of need.

A projected proportionate service delivery in Durham-How we would hope to see activity in Durham



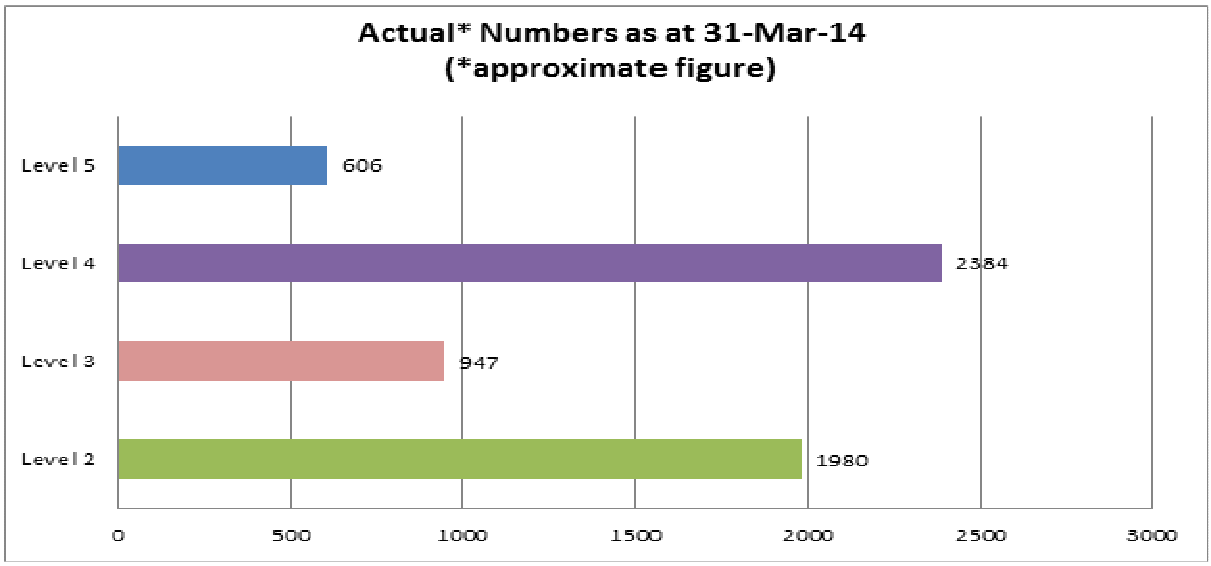
Please note level 1 is not represented on this chart

The projected vision suggests that changes may be needed in the way in services are configured, in order to be able to manage demand across the levels of need

In Durham we need to learn from our successes, do more of those things that work and less of those that don't. We need to develop and deliver services which are more outcome focused and which can demonstrate that they have made real differences to people's lives

One year on from the original graph our work in driving forward an early help offer has started to impact on our activity.

The graph below shows activity in Durham for 2013/14.



We can clearly see from this table that the direction of travel is positive. Initial trends suggest partnership work and awareness raising alongside the transformation of children's services and the imbedding of a 'Think Family' ethos across our partnerships are starting to play a part in turning around our activity.

What we need to do differently?

The change we need to see requires transformation of much of our practice and the culture it operates within. It requires services to be flexible enough to be able to deliver against clearly defined outcomes which are agreed with the family (and not rigidly set by the service) and it requires practitioners to work holistically with whole families in the context of multiagency support.

This is challenging. Creating the capacity for practitioners to be able to think about their clients' needs in the context of the needs of the whole family and ensure that these are being met is a significant shift in ways of working for many of our front line staff. For too long we have put barriers up around our individual remits, our capacity and our ability to share information appropriately.

Some key elements of what we know works when supporting children, young people and their families are outlined below. Elements of this have been recognised by successive governments' for a number of years as good practice and have a sound evidence base. It also harmonises with what families tell us is important about the way in which services are offered to them

Named workers for named families

Families will have a Lead Worker who they can build a trusting relationship with and who is then able to be challenging within the context of this good relationship. These workers will coordinate support for the whole family.

Successful Engagement

Practitioners must develop skills in building trusting relationships with families as well skills in persistence and assertiveness. Management oversight of 'lack of consent' issue needs to be more robust

Think Family

Practitioners must consider the whole family and identify everyone's need for support and then harness the appropriate practitioners and services around the family

Proportionate Assessment

One proportionate, whole family assessment model which adapts to the complexity of the issues in the family with sufficient analysis to understand the root causes of issues and which practitioners share with each other, with a view to avoiding repeated re referrals.

One Family One Plan

A single overarching support plan for the whole family which clearly indicates the objectives of the family and the associated responsibilities of the family and the practitioners. Clear indication of what needs to change and how this will be achieved.

Practical hands on help

Focus on delivering practical help and support to families which will facilitate change and which we know works. Less 'telling' families what is wrong and what needs to change and more 'doing with' families to show them and clearly illustrate what is needed

Strengths based solution focused practice

Strengths based model which is solution focused and identifies what works well within the family and builds on this. A model which truly works in partnership with families and asks them about their priorities for change. Is more likely to result in positive engagement and reduce numbers of families who won't give their consent to work with professionals

Smooth escalation and de-escalation through our continuum of need

We need to stop families falling through the gaps in our services. Support should be seamless and families should not be continuously opened assessed and closed without achieving sustainable and positive outcomes

Outcomes of the Early Help Strategy

Success should be directly measured against the outcomes experienced by children, young people and their families.

This Strategy will drive good practice and by doing that improve the outcomes for children, young people and families across County Durham.

We would expect more families to have received help at an earlier point and be empowered to take control of their own lives, avoiding the need for statutory intervention or repeated help and support.

The outcomes we will see in County Durham from the effective implementation of the principles within the early help strategy are;

- Fewer Looked After Children
- Fewer children subject to a Child Protection Plan
- Fewer re-referrals in to statutory services and services at level 4 and 5 of our continuum of need
- More children young people and their families achieving positive outcomes
- A greater number of identified early and receiving help through our universal, preventative and early help services.
- A greater number of children being 'ready for school'

Commissioning

Current arrangements are failing to work effectively with families at an early enough point, and as a result children are being "pushed" into statutory processes for want of effective help at an earlier stage.

Children's services need to be reshaped to meet need and this may necessitate a range of commissioning actions, including new service provision, restructuring of existing services and creation of new job roles, as well as workforce development.

To date, new service activity has been promoted through government grant and local pilot programmes. This has led to effective service forms such as the Family Intervention Project, the Family Pathfinder Service and the Family Nurse Partnership. More recently, Troubled Families funding has been used to support workforce development activity through Think Family Mentors and new specialist Stronger Families roles in the One Point Service. This activity is targeted at step 3 on the Durham staircase, but is not yet adequately resourced to reach the number of families who need it. Although partners are committed to moulding their workforces to new requirements through Think Family action plans, it is unlikely that this alone will deliver the capacity required to meet need.

For the early help strategy to be fully effective, all commissioners involved in children's services will need to work together to develop coherent plans and strategies to transform activity on a much wider scale. This may require new commissioning partnerships and effective joint commissioning.

Governance and Accountability

It is crucial that this strategy has genuine commitment from everyone and that all partners shift focus to early help and strengthen the work around this

The delivery of an effective early help offer is not the responsibility of a single agency. It requires a Think Family approach owned by all partners working with children, young people and families.

These include Health, Police, Probation, Schools/Education, Adult Services, Housing, Voluntary and Community Organisations

Working Together (2013) requires local agencies to have in place effective ways of identifying emerging problems and potential unmet needs for individual children and their families. It also requires local agencies to work together to put processes in place for the effective assessment of needs of individual children who may benefit from early help services.

Scrutiny and challenge will be provided by Durham's LSCB and this will play an important role in driving good practice and holding to account those who do not share the responsibility for ensuring our offer of early help is embedded across our partnership.

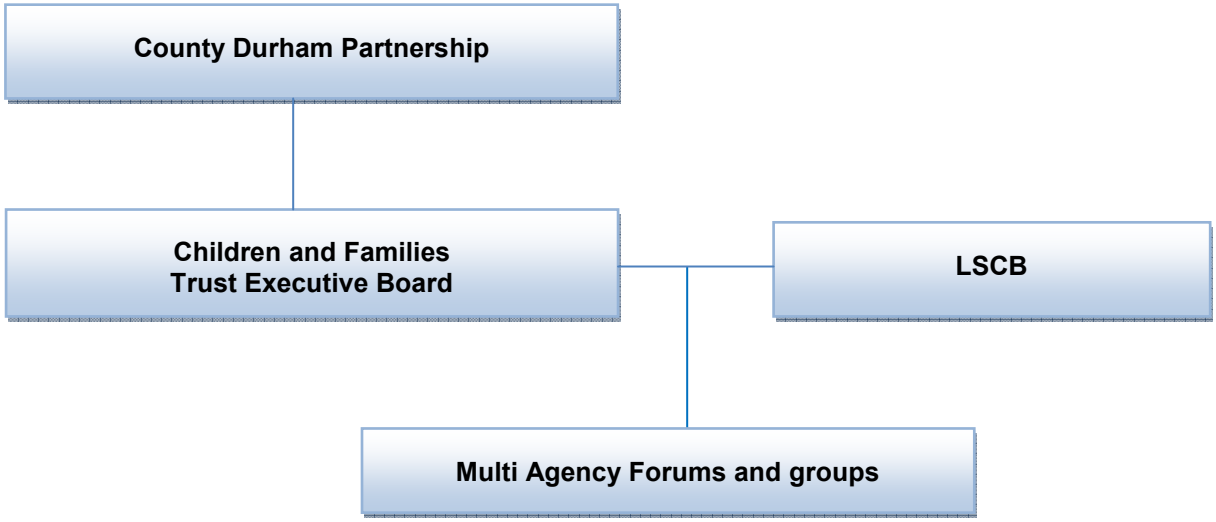
Durham's LSCB will be responsible for the governance of this strategy. They have two priorities for 2014/15

1. Early help
2. Information Sharing

Local Governance arrangements through the LSCB sub groups will provide the opportunity for multi-agency discussion about a child, young person or their family with early help or targeted level needs.

Scrutiny will also be provided by Durham's Children Young People and Families Partnership via the think Family Partnership, and other sub groups of this governance arrangement.

As a result of discussions held within these arrangements there will be a better understanding of what needs our children young people and families have and the services who are best placed to meet them.



Conclusion

The consequences for children and their families of services failing to offer robust early help to all those who need it are significant. Issues and problems are allowed to escalate and become more difficult and entrenched. Resistance to professional support can increase and practitioners give up as the 'family did not consent to work with them'. For some children this means being left in poor conditions with neglectful parenting for too long, with long term consequences for positive outcomes.

Uncoordinated activity with families leads to duplication, it's a waste of resource and more often than not is inefficient and ineffective. If positive change is not achieved families are re-referred and need more support and help. In the longer term, this results in a disproportionate amount of children needing services at levels 4 and 5 on the continuum of need which is costly - both at a human and financial level.

To deliver early help to families in County Durham consistently and ensuring that we target our resources at those who need it most, requires a significant transformation of some current models of service delivery. Some significant changes in practice and culture are necessary for some front line practitioners and managers.

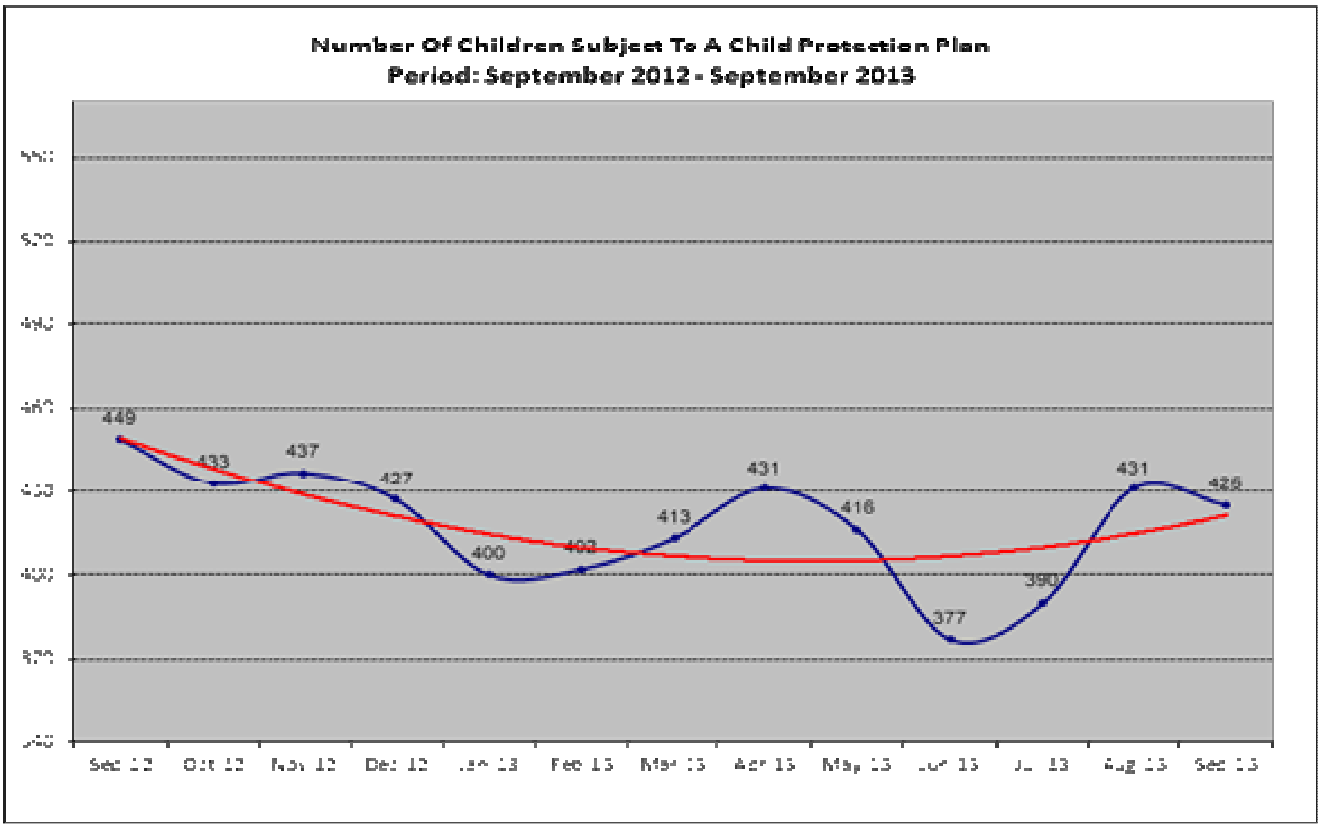
In addition, the accountability, governance and management structures to support this change are essential to ensure that partners are accountable for the early identification of families in need of early help as well as the quality of the support that they offer.

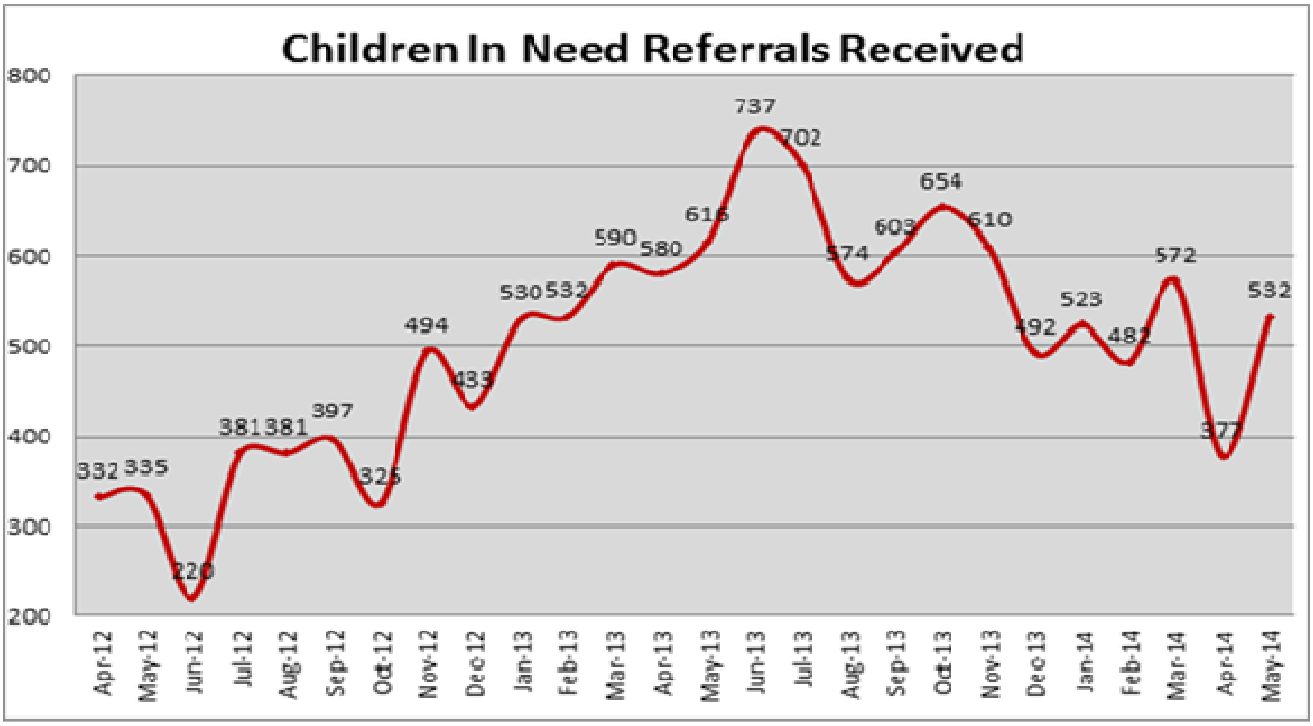
The commitment to the offer of early help has to be owned across the County Durham Partnership and very real changes to the way that many services are delivered currently are necessary. The delivery of the Troubled Families Programme (Stronger Families) has begun to illustrate some of these challenges for agencies who traditionally have only worked with either adults or with children or who only work with individual children but not siblings or who only work with clients for set periods of time when the family support needs to go on for longer; or who have staff with very narrow job roles or job roles which focus on specific issues and who don't currently see this broader 'whole family' agenda as theirs.

The development of the single front assessment and first contact service will assist in ensuring that far fewer families fall through the gaps in service provision. Ensuring that there is a commitment here to an end to 'no further action' and that all families will receive a proportionate and timely response to their needs will assist in the overall delivery of the vision within this strategy. The ability to track progress with families against stated outcomes will be more easily achieved through this model and will aid the development of the governance and accountability around the delivery of early help.

Services will need to be redesigned to ensure that there is sufficient capacity at all levels of need and that job roles and responsibilities are sufficiently flexible to be able to respond to the needs of whole families and to move away from the concept of help for individuals within families. The need to integrate the offer of practical support to families within roles is critical.

In the longer term, there will be the possibility of moving resource from levels 4 and 5 into levels 2 and 3 if the vision for families as described in the graph in 8.6.5 can be realised. This will be cost effective and will lead to better outcomes in the longer term as well as breaking the cycle of intergenerational disadvantage.


Number Of Children Subject To A Child Protection Plan
Period: September 2012 - September 2013
449
433
437
427
400
402
413
431
416
377
390
431
428


Children In Need Referrals Received
800
700
600
500
400
300
200
332
335
220
381
381
397
325
494
433
530
532
590
580
616
737
702
574
603
654
610
492
523
481
572
377
532
Apr-12
May-12
Jun-12
Jul-12
Aug-12
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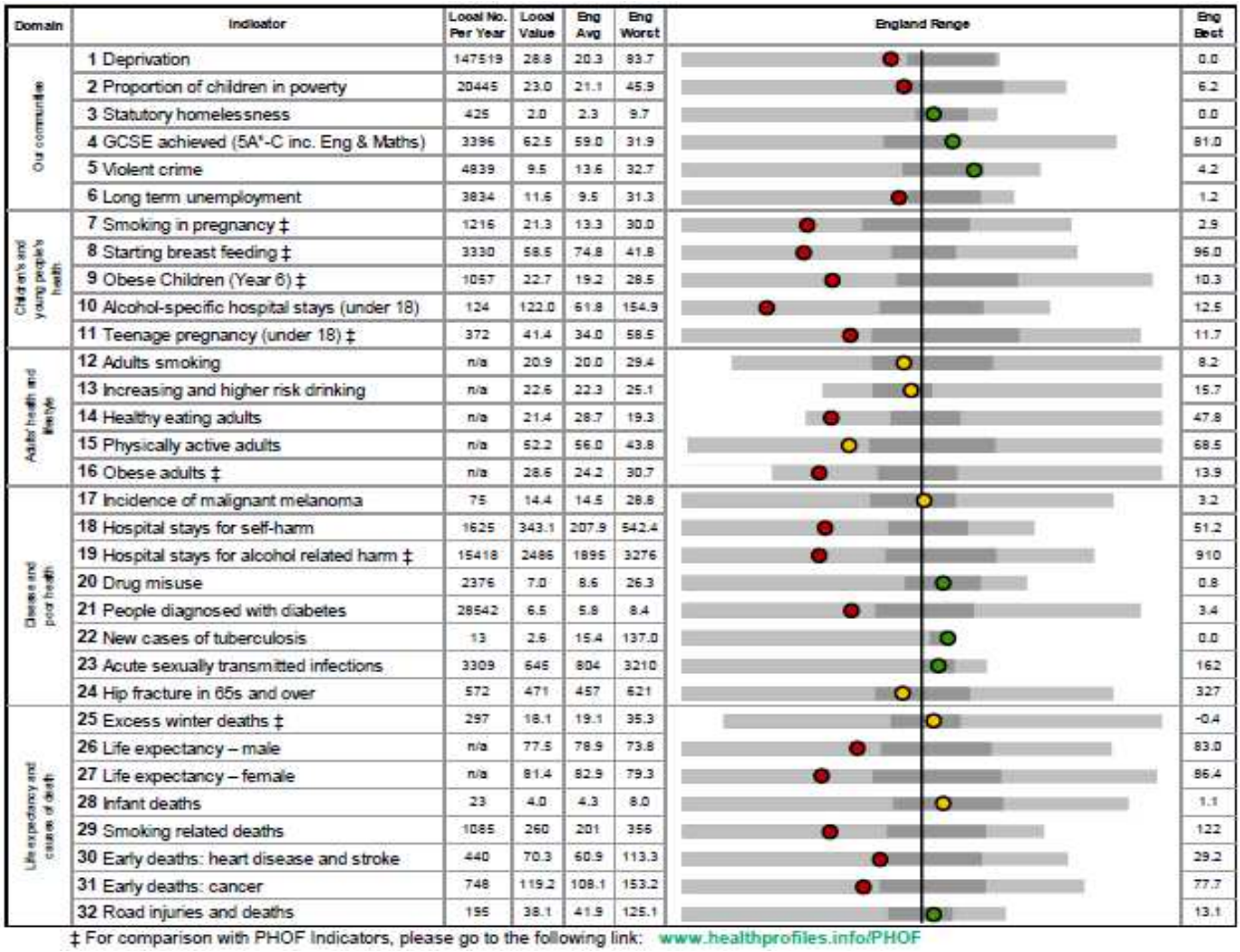
May-14

Table 1. Health summary. County Durham Health Profile 2013. Source: Public Health England.



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	147519	28.8	20.3	83.7		0.0
	2 Proportion of children in poverty	20445	23.0	21.1	45.9		6.2
	3 Statutory homelessness	425	2.0	2.3	9.7		0.0
	4 GCSE achieved (5A*-C inc. Eng & Maths)	3396	62.5	59.0	31.9		81.0
	5 Violent crime	4839	9.5	13.6	32.7		4.2
	6 Long term unemployment	3834	11.6	9.5	31.3		1.2
Children's and young people's health	7 Smoking in pregnancy ‡	1216	21.3	13.3	30.0		2.9
	8 Starting breast feeding ‡	3330	58.5	74.8	41.8		96.0
	9 Obese Children (Year 6) ‡	1057	22.7	19.2	28.5		10.3
	10 Alcohol-specific hospital stays (under 18)	124	122.0	61.8	154.9		12.5
	11 Teenage pregnancy (under 18) ‡	372	41.4	34.0	58.5		11.7
Adults' health and lifestyle	12 Adults smoking	n/a	20.9	20.0	29.4		8.2
	13 Increasing and higher risk drinking	n/a	22.6	22.3	25.1		15.7
	14 Healthy eating adults	n/a	21.4	28.7	19.3		47.8
	15 Physically active adults	n/a	52.2	56.0	43.8		68.5
	16 Obese adults ‡	n/a	28.6	24.2	30.7		13.9
Disease and poor health	17 Incidence of malignant melanoma	75	14.4	14.5	28.8		3.2
	18 Hospital stays for self-harm	1625	343.1	207.9	542.4		51.2
	19 Hospital stays for alcohol related harm ‡	15418	2486	1895	3276		910
	20 Drug misuse	2376	7.0	8.6	26.3		0.8
	21 People diagnosed with diabetes	28542	6.5	5.8	8.4		3.4
	22 New cases of tuberculosis	13	2.6	15.4	137.0		0.0
	23 Acute sexually transmitted infections	3309	645	804	3210		162
	24 Hip fracture in 65s and over	572	471	457	621		327
Life expectancy and causes of death	25 Excess winter deaths ‡	297	18.1	19.1	35.3		-0.4
	26 Life expectancy – male	n/a	77.5	78.9	73.8		83.0
	27 Life expectancy – female	n/a	81.4	82.9	79.3		86.4
	28 Infant deaths	23	4.0	4.3	8.0		1.1
	29 Smoking related deaths	1085	260	201	356		122
	30 Early deaths: heart disease and stroke	440	70.3	60.9	113.3		29.2
	31 Early deaths: cancer	748	119.2	108.1	153.2		77.7
	32 Road injuries and deaths	195	38.1	41.9	125.1		13.1

‡ For comparison with PHOF indicators, please go to the following link: www.healthprofiles.info/PHOF

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

England Worst — Regional average * — England Average — England Best

25th Percentile — 75th Percentile

* In the South East Region this represents the Strategic Health Authority average

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2010 3 Crude rate per 1,000 households, 2011/12 4 % at Key Stage 4, 2011/12 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2011/12 6 Crude rate per 1,000 population aged16-64, 2012 7 % mothers smoking in pregnancy where status is known, 2011/12 8 % mothers initiating breast feeding where status is known, 2011/12 9 % school children in Year 6 (age 10-11), 2011/12 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2007/08 to 2009/10 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2009-2011 12 % acults aged 18 and over, 2011/12 13 % aged 16+ in the resident population, 2008-2009 14 % adults, modelled estimate using Health Survey for England 2006-2008 15 % adults achieving at least 150 mins physical activity per week, 2012 16 % acults, modelled estimate using Health Survey for England 2006-2008 17 Directly age standardised rate per 100,000 population, aged under 75, 2008-2010 18 Directly age sex standard sec rate per 100,000 population, 2011/12 19 Directly age sex standardised rate per 100,000 population, 2010/11 20 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 21 % people on GP registers with a recorded diagnosis of diabetes 2011/12 22 Crude rate per 100,000 population, 2009-2011 23 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 24 Directly age and sex standardised rate for emergency admissions, per 100,000 population aged 65 and over, 2011/12 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.08-31.07.11 26 At birth, 2009-2011 27 At birth, 2009-2011 28 Rate per 1,000 live births, 2009-2011 29 Directly age standardised rate per 100,000 population aged 35 and over, 2009-2011 30 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 31 Directly age standardised rate per 100,000 population aged under 75, 2009-2011 32 Rate per 100,000 population, 2009-2011

-Table 2. Health summary. County Durham Child Health Profile 2013.

Source: CHIMAT.

	Indicator	Local no per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	1 Infant mortality rate	23	4.0	4.4	8.0	2.2
	2 Child mortality rate (age 1-17 years)	11	11.3	13.7	23.7	7.5
Health protection	3 MMR immunisation (by age 2 years)	5,410	94.3	91.2	78.7	97.2
	4 Diphtheria, tetanus, polio, pertussis, Hib immunisations (by age 2 years)	5,640	98.3	96.1	85.7	98.8
	5 Children in care immunisations	380	100.0	83.1	0.0	100.0
	6 Acute sexually transmitted infections (including Chlamydia)	2,520	36.8	35.6	75.2	19.9
Wide determinants of ill health	7 Children achieving a good level of development at age 5	3,163	56.8	63.5	51.5	76.5
	8 GCSE achieved (5A*-C inc. Eng and maths)	3,398	62.5	59.4	40.9	79.6
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	8	17.4	14.6	0.0	40.0
	10 Not in education, employment or training (age 16-18 years)	1,380	7.5	6.1	11.8	1.6
	11 First time entrants to the Youth Justice System	317	680.3	876.4	2,436.3	342.9
	12 Children living in poverty (aged under 16 years)	20,445	23.0	21.1	45.9	7.4
	13 Family homelessness	254	1.2	1.7	7.4	0.1
	14 Children in care	660	66.0	59.0	150.0	19.0
	15 Children killed or seriously injured in road traffic accidents	21	23.8	22.1	47.9	4.4
Health improvement	16 Low birthweight	460	7.7	7.4	11.0	5.0
	17 Obese children (age 4-5 years)	563	10.5	9.5	14.5	5.8
	18 Obese children (age 10-11 years)	1,072	22.5	19.2	27.8	12.3
	19 Participation in at least 3 hours of sport/PE	36,327	56.7	55.1	40.9	79.5
	20 Children's tooth decay (at age 12)	-	1.0	0.7	1.5	0.2
	21 Teenage conception rate (age under 18 years)	384	43.2	35.4	64.7	6.2
	22 Teenage mothers (age under 18 years)	155	2.6	1.3	2.8	0.3
	23 Hospital admissions due to alcohol specific conditions	118	116.0	65.8	138.3	16.9
	24 Hospital admissions due to substance misuse (age 15-24 years)	73	105.6	69.4	186.3	25.7
Prevention of ill health	25 Smoking in pregnancy	1,216	21.3	13.2	29.7	2.9
	26 Breastfeeding initiation	3,330	58.2	74.0	41.8	94.3
	27 Breastfeeding at 6-8 weeks	1,602	27.7	47.2	19.7	82.8
	28 A&E attendances (age 0-4 years)	9,801	347.8	483.9	1,187.4	136.3
	29 Hospital admissions due to injury (age under 18 years)	1,923	152.1	122.6	211.1	72.4
	30 Hospital admissions for asthma (age under 19 years)	210	196.1	193.9	484.4	73.4
	31 Hospital admissions for mental health conditions	90	89.9	91.3	479.7	22.6
	32 Hospital admissions as a result of self-harm	228	227.8	115.5	311.9	26.0

Notes and definitions - Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2009-2011
2 Directly standardised rate per 100,000 children age 1-17 years, 2009-2011
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2011/12
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2011/12
5 % children in care with up-to-date immunisations, 2012
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2011
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2011/12
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2011/12 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2011
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2010/11
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2010
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2011/12
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2012
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2009-2011
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2011
17 % school children in Reception year classified as obese, 2011/12
18 % school children in Year 6 classified as obese, 2011/12
19 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
20 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
21 Under 18 conception rate per 1,000 females age 15-17 years, 2010
22 % of delivery episodes where the mother is aged less than 18 years, 2011/12
23 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2008-11
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2009-12
25 % of mothers smoking at time of delivery, 2011/12
26 % of mothers initiating breastfeeding, 2011/12
27 % of mothers breastfeeding at 6-8 weeks, 2011/12
28 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2010/11
29 Crude rate per 10,000 (age 0-17 years) for emergency hospital admissions following injury, 2011/12
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2011/12
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2011/12
32 Crude rate per 100,000 (age 0-17 years) for hospital admissions for self-harm, 2011/12

Health and Wellbeing Board

5 November 2014

Joint Health & Wellbeing Strategy 2nd Quarter 2014/15 Performance Report

Report of Peter Appleton, Head of Planning & Service Strategy, Children & Adults Services

Purpose of Report

1. To describe the progress being made against the priorities and outcomes set within the County Durham Joint Health & Wellbeing Strategy (JHWS) 2014-17.

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. This includes performance indicators linked to the Better Care Fund and Clinical Commissioning Group (CCG) Quality Premium Indicators, which are identified throughout this report.

3. The Performance Scorecard attached at **Appendix 2** includes performance indicators within the JHWS where updated data has been made available since the previous performance report in July 2014.

4. Those indicators where performance data has not been updated since the previous performance report are included for information only at **Appendix 3.** This information was considered at the Board meeting in July 2014.

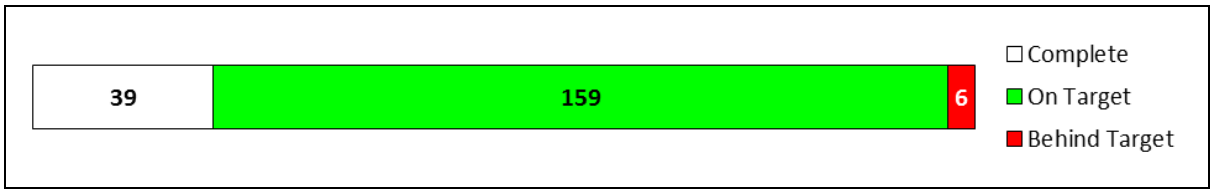
5. This report also includes the latest performance information available nationally and regionally for benchmarking purposes.

6. The following rating system is used for performance indicators and is consistent with the rating system used by the County Durham Partnership:

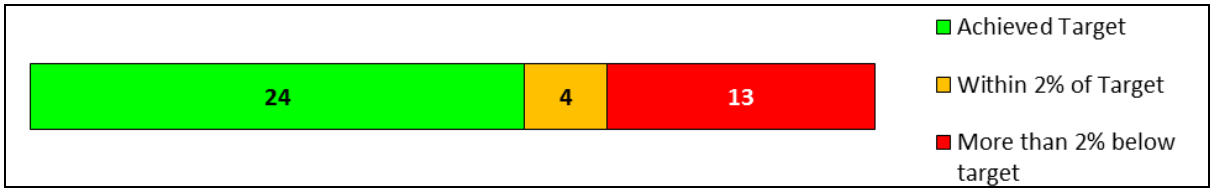
Performance Against Target	Direction of Travel	Performance Against Comparators	Banding
Target achieved or exceeded	Improved/Same	Better than comparator	
Performance within 2% of target	Within 2% of previous performance	Within 2% of comparator	
Performance more than 2% away from target	Deteriorated by more than 2%	More than 2% worse than comparator	

Overview of Performance

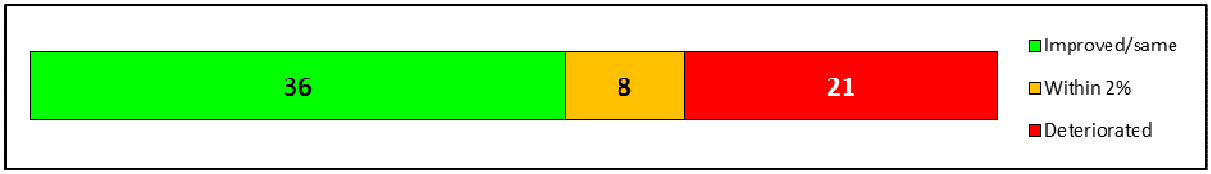
7. There are 211 actions within the JHWS 2014-17 Delivery Plan. Of these, 2 are to be deleted and 5 have been rescheduled (i.e. a decision has been taken by the responsible organisation to commence the action at a later date). These actions are highlighted in the report. Progress against the remaining 204 actions is as follows:



8. There are 41 indicators with targets where updated data is available and included in the report. **Performance against target** is as follows:



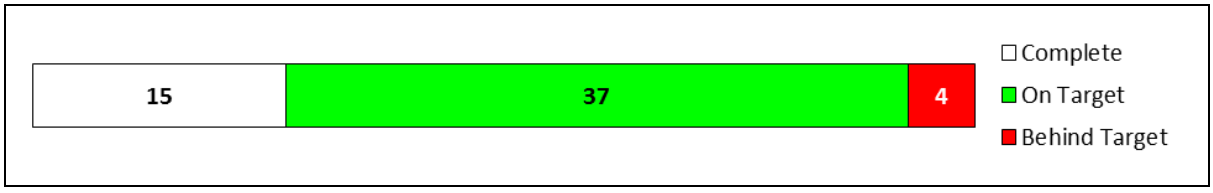
9. There are 65 indicators where updated data is available and it is possible to track **Direction of Travel.** Performance is as follows:



10. The following sections (structured by JHWS Objective) identify:
    - Delivery Plan actions behind target/deleted/rescheduled
    - Performance indicators behind target,
    - Performance highlights and
    - Other areas for improvement i.e. where performance has a significantly deteriorating trend and/or is significantly behind the national average.

Objective 1: Children and young people make healthy choices and have the best start in life

11. There are 56 actions under Objective 1. Progress is as follows:



12. The following 4 actions are behind target:

- Public Health, through their smoking cessation and smoke free family initiatives, to work with CCGs to reduce the number of children developing lower respiratory tract conditions. The target date has been revised by Public Health from March 2015 to March 2016.
- Work together to reduce incidents of self-harm by young people: Clarify safe and effective support pathways, and raise awareness of key professionals that can be involved in complex cases. The target date has been revised by Public Health from December 2014 to April 2015.
- Re-commission specialist short breaks (for children with a disability and their families) to ensure increased choice and value for money. The target date has been revised by Children & Adult Services (Commissioning) from November 2014 to June 2015.
- Develop SEN and Disability Strategy and implement recommendations. The target date has been revised by Children & Adult Services (Education) from September 2014 to November 2014.

13. There are 2 indicators with targets under Objective 1 for which new data is reported. Performance against target is as follows:

Performance Highlights

14. Progress since the previous performance report includes:

- Undertake an intelligence-led approach to tackling cheap and illicit tobacco and alcohol. An intelligence-led approach is firmly embedded. Raids take place on illicit tab houses on a regular basis as well as overt inspections of commercial premises including the use of tobacco sniffer dogs.

- Following review, commission children's Occupational Therapy and Speech and Language Therapy services. The contract has been awarded and the service will commence in December 2014.

- Introduce a Single Front Door (First Contact Service) for referrals *and* Introduce a single assessment framework. The First Contact Service was launched in April 2014 and Children's Services have implemented a single assessment framework.

- Implement suicide and attempted suicide early alert process for young people at risk of suicide or self-harm. A new early alert process was implemented in September 2014 which identifies suspected suicide and attempted suicide within a maximum of 48 hours.

- Between April and June 2014, 92% of exits from young person's treatment for drug and alcohol were planned discharges. This is better than target (79%) and the national average (82%).

- Between April and June 2014, 17.9% of mothers were smoking at time of delivery. This is a significant improvement from the corresponding period of the previous year (21.6%). Performance is better than the regional average (20.1%) but remains above the national rate (11.5%).

Other Areas for Improvement

Under 18 conception rate

15. Provisional data for April to June 2013 indicates that there were 84 under 18 conceptions. This equates to a rate of 38.9 per 1,000 15-17 year old females, which is an increase from the same period of the previous year. Durham's rate is higher than both the national and regional averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
34.4 (Apr-Jun12)	Under 18 conception rate	38.9 (Apr-Jun13)	Tracker	25.2 (Apr-Jun13)	32.1 (Apr-Jun13)	⇧

16. Public Health colleagues advise that this indicator should be considered in terms of longer term trends, as quarterly can vary significantly. The long term trend for under 18 conceptions shows that the rate per 1,000 population in County Durham improved from 54.4 in 1998 to 33.7 in 2012, a reduction of 38.1%. Over the same period, the national rate decreased by 40.8% and the North East by 37.2%.

17. Actions being taken to reduce teenage conceptions include:
    - The Teenage Pregnancy & Sexual Health Steering Group will undertake a health needs assessment (HNA), which will systematically review under 18 conceptions. The HNA will be completed by April 2015 and will lead to agreed priorities and resource allocation to ensure services are delivered based on need.

    - A social norms project has taken place in secondary schools across County Durham, which aimed to correct identified misperceptions of young people about sex and relationships to help change behaviour. A project report will be presented to Public Health Senior Management Team in December 2014 and the Teenage Pregnancy & Sexual Health Steering Group and Alcohol Steering Group in January 2015. All schools participating have received their own data to inform action planning.

Young people admitted to hospital as a result of self harm

18. In 2012/13 the rate of young people (aged 10-24) admitted to hospital as a result of self harm in County Durham was 410.5 per 100,000. This is significantly higher than the national average but is better than the North East.

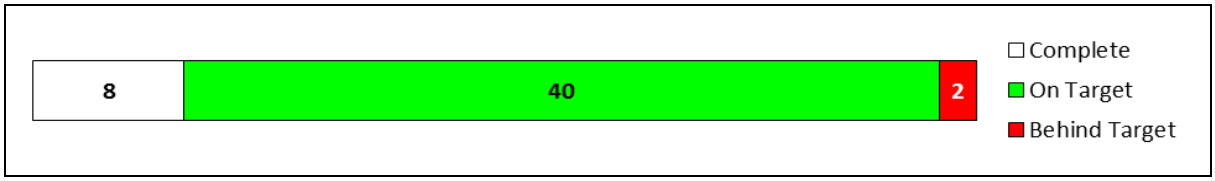
Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
Not reported	Young people aged 10-24 admitted to hospital as a result of self-harm	410.5 (2012/13)	Tracker	346.3 (2012/13)	479.6 (2012/13)	N/A

19. The 3-year pooled data for 2010/11 to 2012/13 indicates that County Durham had a rate of 504.8 per 100,000, which was an improvement from 561.8 for the previous period and was significantly better than the North East (532.2). This reduction had narrowed the gap between County Durham and England (352.3).

20. Actions to reduce self-harm include:
    - A Suicide Prevention Group is in place to develop and implement an action plan aimed at reducing suicide and self-harm rates for all ages. A report on suicide, attempted suicide and self-harm, including recommendations for actions has been produced. The report is being considered by the Clinical Commissioning Groups before being presented to the Health and Wellbeing Board in the new year.

Objective 2: Reduce health inequalities and early deaths

21. There are 55 actions under Objective 2. Of these, 2 actions are to be deleted and 3 have been rescheduled. Progress against the other 50 actions is as follows:

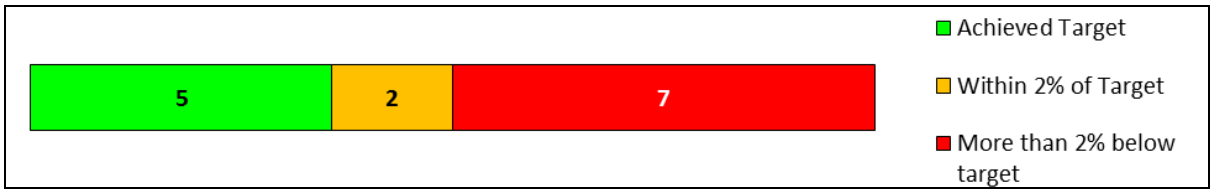


22. The 2 actions that are to be deleted are:
    - Carry out a review of referrals thresholds for suspected cancer which will result in an increase in the diagnosis of cancer at an earlier stage
    - Evaluate the primary care cancer risk assessment tool
        - These actions are to be deleted as there is a lack of evidence that a reduction in referrals thresholds will increase the diagnostic rate. The Clinical Commissioning Groups reduced the referrals thresholds for suspected cancer but this did not result in an increase in diagnoses.

23. The following 3 actions have been rescheduled by the Clinical Commissioning Groups (CCG) following re-prioritisation of activities i.e. these actions have been aligned to year 2 of the CCG delivery plan and the target date has been amended from March 2015 to March 2016:
    - Implement the Experience Led Commissioning Stroke Prevention and management strategy and action plan
    - Implement model of care for community stroke/transient ischemic attack (TIA) services which will reduce the number of incidences of stroke/TIA improved access to therapies and improved patient experience
    - Evaluate the heart failure service in community/primary care

24. The following 2 actions are behind target:
    - Undertake two “Fulfilling Lives” engagement events to seek the views of people with a learning disability on how they access universal services in their local communities. The target date has been revised by Children & Adult Services (Adult Care) from September 2014 to November 2014.
    - Develop an integrated and holistic wellbeing service: Complete phase one of the wellbeing approach, with a provider in place to deliver services from existing access points and community buildings. The target date has been revised by Public Health from September 2014 to November 2014.

25. There are 14 indicators with targets under Objective 2 for which new data is reported. Performance against target is as follows:



Indicators Behind Target

NHS Health Checks

26. From April to June 2014, 1.5% of eligible people received an NHS Health Check. Performance is below target, has reduced from 2.4% in the same period of 2013, and is below both the national and regional averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
2.4% (Apr-Jun13)	Percentage of the eligible population aged 40-74 who received an NHS Health Check	1.5% (Apr-Jun14)	2% (Apr-Jun14)	2.2% (Apr-Jun14)	2.1% (Apr-Jun14)	⇩

27. Public Health has changed the focus of health checks from a universal to a targeted approach aimed at those with a high prevalence of cardiovascular disease (CVD) risk factors. There are planned to be 71 GP practices taking part in total.

28. Durham’s Health Check programme has been recognised in a national bulletin by the NHS Health Check National Lead, who visited Claypath Medical practice and the ‘Check4Life’ bus in the city centre. The National Lead highlighted as good practice the IT system in the community outreach programme, which collects and transfers data from the NHS Health Check back to GPs.

Patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral

29. From April to June 2014, the percentage of patients receiving first definitive treatment within 62 days of an urgent GP referral across both Durham Dales,

Easington and Sedgefield (DDES) and North Durham CCGs was below target and lower than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	Regional Average*	Direction of Travel
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer						
88.0% (Apr-Jun13)	DDES CCG	78.9% (Apr-Jun14)	85%	83.9% (Apr-Jun14)	83.0% (Apr-Jun14)	⇩
90.3% (Apr-Jun13)	North Durham CCG	81.9% (Apr-Jun14)	85%	83.9% (Apr-Jun14)	83.0% (Apr-Jun14)	⇩

*Durham, Darlington & Tees Area Team

30. Three 'Be Clear on Cancer' campaigns ran concurrently earlier in the year, which resulted in an increase in demand for treatment. Actions being taken to improve performance include:
    - The Durham, Darlington & Tees Area Team and North of England Strategic Clinical Network are being invited to the County Durham & Darlington Cancer Operations Group on 24th October 2014 to discuss with local commissioners and providers how they can support in trying to improve cancer performance.
    - The Area Team are in the process of setting up a Task & Finish group to review Cancer 62 day performance across the region.
    - A questionnaire has been sent to all Lung Multi Disciplinary Team Leads across the North East to understand how the early part of the pathway is managed. Results will be analysed and discussed at the next Lung Network Site Specific Group to assess if there is an opportunity to enable earlier diagnosis.

31. Specific actions being undertaken in Durham Dales, Easington and Sedgefield CCG include:
    - North Tees & Hartlepool Foundation Trust has implemented a series of initiatives:
        - Daily and Weekly Patient Target List meetings are in place.
        - Departments are being held to account to ensure clinic letters are typed within 24 hours to reduce delay between appointments.
        - From 1st October 2014 a pilot commenced for patients to progress direct to a CT scan where they have had a chest x-ray and the Radiologist considers it to be highly suggestive of lung cancer. This will result in patients attending their first appointment with a CT result and potentially removing 10–14 days from the pathway.

32. Specific actions being undertaken in North Durham CCG include:
    - Lung and Urology are common areas for breaches to occur and detailed analysis is being undertaken for the last 6 months to determine if there are opportunities for local pathway redesign to improve performance.
    - In Urology, City Hospitals Sunderland has a detailed action plan in place to address performance issues. This is being monitored through contract management meetings.

Successful completions of those in drug treatment – opiates

33. Successful completions of those in drug treatment for opiates has not achieved target and is lower than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
7.3% (Re-presentations from Jan-Jun13)	Successful completions as a percentage of total number in drug treatment – Opiates	6.8% (Re-presentations from Jan-Jun14)	7.9%	7.7% (2013)	Not available	⇩

34. Actions being taken to improve performance include:
- The Drug and Alcohol Service is currently being reviewed and the new integrated model, which will have a greater focus on recovery, will be in place from April 2015.
- A new process for ensuring the appropriate recording of re-presentations, so that any individual returning to treatment services within the first 6 months of discharge will be recorded as receiving recovery support and not as a re-presentation unless assessed as requiring structured interventions.

Four week smoking quitters

35. Between April and June 2014, there were 817 four week smoking quitters (a rate of 191.1 per 100,000). Performance was below the quarterly target of 293 per 100,000 and declined from the same period of the previous year.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
257 per 100,000 (1,092) (Apr-Jun13)	Four week smoking quitters per 100,000 population	191.1 per 100,000 (817) (Apr-Jun14)	293 per 100,000	688 per 100,000 (2013/14)	932 per 100,000 (2013/14)	⇩

36. Actions being taken to improve performance include:
- Public Health is undertaking a review of the Stop Smoking Service, which is due to be completed by June 2015.
- Fresh, the regional tobacco programme funded by all North East Local Authorities, began to re-run the “Don’t be the 1” media campaign in mid-August. The aim of this campaign is to increase concern levels among local smokers before the positive support of Stoptober in Quarter 3 to increase sign-ups and registrations with the Stop Smoking Service.

37. Whilst County Durham is currently performing below target, an important aspect of service delivery is quality assurance:
- The success rate of quitters has continued to rise. In Quarter 1, 52% of those setting a quit date did quit smoking, in comparison to 49% in the same quarter of the previous year.

- In a national study to measure longer term quitters at 12 months, the Stop Smoking Service achieved a higher percentage of validated quitters (10%) in comparison to the national average (8%).

Potential years life lost from amenable causes (CCG Quality Premium Indicator)

38. Potential years life lost from amenable causes has not achieved target and is higher than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
2,408.1 (2012)	Potential years life lost from amenable causes per 100,000 – DDES CCG	2,396.3 (2013)	2,341	2,027.4 (2013)	2338.1 (2013)	⇩
2,124.3 (2012)	Potential years life lost from amenable causes per 100,000 – ND CCG	2,286.5 (2013)	2,093	2,027.4 (2013)	2338.1 (2013)	⇧

39. The Clinical Commissioning Groups have a programme of work around long term conditions and ambulatory sensitive care conditions with a specific focus on Chronic Obstructive Pulmonary Disease, diabetes and dementia. This work involves clinical leads from primary care and secondary care and Public Health consultants.

Performance Highlights

40. Progress since the previous performance report includes:

- Implement the Tobacco Alliance Action Plan. The Action Plan was developed and signed off by Children & Adult Services and Cabinet and is monitored quarterly.

- Implement Eye Check Pilot for people with learning disabilities. The contract for this service is now in place.

- Commission a Warm and Healthy Homes project integral to the Warm Up North programme. This programme is delivered by Regeneration & Economic Development and is linked to the Warm Up North scheme through British Gas.

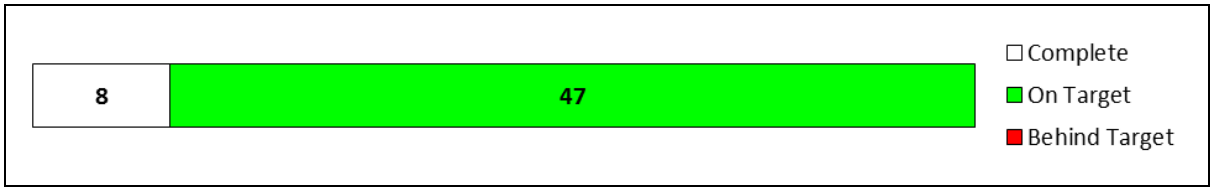
- Undertake Health Equity Audits and Undertake Health Needs Assessments. A cancer Health Equity Audit and a Health Needs Assessment (HNA) of eye health have been completed. A dementia HNA is underway.

- Both Clinical Commissioning Groups are exceeding the 96% target for the percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis. North Durham achieved 97.3% between April and June 2014, with DDES at 98.2% for the same period.

- Alcohol related admissions to hospital have reduced to 184.6 per 100,000 during April to June 2014 from 198.1 in the same period of the previous year. This is better than the North East average (206.5) but higher than the national rate (152.8).

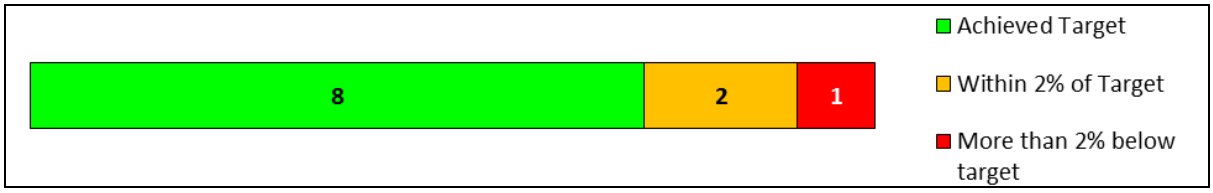
Objective 3: Improve the quality of life, independence and care and support for people with long term conditions

41. There are 56 actions under Objective 3. Of these, 1 action has been rescheduled. Progress against the other 55 actions is as follows:



42. The following action has been rescheduled:
    - Review and implement the home equipment loans service for adults and children and determine a sustainable service model to cope with increasing demand. The review and re-commissioning of the Home Equipment Loans Service has been planned by the CCGs to start in October 2014, with the new service to commence in June 2015. The procurement plan was put back due to the need for some technical information relating to stock from the current provider. The target date has been revised by the CCGs from March 2015 to June 2015.

43. There are 11 indicators with targets under Objective 3 for which new data is reported. Performance against target is as follows:



Indicator Behind Target

Adults aged 18-64 admitted to residential / nursing care

44. The number of adults aged 18-64 admitted on a permanent basis to residential or nursing care between April and September 2014 was 8.6 per 100,000. This is an increase from the same period of the previous year (5.4) and has not achieved target.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
5.4 per 100,000 (Apr-Sep13)	Adults aged 18-64 per 100,000 admitted on a permanent basis to residential or nursing care	8.6 (Apr-Sep14)	7.6 per 100,000 (Apr-Sept 14)	14.4 (2013/14)	16.6 (2013/14)	⇧

45. There has been an increase in the number of complex younger disabled people and a lack of alternative supported housing provision, particularly for those with brain injuries. Additionally, Learning Disability Services are reducing high cost supported housing and using residential care, where appropriate, for older people with learning disabilities. All admissions have been screened and no inappropriate admissions have been identified.

Performance Highlights

46. Progress since the previous performance report includes:

- Introduce 'Time to Think' opportunities as part of the intermediate care continuum, allowing individuals the opportunity to consider their options or alternatives to long term care. This has been completed as part of the implementation of the Integrated Short-term Intervention Service.

- Develop a post-diagnosis support service in County Durham (Autism). The contract was awarded to MAIN to deliver services from May 2014.

- Review wheelchair service. The review has been completed and an options paper is with North Durham and DDES CCGs for approval.

- In the 12 months to end of September 2014, the proportion of carers receiving a specific carers service as a percentage of service users receiving community based services was 38.2%. This is an increase from 37.9% in the same period of the previous year and is higher than national and regional averages.

- Children & Adult Services continue to refer carers to Durham County Carers Support for assessment and support. The number of carers registered with Durham County Carers Support has increased from 8,065 in 2011/12 to 10,501 in June 2014.

- The number of adults aged 65 and over admitted on a permanent basis to residential or nursing care between April and September 2014 was 358.4 per 100,000 population aged 65 and over, which has achieved the profiled target (387.9). This is a Better Care Fund Indicator.

- The proportion of older people still at home 91 days after discharge from hospital into a reablement/rehabilitation service was 89.8%, which is achieving target (85.6%) and is better than national (81.9%) and regional (87.2%) averages.

- The percentage of people with no ongoing care needs following completion of a reablement service is 64.6% which has exceeded target (55%).

- The latest figure (April – August 2014) for delayed transfers of care in Durham is 8.3 per 100,000 population. This is lower than the national average (10.1). Delays attributable to adult social care (1.5 per 100,000 population) are also

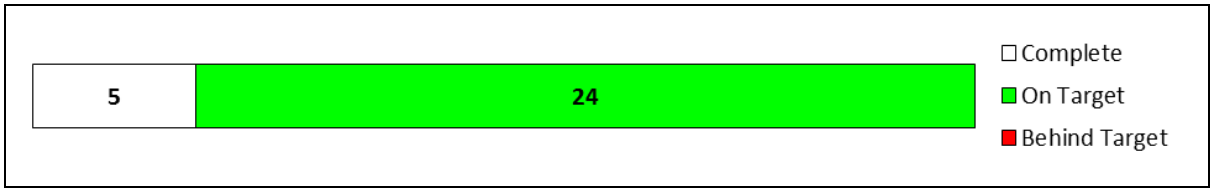
lower than the national average (3.2). As part of the monitoring of the Better Care Fund, the number of bed days delayed is being tracked against quarterly targets. There has been an increase in the numbers of delayed days attributable to the NHS within the Acute Sector in July and August 2014:

Month	April	May	June	July	August
Number of bed days delayed attributable to NHS	464	706	639	852	748

A meeting was held on the 8th October 2014 which was attended by representatives from County Durham and Darlington NHS Foundation Trust, Durham County Council, North East Commissioning Support, the regional NHS team and Clinical Commissioning Groups to discuss performance in relation to delayed transfers of care. Delays in completing Continuing Health Care assessments was identified as the main pressure on delayed transfers and a further meeting is convened for the 18th November 2014 to discuss how this process can be streamlined.

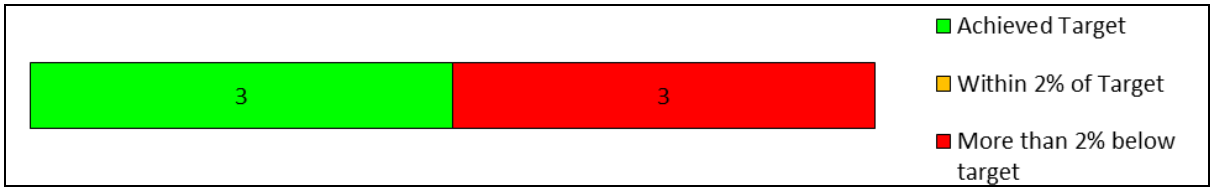
Objective 4: Improve Mental Health and Wellbeing of the Population

47. There are 30 actions under Objective 4. Of these, 1 action has been rescheduled. Progress against the other 29 is as follows:



48. The following action has been rescheduled:
- Develop an integrated primary care mental health model.
    - This has been delayed for 12 months following an extensive engagement process with GPs. This postponement will allow CCGs to examine alternatives to the model, engage with potential providers and fully mobilise any new services. The target date has been amended from March 2015 to March 2016.

49. There are 6 indicators with targets under Objective 4 for which new data is reported. Performance against target is as follows:



Indicators Behind Target

Improving Access to Psychological Therapies (IAPT) (CCG Quality Premium Indicators)

50. The recovery rate of those completing IAPT treatment in DDES CCG between April and August 2014 was 46.6%. Performance did not achieve the target. North Durham CCG performance was 51.1% and exceeded target.

51. Access to IAPT treatment is below target in both CCG areas but has exceeded the latest national performance.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
45.4% (2013/14)	IAPT: Recovery rate of those completing treatment – DDES CCG	46.6% (Apr-Aug14)	50% [1410]	45.5% (Jan-Mar14)	46.8% (Jan-Mar 14)	⇧
52.5% (2013/14)	IAPT: Recovery rate of those completing treatment – ND CCG	51.1% (Apr-Aug14)	50% [1238]	45.5% (Jan-Mar14)	46.8% (Jan-Mar 14)	⇩
8.2% (2013/14)	Access to IAPT – DDES CCG	12.3% (Apr-Aug14)	12.8%	9.5% (Dec 2013)	Not available	⇧
9.1% (2013/14)	Access to IAPT – ND CCG	12.1% (Apr-Aug14)	12.8%	9.5% (Dec 2013)	Not available	⇧

* Durham, Darlington & Tees Area Team.

52. The provider of IAPT services and the Clinical Commissioning Groups have improved performance during 2013/14 through the operation of a jointly agreed remedial action plan. The provider is under a performance notice whereby if the action plan is not adhered to they are in breach of contract. The action plan is ongoing and key issues that are being addressed are staffing recruitment and retention, publicity and promotion of the service and patient retention.

53. Within County Durham therapy is also provided by counselling services; these services are not currently counted in the IAPT minimum datasets. The CCGs are looking into possible solutions to ensure all therapy provision counts towards these targets.

Performance Highlights

54. Progress since the previous performance report includes:

- Provide a forum where the voice of the armed services community can be heard and can help influence service development. The Armed Forces Forum meets twice per year and a dedicated page for support available for the Armed Forces community is on the new Durham County Council Website.

- Implement the Recovery College to offer training opportunities for people with mental health difficulties to gain a better understanding of their difficulties and how to manage them as well as providing opportunities to learn from others

with similar experiences. The Recovery College officially opened in September 2014, offering a range of courses.

- Implement specialist mental health advocacy services *and* Implement supported living (Richmond Fellowship) service. These are contracted services which are in place.

- The proportion of adults in contact with secondary mental health services who are in paid employment is 10.8% in the 12 months to September 2014. This is exceeding target (9%) and is above the 2013/14 national average (97.1%).

- The percentage of service users who have as much social contact as they would like was 85.3% between April and September 2014 and is exceeding target (80%).

Other Areas for Improvement

Self-reported wellbeing

55. Self-reported wellbeing in County Durham is worse than the national averages (low percentages represent good performance). However, performance has improved for all indicators in comparison to the previous year.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
Self-reported wellbeing						
8.8 (2012/13)	People with a low satisfaction score (% of respondents scoring 0-4 to "how satisfied are you with your life nowadays?")	6.1% (2013/14)	Tracker	5.6% (2013/14)	6.5% (2013/14)	⇩
6.4 (2012/13)	People with a low worthwhile score (% of respondents scoring 0-4 to "To what extent do you feel the things you do in your life are worthwhile?")	5.6% (2013/14)	Tracker	4.2% (2013/14)	5.0% (2013/14)	⇩
14.8 (2012/13)	People with a low happiness score (% of respondents scoring 0-4 to "How happy did you feel yesterday?")	13.0% (2013/14)	Tracker	9.7% (2013/14)	11.6% (2013/14)	⇩
25.4 (2012/13)	People with a high anxiety score (% of respondents scoring 6-10 to "How anxious did you feel yesterday?")	21.5% (2013/14)	Tracker	20.0% (2013/14)	21.6% (2013/14)	⇩

56. The four personal wellbeing questions are part of the Annual Population Survey, administered by the Office of National Statistics. This is a very large household survey which uses both face-to-face and telephone interviewing methods and provides a representative sample of people aged 16 and over living in residential households in the UK.

57. Actions being taken to improve self-reported wellbeing include:
- The implementation of the Public Mental Health Strategy. The primary purpose of the Strategy is to reduce the number of people developing mental health problems through promotion of good mental health, prevention of mental ill-health, and improving the quality of life for those with poor mental health through early identification and recovery.

Hospital admissions as a result of self-harm

58. Latest data for hospital admissions as a result of self-harm is significantly higher than the national average.

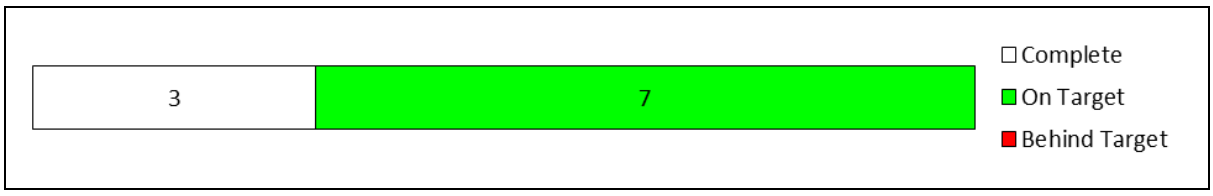
Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
343.1 (2011/12)	Hospital admissions as a result of self-harm. (Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000)	269.5 (2012/13)	Tracker	188.0 (2012/13)	292.8 (2012/13)	⇩

59. A Suicide Prevention Group is in place to develop and implement an action plan aimed at reducing suicide and self-harm rates for all ages. A report on suicide, attempted suicide and self-harm, including recommendations for actions has been produced. The report is being considered by the Clinical Commissioning Groups before being presented to the Health and Wellbeing Board in the new year.

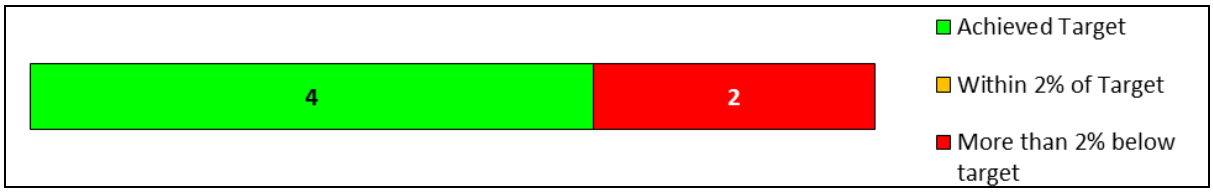
60. A workshop is planned for February 2015 with all key partners to work through example scenarios and develop pathways which enable access to a range of services from community provision, GP to secondary mental health services. The example scenarios are being collated through the suicide and attempted suicide early alert pilot which began in late September 2014.

Objective 5: Protect vulnerable people from harm

61. There are 10 actions under Objective 5. Progress is as follows:



62. There are 6 indicators with targets for Objective 5 for which new data is reported. Performance is as follows:



Indicators Behind Target

Reported number of medication-related safety incidents (CCG Quality Premium Indicators)

63. The percentage of reported medication-related safety incidents is below target in both Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and CDDFT.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
9.4% (Oct12-Mar13)	Reported number of medication-related safety incidents - CDDFT	7.4% (Oct13-Mar14)	10%	10.3% (Oct13-Mar14)	Not available	⇩
24% (Oct12-Mar13)	Reported number of medication-related safety incidents - TEWV	16.1% (Oct13-Mar14)	26%	9.0% (Oct13-Mar14)	Not available	⇩

64. Improving the reporting of medication-related safety incidents is a major contributing factor to Domain 5 of the NHS Outcomes Framework: 'Treating and caring for people in a safe environment and protecting them from avoidable harm'. Research shows that organisations which regularly report more patient safety incidents usually have a stronger learning culture where patient safety is a high priority, thereby driving improvement in the safety of care received by patients.

65. County Durham and Darlington NHS Foundation Trusts performance of 7.4% is below the large acute trust average of 10.3%. Incident reporting in general is being monitored by the Clinical Quality Review Group (CQRG) and CDDFT is looking at ways of improving reporting to increase their position against their peers over the forthcoming 6 months through campaigns and training, including through care groups and the Trust medicines bulletin.

66. TEWV report more medication incidents than other Mental Health Trusts, with performance of 16.1% compared to the mental health trust average of 9.0%. As above, the CQRG receive specific reports on medication incidents, whilst TEWV continue to deliver reporting campaigns throughout the Mental Health divisions.

Performance Highlights

67. Progress since the previous performance report includes:

- Review Safeguarding Framework to clarify the working arrangements between the Safeguarding Adults Board (SAB) and Local Safeguarding

Children's Board (LSCB) and the relationships with the Health & Wellbeing Board, Children & Families Partnership and Safe Durham Partnership. The Safeguarding Framework was approved by the SAB and LSCB in July/ August 2014.

- Ensure all partners are aware of overarching safeguarding procedures by ensuring they are represented on the SAB and LSCB. Attendance at the SAB/LSCB is reviewed annually. It includes representatives from Children & Adults Services, Public Health, Health Trusts and Durham Constabulary.

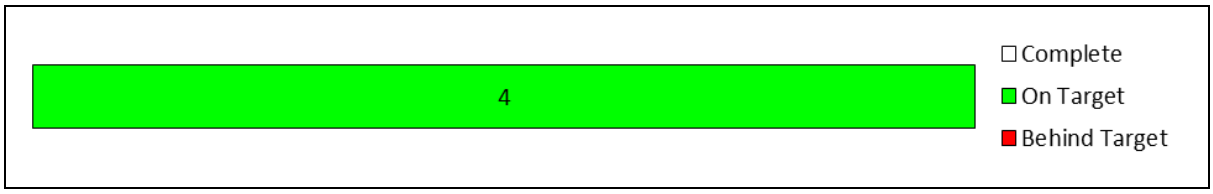
- Between April and June 2014, 14.1% of presentations at the Multi Agency Risk Assessment Conference (MARAC) were repeat victims, which continues to achieve the target of 25%. Performance is better than the average repeat referral rate for England (24%) and the North East (28%).

- The number of children with a Child Protection Plan at the end of September 2014 is 38.4 per 10,000 population. This is significantly lower than the latest regional average at March 2013 (51.1) and close to the national average (37.9).

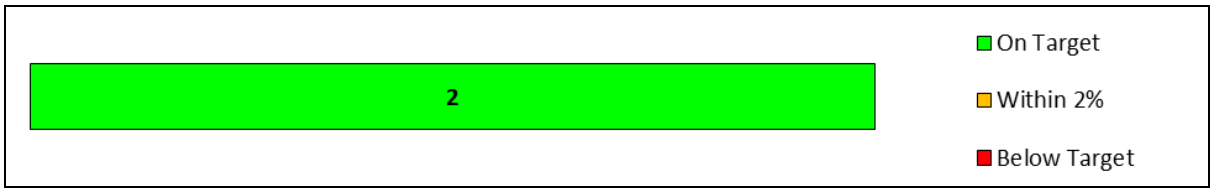
- The rate of looked after children at September 2014 is 61 per 10,000 population, which is lower than the latest North East average at March 2013 (80) and similar to the national average (60).

Objective 6: Support people to die in the place of their choice with the care and support that they need

68. There are 4 actions under Objective 6. Progress is as follows:



69. There are 2 indicators with targets under Objective 6 for which new data is reported. Performance is as follows:



Performance Highlights

70. Progress since the previous performance report includes:

- The proportion of deaths in usual place of residence has increased across both CCG areas in 2013/14. In Durham Dales, Easington and Sedgefield CCG the figure was 45.4%. In North Durham CCG the figure was 46.6%.

The national average for the same period is 44.7% and North East average is 44.6%.

- The number of patients in need of palliative care/support as recorded on practice disease registers is above target for both CCG areas between April and August 2014. In Durham Dales, Easington and Sedgefield CCG the figure was 653 against a target of 598. In North Durham CCG the figure was 708 against a target of 304. Thisis a CCG Quality Premium Indicator.

Recommendations

71. The Health and Wellbeing Board is recommended to:

- Note the performance highlights and areas for improvements identified throughout this report.
- Note the actions taking place to improve performance and agree any additional actions where relevant.

Contact: **Keith Forster, Strategic Manager – Performance & Information Management, Children & Adults Services;**
Tel: 03000 267396

Appendix 1: Implications

Finance - Performance Management is a key activity in delivering efficiencies and value for money

Staffing - Performance management is a key element of resource allocation

Risk - Effective performance management can help to highlight and manage key risks

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - The Joint Health and Wellbeing Strategy includes actions which contribute to community safety priorities and includes an objective to protect vulnerable people from harm.

Human Rights - None

Consultation - The content of the performance management process has been agreed with the Board and has been part of the consultation on the JHWS

Procurement - None

Disability Issues - A range of indicators which monitor services to people with a disability are included within the performance system

Legal Implications - Performance management is crucial to ensure that key legal/statutory requirements are being discharged appropriately

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Joint Health and Wellbeing Board Performance Scorecard: 2nd Quarter 2014/15

Key - Direction of Travel: Improvement Deterioration Within 2%

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	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									
58.9% (2012/13)	57.4% (2013/14)	Breastfeeding initiation	57.1% (Apr-Jun 14)	Tracker	⇧	Qtr 3 (Jul - Sept 2014)	74.0% (Apr-Jun 14)	56.5% (Apr-Jun 14) [Durham, D'ton & Tees Area Team]	Not available
28.1% (2012/13)	28.5% (2013/14)	Prevalence of breastfeeding at 6-8 weeks from birth	28.9% (Apr-Jun 14)	Tracker	⇧	Qtr 3 (Jul - Sept 2014)	47.2% (2012/13)	27.9% (Apr-Jun 14) [Durham, D'ton & Tees Area Team]	Not available
2150 (2012/13)	2667 (2013/14)	Number of new referrals to Child and Adolescent Mental Health Services (CAMHS)	996 (Apr-Aug 14)	Tracker	⇩	Qtr 3 (Apr- Nov 14)	Not available	Not available	Not available
232 (2012/13)	220 (2013/14)	Number of young people in Tier 3 treatment for drugs and alcohol with 4Real	230 (Jul 13 - Jun 14)	295	⇧	Qtr 3 (Oct 13 - Sept 14)	Not applicable	Not applicable	Not applicable
88% (2012/13)	74% (2013/14)	Percentage of exits from young person's treatment that are planned discharges	92% (Apr-Jun 14)	79%	⇧	Qtr 3 (Jul-Sept 14)	82% (Apr-Jun 14)	Not available	Not available
37.4 (2011)	33.7 (2012)	Under 18 conception rate	38.9 [Prov] (Apr-Jun 13)	Tracker	⇧	Qtr 3 (Jul - Sept 13)	25.2 [Prov] (Apr-Jun 13)	32.1 [Prov] (Apr-Jun 13)	Not available
19.9% (2012/13)	19.9% [Prov] (2013/14)	Percentage of mothers smoking at time of delivery	17.9% (Apr - Jun 14)	20.5%	⇩	Qtr 3 (Jul-Sept 14)	11.5% (Apr - Jun 14)	20.1% (Apr - Jun 14) [Durham, D'ton & Tees Area Team]	Not available
493.7 (2012/13)	431.5 [Prov] (2013/14)	Emergency admissions for children with lower respiratory tract infections - DDES CCG	75.7 (Apr-Jul 14)	Tracker	⇩	Qtr 3 (Apr-Oct 14)	368.6 [Prov] (2013/14)	443.4 [Prov] (2013/14) [Durham, D'ton & Tees Area Team]	Not available
510.0 (2012/13)	467.6 [Prov] (2013/14)	Emergency admissions for children with lower respiratory tract infections - North Durham CCG	62.4 (Apr-Jul 14)	Tracker	⇩	Qtr 3 (Apr-Oct 14)	368.6 [Prov] (2013/14)	443.4 [Prov] (2013/14) [Durham, D'ton & Tees Area Team]	Not available
231 (2012/13)	282 (2013/14)	Proportion of pregnant women accessing stop smoking support and setting a quit date	70 (32 quit) (Apr-Jun 14)	Tracker	⇩	Qtr 3 (Apr-Sept 2014)	Not available	Not available	Not available
Not available	Not available	Young people aged 10-24 admitted to hospital as a result of self-harm	410.5 (2012/13)	Tracker	N/A	Qtr 4 2014/15 (2013/14)	346.3 (2012/13)	479.6 (2012/13)	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
Strategic Objective 2: Reduce health inequalities and early deaths									
14.2% (2012/13)	10.3% (2013/14)	Percentage of the eligible population aged 40-74 who received an NHS Health Check	1.5% (Apr-Jun 14)	2% (Apr-Jun 14)	⇩	Q3 (Apr-Sept 2014)	2.2% (Apr-Jun 14)	2.1% (Apr-Jun 14)	Not available
99.5% (Oct-Dec 2013)	98.9% (Jan - Mar 2014)	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date) DDES CCG	98.2% (Apr-Jun 14)	96%	⇩	Qtr 3 (July-Sept 14)	97.7% (Apr - Jun 2014)	98.1% [Durham, D'ton & Tees Area Team] (Apr - Jun 2014)	Not available
98.4% (Oct - Dec 2013)	96.5% (Jan - Mar 2014)	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date) North Durham CCG	97.3% (Apr-Jun 14)	96%	⇩	Qtr 3 (July-Sept 14)	97.7% (Apr - Jun 2014)	98.1% [Durham, D'ton & Tees Area Team] (Apr - Jun 2014)	Not available
83.3% (Oct - Dec 2013)	84.1% (Jan - Mar 2014)	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer DDES CCG	78.9% (Apr-Jun 14)	85%	⇩	Qtr 3 (July-Sept 14)	83.9% (Apr - Jun 2014)	83.0% [Durham, D'ton & Tees Area Team] (Apr - Jun 2014)	Not available
86.2% (Oct - Dec 2013)	78.7% (Jan - Mar 2014)	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer North Durham CCG	81.9% (Apr-Jun 14)	85%	⇩	Qtr 3 (July-Sept 14)	83.9% (Apr - Jun 2014)	83.0% [Durham, D'ton & Tees Area Team] (Apr - Jun 2014)	Not available
7.3% (2011)	7.3% (2012)	Successful completions as a percentage of total number in drug treatment - Opiates	6.8% (2013)	7.9%	⇩	Qtr 3 (Apr 13 - Mar 14)	7.7% (2013)	Not available	Not available
26.0% (2011)	36.1% (2012)	Successful completions as a percentage of total number in drug treatment - Non Opiates	39.9% (2013)	40.4%	⇧	Qtr 3 (Apr 13 - Mar 14)	40.3% (2013)	Not available	Not available
792.8 (2012/13)	784.4 [Prov] (2013/14)	Alcohol related admissions to hospital per 100,000	184.6 [Prov] (Apr-Jun 14)	Tracker	⇩	Qtr 4 (Apr-Sept 14)	152.8 [Prov] (Apr-Jun 14)	206.5 [Prov] (Apr-Jun 14)	Not available
43.7% (2012/13)	34.8% (2013/14)	Successful completions as a percentage of total number in treatment – Alcohol	36.5% (Jul 13-Jun 14)	36.6%	⇩	Qtr 3 (Oct '13 - Sept 14)	39.8% (Jul '13-Jun '14)	Not available	Not available
1,165 per 100,000 (4,949 quitters) (2012/13)	967 per 100,000 (4,134 quitters) (2013/14)	Four week smoking quitters per 100,000 population	191.1 per 100,000 (817) (Apr-Jun 14)	293 per 100,000	⇩	Qtr 3 (Apr-Sept 14)	688 per 100,000 (2013/14)	932 per 100,000 (2013/14)	Not available
Previous data not comparable	52.2 (2012)	Proportion of physically active adults	53.4% (2013)	Tracker	⇧	Qtr 2 2015/16 (2014)	55.6% (2013)	52.8% (2012)	Not available
	29.3 (2012)	Proportion of physically inactive adults	32.4% (2013)	Tracker	⇧	Qtr 2 2015/16 (2014)	28.9% (2013)	31.3% (2013)	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
2,763.4 (2011)	2,408.1 (2012)	Potential years life lost from amenable causes per 100,000 - DDES	2,396.3 (2013)	2341	⇩	Qtr 2 2015/16 (2014)	2,027.4 (2013)	2338.1 (2013)	Not available
2,133.7 (2011)	2,124.3 (2012)	Potential years life lost from amenable causes per 100,000 - ND	2,286.5 (2013)	2093	⇧	Qtr 2 2015/16 (2014)	2,027.4 (2013)	2338.1 (2013)	Not available
Not available	71.2% (Mar 14)	Friends and Family Test (whether people receiving NHS treatment would recommend the place where they received care to their friends and family) - CDDFT A&E	76.6% (Jul 14)	81.2% by March 15	⇧	Qtr 3 (Apr-Oct 14)	86.2% (Jul 14)	82.7% [Durham, D'ton & Tees Area Team] (Jul 14)	Not available
Not available	75.2% (Mar 14)	Friends and Family Test (whether people receiving NHS treatment would recommend the place where they received care to their friends and family) - Darlington Memorial Hospital A&E	78% (Jul 14)	85.2% by March 15	⇧	Qtr 3 (Apr-Oct 14)	86.2% (Jul 14)	82.7% [Durham, D'ton & Tees Area Team] (Jul 14)	Not available
Not available	68.2 (Mar 14)	Friends and Family Test (whether people receiving NHS treatment would recommend the place where they received care to their friends and family) - University Hospital North Durham A&E	74.7% (Jul 14)	78.2% by March 15	⇧	Qtr 3 (Apr-Oct 14)	86.2% (Jul 14)	82.7% [Durham, D'ton & Tees Area Team] (Jul 14)	Not available
Strategic Objective 3: Improve the quality of life, independence and care and support for people with long term conditions									
34% (2012/13)	33.8% (2013/14)	Number of carers (all service user type) receiving a specific carers service as a percentage of service users receiving community based services	38.2% (Oct 13 -Sept 14)	35%	⇧	Qtr 3 (Apr-Sept 14)	33.5% (2013/14)	31.9% (2013/14)	Not available
94.9% (2012/13)	94.5% (2013/14)	The percentage of service users reporting that the help and support they receive has made their quality of life better	93.0% (Apr-Sep 14)	93%	⇩	Qtr 3 (Apr-Aug 14)	Not reported	Not reported	Not reported
84.4% (2012/13)	94.5% (2013/14)	Proportion of people who use services who have control over their daily life	90.5% (Apr-Jun 14)	80.0%	⇩	Qtr 3 (Apr-Sept 14)	Not reported	Not reported	Not reported
60.0% (2012/13)	60.1% (2013/14)	Proportion of people using social care who receive self-directed support	59.1% (Oct 13 - Sept 14)	56.5%	⇩	Qtr 3 (Apr-Sept 14)	62.1% (2013/14)	60.6% (2013/14)	54.7% (2013/14)
13.4 (2012/13)	15.1 per 100,000 (2013/14)	Adults aged 18-64 per 100,000 population admitted on a permanent basis in the year to residential or nursing care	8.6 (Apr-Sept 14)	7.6 per 100,000 (Apr-Sept 14)	⇧	Qtr 3 (Apr-Sept 14)	14.4 (2013/14)	16.6 (2013/14)	13.4 (2013/14)
840.7 (2012/13)	736.2 per 100,000 (2013/14)	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	358.4 Per 100,000 (Apr-Sept 14)	387.9 per 100,000 (Apr-Sept 14)	⇧	Qtr 3 (Apr-Sept 14)	668.4 (2013/14)	823.2 (2013/14)	745.9 (2013/14)
85.4% (Oct-Dec 2012)	89.4% (Oct-Dec 2013)	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	89.8% (Jan-Jun 2014)	85.6%	⇧	Qtr 3 (Jan-Jun 14)	81.9% (2013/14)	87.2% (2013/14)	85.3% (2013/14)
60.3% (2012/13)	62.3% (2013/14)	Percentage of people who have no ongoing care needs following completion of provision of a reablement package	64.6% (Apr-Sept 14)	55%	⇧	Qtr 3 (Apr-Sept 14)	Not available	60.2% (Q2 2012-13)	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
10.7 per 100,000 (2012/13)	10.5 per 100,000 (2013/14)	Delayed transfers of care from hospital per 100,000 population	8.3 per 100,000 (Apr-Aug 14)	Tracker	⇩	Qtr 3 (Apr-Sept 14)	10.1 (Apr-Aug 14)	8.1 (2013/14)	8.0 (2013/14)
1.76 per 100,000 (2012/13)	1.0 per 100,000 (2013/14)	Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	1.5 per 100,000 (Apr-Aug 14)	Tracker	⇧	Qtr 3 (Apr-Sept 14)	3.2 (Apr-Aug 14)	2.0 (2013/14)	2.0 (2013/14)
85.9% (2012/13)	86.1 (2013/14)	Proportion of adults with learning disabilities who live in their own home or with their family	83.9% (Apr-Sept 14)	85%	⇩	Qtr 3 (Apr-Sept 14)	74.8% (2013/14)	80.8% (2013/14)	81.9% (2013/14)
89.2% (2012/13)	88.5% (2013/14)	Proportion of adults in contact with secondary mental health services living independently, with or without support	87.9 (Oct 13-Sept 14)	88.5%	⇩	Qtr 3 (Oct 13-Sept 14)	60.9% [Prov] (2013/14)	Not available	58.7% [Prov] (2013/14)
70.9% (2011/12)	67.1% (2012/13)	Proportion of people feeling supported to manage their condition	67.3% (2013/14)	Tracker	⇧	Qtr 2 2015/16 (2014/15)	65.1% (2013/14)	68.7% (2013/34)	Not available
197.0 (2012/13)	243.9 (31-Mar-14)	The number of people in receipt of Telecare per 100,000	253.8 (30-Sep-14)	215	⇧	Qtr 2 2014/15 (2013)	Not available	Not available	Not available
Strategic Objective 4: Improve mental health and wellbeing of the population									
6.4 (2011/12)	8.8 (2012/13)	Self-reported well-being - people with a low satisfaction score (% of respondents scoring 0-4 to the question "Overall, how satisfied are you with your life nowadays?") *Low percentage represents good performance*	6.1 (2013/14)	Tracker	⇩	Qtr 2 2014/15	5.6 (2013/14)	6.5 (2013/14)	Not available
6.1 (2011/12)	6.4 (2012/13)	Self-reported well-being - people with a low worthwhile score (% of respondents scoring 0-4 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?") *Low percentage represents good performance*	5.6 (2013/14)	Tracker	⇩	Qtr 2 2014/15	4.2 (2013/14)	5.0 (2013/14)	Not available
13.3 (2011/12)	14.8 (2012/13)	Self-reported well-being - people with a low happiness score (% of respondents scoring 0-4 to the question "Overall, how happy did you feel yesterday?") *Low percentage represents good performance*	13.0 (2013/14)	Tracker	⇩	Qtr 2 2014/15	9.7 (2013/14)	11.6 (2013/14)	Not available
25.1 (2011/12)	25.4 (2012/13)	Self-reported well-being - people with a high anxiety score (% of respondents scoring 6-10 to the question "Overall, how anxious did you feel yesterday?") *Low percentage represents good performance*	21.5 (2013/14)	Tracker	⇩	Qtr 2 2014/15	20.0 (2013/14)	21.6 (2013/14)	Not available
17.4% (Jul-Sept '13)	18.3% (Oct-Dec '13)	Gap between the employment rate for those with a long term health conditions and the overall employment rate	16.5% (Jan-Mar '14)	Tracker	⇧	Qtr 3 (Apr-Jun 14)	13.9% (Jan-Mar '14)	16.1% (Jan-Mar '14)	Not available
11% (2012/13)	10.9% (2013/14)	Proportion of adults in contact with secondary mental health services in paid employment	10.8% (Oct 13-Sept 14)	9%	⇩	Qtr 3 (Apr-Jun14)	7.1 (2013/14)	Not available	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
354.6 (2010/11)	343.1 (2011/12)	Hospital admissions as a result of self-harm. (Age-sex standardised rate of emergency hospital admissions for intentional self-harm per 100,000 population)	269.5 (2012/13)	Tracker	⇩	Qtr 2 2015/16 (2013/14)	188.0 (2012/13)	292.8 (2012/13)	Not available
79.5% (2012/13)	83.4% (13/14)	Percentage of service users who have as much/adequate social contact with people as they like - social care users	85.3% (Apr-Sept 14)	80%	⇧	Q3 (Apr-Sept 14)	Not available	Not available	Not available
45.4% (2012/13)	45.4% (2013/14)	Improving Access to Psychological Therapies (IAPT): Recovery rate of those completing treatment - DDES	46.6% (Apr-Aug 14)	50% [1410]	⇧	Qtr3 (Apr-Nov 14)	45.5% (Jan-Mar 14)	46.8% [Durham, D'ton & Tees Area Team] (Jan-Mar 14)	Not available
45.4% (2012/13)	52.5% (2013/14)	Improving Access to Psychological Therapies (IAPT): Recovery rate of those completing treatment - ND	51.1% (Apr-Aug 14)	50% [1238]	⇩	Qtr3 (Apr-Nov 14)	45.5% (Jan-Mar 14)	46.8% [Durham, D'ton & Tees Area Team] (Jan-Mar 14)	Not available
Not available	8.2% (2013/14)	Access to IAPT - DDES	12.3% (Apr-Aug 14)	12.8%	⇧	Qtr3 (Apr-Nov 14)	9.5% (Dec 2013)	Not available	Not available
Not available	9.1% (2013/14)	Access to IAPT - ND	12.1% (Apr-Aug 14)	12.8%	⇧	Qtr3 (Apr-Nov 14)	9.5% (Dec 2013)	Not available	Not available
Strategic Objective 5: Protect vulnerable people from harm									
12.6% (2012/13)	8.9% (2013/14)	Percentage of repeat incidents of domestic violence (referrals to MARAC)	14.7% (Apr-Sept 14)	Less than 25%	⇧	Qtr 3 (Apr-Sep 14)	24% (2013)	28% (2013)	Not available
86.8% (2012/13) [Local Survey]	93.0% (2013/14) [Local Survey]	The proportion of people who use services who say that those services have made them feel safe and secure	93.6% (Apr-Sept14) [Local Survey]	85%	⇧	Qtr 3 (Apr-Sept 14)	Not available	Not available	Not available
Not available	8.5% [Prov] (2013/14)	Percentage of children becoming the subject of a Child Protection Plan for a second or subsequent time (within two years of the previous plan)	7.5% (Apr-Sept 14)	14.5%	⇩	Qtr 3 (Apr-Sept 14)	Not available	Not available	Not available
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	85 (2013/14)	Tracker	⇧	Qtr 3 (Apr-Sept 14)	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	118 (2013/14)	Tracker	⇧	Qtr 3 (Apr-Sept 14)	Not available	Not available	Not available
Not available	162 (2012/13)	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	196 (2013/14)	Tracker	⇧	Qtr 3 (Apr-Sept 14)	Not available	Not available	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
40.9 (March 13)	45.5 [Prov] (March 14)	Number of children with a Child Protection Plan per 10,000 population	38.4 (Sept 14)	Tracker	⇩	Qtr 3 (Sept 14)	37.9 (March 2013)	51.1 (March 2013)	49.9 (March 2013)
51.1% (2012/13)	49.3% (2013/14)	Percentage of adult safeguarding referrals substantiated or partially substantiated	55.5% (Apr-Sept14)	Tracker	⇧	Qtr 3 (Apr-Sep 14)	Not available	Not available	Not available
63.4 (March 13)	60.5 [Prov] March 2014	Rate of Looked After Children per 10,000 population	61.0 (Sept 14)	Tracker	⇩	Qtr 3 (Sept 14)	60 (March 2013)	80 (March 2013)	81 (March 2013)
16.8% (2012/13)	28.5% [Prov] (2013/14)	Percentage of Children in Need (CIN) referrals occurring within 12 months of previous referral	26.3% (Apr - Sept 14)	28%	⇩	Qtr 2 (Apr-Jun 14)	24.9% (2012/13)	22.5% (2012/13)	22.5% (2012/13)
9.4% (Oct 12 - Mar-13)	12.7% (Apr 13 - Sep 13)	Reported number of medication-related safety incidents - CDDFT	7.4% (Oct 13 - Mar-14)	10%	⇩	Qtr 4 (Apr 14-Sep 14)	10.3% (Oct 13 - Mar 14)	Not available	Not available
24% (Oct 12 - Mar-13)	17% (Apr 13 - Sep 13)	Reported number of medication-related safety incidents - TEWV	16.1% (Oct 13 - Mar-14)	26%	⇩	Qtr 4 (Apr 14-Sep 14)	9.0% (Oct 13 - Mar 14)	Not available	Not available
Strategic Objective 6: Support people to die in the place of their choice with the care and support that they need									
44.1% (2011/12)	44.1% (2012/13)	Proportion of deaths in usual place of residence (DDES CCG)	45.4% (2013/14)	Tracker	⇧	Qtr 3 (Jul 13-Jun 14)	44.7% (2013/14)	44.6% (2013/14)	Not available
42.7% (2011/12)	45.6% (2012/13)	Proportion of deaths in usual place of residence (North Durham CCG)	46.6% (2013/14)	Tracker	⇧	Qtr 3 (Jul 13-Jun 14)	44.7% (2013/14)	44.6% (2013/14)	Not available
Not available	1148 (0.4%) (2012/13)	Number and percentage of patients in need of palliative care/support, as recorded on practice disease registers - DDES	653 (0.2%) (Apr-Aug 14)	598 (0.2%) (Apr-Aug 14)	N/A	Qtr 3 (Apr-Nov 14)	0.2% (2012/13)	Not available	Not available
Not available	486 (0.2%) (2012/13)	Number and percentage of patients in need of palliative care/support, as recorded on practice disease registers - ND	708 (0.3%) (Apr-Aug 14)	304 (0.1%) (Apr-Aug 14)	N/A	Qtr 3 (Apr-Nov 14)	0.2% (2012/13)	Not available	Not available

Joint Health and Wellbeing Board Performance Scorecard: Indicators with no new data since previous performance report

Key - Direction of Travel: Improvement Deterioration Within 2%

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	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									
22.9% (2010/11)	23.6% (2011/12)	Percentage of children aged 4-5 classified as overweight or obese	21.9% (2012/13)	Tracker	⇩	Qtr 3 (2013/14)	22.2% (2012/13)	24.1% (2012/13)	22.8% (2012/13)
36.0% (2010/11)	38.4% (2011/12)	Percentage of children aged 10-11 classified as overweight or obese	35.9% (2012/13)	Tracker	⇩	Qtr 3 (2013/14)	33.3% (2012/13)	35.7% (2012/13)	34.7% (2012/13)
116.9 (2008/09-2010/11)	102.6 (2009/10-2011/12)	Alcohol specific hospital admissions for under 18's (rate per 100,000)	81.5 (2010/11-2012/13)	Tracker	⇩	Qtr 1 2015/16 (2011/12-2013/14)	44.9 (2010/11-2012/13)	72.2 (2010/11-2012/13)	73.1 (2010/11-2012/13)
10.8 (2010)	7.7 (2011)	Under 16 conception rate	8.9 (2012)	Tracker	⇧	Qtr 4 (2013)	5.6 (2012)	8.4 (2012)	8.3 (2012)
3.9 (2008-10)	4.0 (2009-11)	Infant mortality rate, per 1,000 live births and stillbirths	3.9 (2010-12)	Tracker	⇩	Qtr 3 2014/15 (2011-13)	4.3 (2010-12)	3.7 (2010-12)	4.0 (2010-12)
6.5 (2010)	9.0 (2011)	Stillbirth and neonatal mortality rate, per 1,000 live births and stillbirths	5.9 (2012)	Tracker	⇩	Data release date TBC	7.6 (2012)	6.3 (2012)	Not available
15.9 (2011/12)	16.3 (2012/13)	Emotional and behavioural health of Looked After Children [lower score is better]	15.1 (Prov) (2013/14)	Tracker	⇩	Qtr 4 (2014/15)	14.0 (2012/13)	14.1 (2012/13)	13.9 (2012/13)
Strategic Objective 2: Reduce health inequalities and early deaths									
299.2 (2010)	307.0 (2011)	Mortality rate from all causes for persons aged under 75 years per 100,000 population	294.6 (2012)	Tracker	⇩	Qtr 3 2014/15 (2013)	256.4 (2012)	298.3 (2012)	Not available
101.9 (2008-10)	96.6 (2009-11)	Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population	91.3 (2010-12)	Tracker	⇩	Qtr 4 2014/15 (2011-13)	81.1 (2010-12)	92.4 (2010-12)	Not available
165.7 (2008-10)	163.5 (2009-11)	Mortality from cancer for persons aged under 75 years per 100,000 population	164.2 (2010-12)	Tracker	⇧	Qtr 4 2014/15 (2011-13)	146.5 (2010-12)	171.4 (2010-12)	Not available
8.9 (2008-10)	8.6 (2009-11)	Slope Index of Inequality (Males)	7.0 (2010-12)	Tracker	⇩	Q1 2015/16 (2011-13)	Not available	Not available	Not available
6.8 (2008-10)	7.2 (2009-11)	Slope Index of Inequality (Females)	7.2 (2010-12)	Tracker	⇔	Q1 2015/16 (2011-13)	Not available	Not available	Not available
20.6 (2008-10)	22.1 (2009-11)	Mortality from liver disease for persons aged under 75 years per 100,000 population	21.7 (2010-12)	Tracker	⇩	Qtr 4 2014/15 (2011-13)	18.0 (2010-12)	22.3 (2010-12)	Not available
43.1 (2008-10)	42.1 (2009-11)	Mortality from respiratory disease for persons aged under 75 years per 100,000 population	40.1 (2010-12)	Tracker	⇩	Qtr 4 2014/15 (2011-13)	33.5 (2010-12)	42.2 (2010-12)	Not available

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
77 (2008-10)	77.5 (2009-11)	Male life expectancy at birth (years)	77.9 (2010-12)	Tracker	⇧	Qtr3 2014/15 (2011-13)	79.2 (2010-12)	77.8 (2010-12)	Not available
81 (2008-10)	81.4 (2009-11)	Female life expectancy at birth (years)	81.5 (2010-12)	Tracker	⇧	Qtr3 2014/15 (2011-13)	83.0 (2010-12)	81.6 (2010-12)	Not available
23.2 (2010)	21.2 (2011)	Estimated smoking prevalence of persons aged 18 and over	22.2 (2012)	21.1%	⇧	Qtr 4 (2013)	19.5 (2012)	22.1 (2012)	Not available
Not available		Excess weight in adults (Proportion of adults classified as overweight or obese)	72.5 (2012)	Tracker	N/A	Data release date unknown	63.8 (2012)	68.0 (2012)	67.8 (2012)
79.75 (2011)	79.3% (2012)	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	78.6% (2013)	70%	⇩	Data release date unknown	76.3 (2013)	77.9 (2013)	75.8 (2013)
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	77.7% (2013)	80%	⇩	Data release date unknown	73.9 (2013)	75.9 (2013)	77.3 (2013)
N/A		The percentage of people eligible for bowel screening who were screened adequately within a specified period (PHOF 2.20iii)	Indicator under development	60%	N/A	Data release data unknown	Not available		
19.8% (2007/10)	18.1% (2008/11)	Reduce excess winter deaths	16.8% (2009/12)	Tracker	⇩	Qtr 4 (2010/13)	16.5 (2009/12)	13.7 (2009/12)	15.1 (2009/12)
Strategic Objective 3: Improve the quality of life, independence and care and support for people with long term conditions									
Not reported	8.7 (2012/13)	Carer reported quality of life	Not reported 2013/14	9.0	N/A	Qtr 4 (2014/15)	8.1 (2012/13)	8.6 (2012/13)	Not reported
79.2% (2011/12) [Local Survey]	83.6% (2012/13) [National Survey]	Overall satisfaction of carers with support and services they receive	National Survey N/A (74.2% [2013/14 Local Survey])	78% [National Survey]	N/A	Qtr 4 (2014/15)	Not available	Not available	Not available
76% (2011/12) [Local Survey]	79.2% (2012/13) [National Survey]	Percentage of carers who feel they have been involved or consulted as much as they wanted to be about the support or services provided to the person they care for	73% (2013/14) [Local Survey]	Not set for 2013/14	⇩	Qtr 4 (2014/15)	Not available	Not available	Not available
Not reported	51.5 (2011/12)	Estimated diagnosis rate for people with dementia DDES CCG	55.2 (2012/13)	Tracker	⇧	Data release date TBC	48.7 (2012/13)	Not reported	Not reported
Not reported	49.7% (2011/12)	Estimated diagnosis rate for people with dementia North Durham CCG	52.6 (2012/13)	Tracker	⇧	Data release date TBC	48.7 (2012/13)	Not reported	Not reported
11.2 (2009/10)	12.1 (2010/11)	Emergency readmissions within 30 days of discharge from hospital	12.4 (2011/12)	Tracker	⇧	Qtr 3 (2012/13)	11.8 (2011/12)	(Q2 2012-13)	Not available
2,038 (2010/11)	2,062 (2011/12)	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)	2,085 (2012/13)	Tracker	⇧	Data release date TBC	2,011 (2012/13)	2,172 (2012/13)	Not reported

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
653.9 (2010/11)	601.5 (2011/12)	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)	636.0 (2012/13)	Tracker	⇧	Qtr 2 2015/16 (2013/14)	568.1 (2012/13)	627.8 (2012/13)	Not reported
		Non-elective admissions (Better Care Fund Indicator - baselines TBC and performance will be reported from Jan 2015)							
Strategic Objective 4: Improve mental health and wellbeing of the population									
TEWV 87.4 (2011)	TEWV 88.4 (2012)	Patient experience of community mental health services (scored on a scale of 0-100)	TEWV 89.4 (2013)	Tracker	⇧	Qtr 3 (2014)	85.8 (2013)	Not reported	Not reported
11.4 per 100,000 (2008-10) [173]	12.0 per 100,000 (2009-11) [181]	Suicide rate	11.3 per 100,000 (2010-12) [172]	Tracker	⇩	Qtr 4 (2011-13)	8.5 per 100,000 (2010-12)	9.8 per 100,000 (2010-12)	Not reported
Not available	64.4% (2011/12)	Percentage of service users reporting that care and support services help in having social contact with people	66.3% (2012/13)	Not set for 2013/14	⇧	Qtr 3 (2013/14)	58.8% [2012/13]	61.2% [2012/13]	Not available
Not available	85.7% (2012/13)	Percentage of service users who have as much/adequate social contact with people as they like - carers	Survey not carried out in 2013/14	86%	N/A	Q4 (2014/15)	Not available	Not available	Not available
384.3 (2009/10)	365.4 (2010/11)	Excess under 75 mortality rate in adults with serious mental illness per 100,000 population	427.8 (2011/12)	Tracker	⇧	Qtr 3 (2012/13)	337.4 (2011/12)	Not reported	Not reported
Strategic Objective 5: Protect vulnerable people from harm									
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 hospital admissions ending in death (terminal admissions) that are emergencies	91.0% (2010/11)	Tracker	N/A	Data release date TBC	89.7% (2010/11))	Not available	Not available

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Health and Wellbeing Board

5 November 2014

Update - Implementing "Fulfilling and Rewarding Lives"- the statutory guidance for local authorities and NHS bodies regarding the implementation of the Autism Act (2010)

Report of Jane Robinson, Head of Commissioning, Children and Adults Services, Durham County Council

Purpose of the Report

1. This report provides an update on progress in response to the statutory guidance Implementing "Fulfilling and Rewarding Lives" and the report to Health and Wellbeing Board on 21 January 2014.

Background

2. There have been a number of recent policy developments that aim to promote the long term vision that "all adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it and they can depend on mainstream public services to treat them fairly as individuals, helping them to make the most of their lives." (DH Guidance p7)." These include:

    - The Autism Act 2009
    - Statutory Guidance to implementing the Act
    - The national strategy: Fulfilling and Rewarding Lives

    The guidance covers four main areas of activity:

    - Training of staff who provide services to adults with autism.
    - Identification and diagnosis of autism in adults, leading to an assessment of need for relevant services.
    - Planning in relation to the provision of services, especially as people with autism move through transition from being children to adulthood.
    - Local planning and leadership in relation to the provision of services.

3. In response to the above Durham County Council compiled an action plan to progress the autism agenda and areas identified in the SAF as requiring development. Progress against the action plan is positive and we are aware from our work with the regional group that we compare favourably with other authorities in terms of new developments. An updated version is at Appendix 2 and details steps taken so far to meet the plan and a number of developments are highlighted below.

4. One of the most significant developments has been the commissioning of the post diagnosis service which was awarded to an organisation called MAIN. This has been jointly commissioned with the NHS through the North East Commissioning Service. People are eligible to use this service from age 16 to improve transition between childrens and adult services.

5. The service is currently providing direct support to over 30 people and has quickly established links with organisations and professionals across the County. In addition to direct support to individuals the service will also develop the autism strategy in the following ways:

   - **Provide autism training**

     Training will focus on improving the skills and knowledge of a range of public and private services to improve employee understanding, knowledge and skills in supporting people with autism and improve the services available to people with autism. This will include supporting organisations in making reasonable adjustments. Examples of organisations to be targeted include GP surgeries, jobcentre plus, leisure centres, carer centres, advice agencies and other community groups.

   - **Act as an expert practitioner**

     The provider has a level of knowledge and expertise that will benefit staff from other organisations and they will offer advice and guidance to improve other services. Support and advice will also be made available to families and the provider will offer specific advice and guidance on issues that are causing difficulties. This could include communication skills and techniques and how to continue to offer support in relation to specific areas when support from the provider is withdrawn.

6. One of the more challenging areas of the action plan is to increase employment opportunities for people with autism. This is one of the areas the post diagnosis service focuses on in individual support and also an outcome for a Community Chest funded project that seeks to increase people's skills and confidence in an attempt to make them "job ready." A bid has also been made to the Autism Innovation Fund and if this is successful will provide apprenticeships to individuals with autism. The result of this bid is expected later in October. Additional work will

be undertaken in 2015 to improve training and employment through European Funding managed by Economic Development.

7. A multi-agency event was organised by the police in July 2014 and focused on autism and criminal justice issues. It featured a nationally recognised speaker and plans are underway to host a regional event in 2015.

8. Autism issues in relation to the criminal justice system will be the subject of further detailed work as part of the implementation of the Mental Health Crisis Care Concordat.

Next steps

9. The next autism self-assessment (SAF) is expected to be issued for completion in November 2014. We intend to increase the level of carer and service user involvement in identifying priority areas for development in the SAF and the 2015/16 action plan for Durham. This will be supported through providers and the carer support service

10. Further statutory guidance is expected to be published towards the end of October 2014 on implementing the autism strategy and plans are underway to consult with carers and service users on this.

Recommendations

11. The Health and Wellbeing Board is recommended to:

- Receive this report for information

Contact: David Shipman, Strategic Commissioning Manager, Durham County Council Tel - 03000267391

Appendix 1: Implications

Finance – No additional funding was made available to implement the Autism Act. Additional projects have been funded through Community Chest and Section 256.

Staffing – Training to develop skills and knowledge of autism available from MAIN.

Risk – N/A

Equality and Diversity / Public Sector Equality Duty – Developments included in this report support reasonable adjustments and have a positive impact on E&D.

Accommodation – Accommodation developed on a needs basis. Respite accommodation at New Warlands farm now open.

Crime and Disorder – Work underway with police. Additional work to assess need for initiatives in prisons as part of Care Act Implementation.

Human Rights – Rights of people with autism strengthened by the Act.

Consultation – Consultation with carers and service users to be further developed through Durham Implementation Group.

Procurement - Post diagnosis service now operational.

Equality Act – Action plan has had a positive impact on DCC duties.

Legal Implications – Further statutory guidance to be consulted on.

Appendix 2: The Continuing Implementation of the 2010 Adult Autism Strategy

"Fulfilling and Rewarding Lives" in County Durham County Council

Action Plan for 2014/15

	Quality Outcome/Service Ambition	**Action**	**Lead Person**	**Date for Completion**	**Update 1.10.14**	**Progress Monitoring/Outcomes Indicator**
1.	Adults with autism achieve better health and social outcomes	Development of a post-diagnosis support service in County Durham	D. Shipman (CAS)	July 2014	Service operational since May 2014	Tender issued Jan 14
					30 service users currently being supported	Tender awarded Feb 14
					Training courses commenced and attracting positive response.	Service in place June 14
2.	Adults with autism access a range of mainstream and specialist accommodation options	Development of specialist packages	**D. Shipman** (CAS)	March 2015	Packages developed as and when required through Commissioning Advisory Group, Budget Panel and care coordination.	New packages in place
		Improved access to mainstream options in DCC Housing Solutions Service	**L. Hall** (Housing Solutions)	March 2015	Post diagnosis service to support with accommodation options on individual basis.	People with autism placed in mainstream housing
		Inclusion of Autism needs in The County Durham Housing Strategy	**D. Siddle** (RED)	March 2015	DCC Housing Strategy to be refreshed and Commissioning Service will work to include specialist autism provision within this.	Revised strategy published

	Quality Outcome/Service Ambition	Action	Lead Person	Date for Completion	Update 1.10.14	Progress Monitoring/Outcomes Indicator
3.	Adults with autism are dealt with appropriately/ effectively in the Local Criminal Justice Services	Work between partner agencies, including Prison, Probation, Police and Youth Offending to identify issues for County Durham	**D. Shipman** (CAS) **K. Weir** (Police) **C. Carey** (Probation) **G. Eshelby** (Youth Offending)	March 2014	Multi agency work underway through Safer Durham partnership.	Completed
		Develop responses to identified issues	**All**	September 2014	Check point diversion service; autism to be built into appropriate adult service.	Being addressed as part of Mental Health Crisis Care Concordat work and consideration of an Appropriate Adults Scheme
		Host a local/regional seminar to spotlight the issues and best practice responses	**All**	December 2014	Multi agency event held September 2014. Durham event planned for 2015.	To be determined
4.	Adults with autism are able to access employment opportunities	Work with the Social Inclusion/Economic Partnership to identify and develop future employment opportunities	**T. L. Payne**	March 2015	Innovation Fund bid submitted to create apprentice and employment opportunities.	Working group established March 14
					Support to develop employability skills available through commissioned services.	Targets achieved March 15
					Training on employing people with autism to be provided by MAIN.	

	Quality Outcome/Service Ambition	Action	Lead Person	Date for Completion	Update 1.10.14	Progress Monitoring/Outcomes Indicator
5.	Staff working with people with autism have appropriate skills, knowledge and training.	Development and Implementation of an autism-specific training programme which will incorporate the following;	**H. Ostele** (CAS Learning & Development)	March 2014 Onwards	Autism awareness training by post diagnosis provider underway.	Programme developed and delivered to key personnel from March 2014.
		Equality & Diversity Training				
		Communication and Sensory Issues				
		Awareness Raising				
		Specialist training for staff provided direct support and carer				
		Joint training with Criminal Justice partners	**H. Ostele** (CAS Learning & Developments)	March 2014 Onwards	As above. Awareness training underway. 2 sessions held in September 2014.	Programme developed and delivered from March 2014
		Advice and information for Carers				

	Quality Outcome/Service Ambition	Action	Lead Person	Date for Completion	Update 1.10.14	Progress Monitoring/Outcomes Indicator
6.	Adults with autism and Carers receive regular information about autism support services in County Durham	Regular Service updates to be provided to Carers Centres & Partnership groups	**D. Shipman** (CAS)	Quarterly	Service update provided through the carers Echo and DCC staff publications. Quarterly meetings with the carers support service.	
		Market Place event for Autism Service providers	**S. Garrett**	March 2014	Event held March 2014.	
		Marketing/Publicity/Press releases	**C. Smith**	On-going	Releases in Carers Echo and DCC staff updates. Press adverts taken out by MAIN	On-going
		On-going support from Co Durham Carers support	CDCS	On-going	Service takes up issues with individual carers as an ongoing part of their role.	On-going
7.	Older adults with autism received appropriate support	Work with colleagues in Older peoples Services to identify any autism specific issues	**Denise Elliott**	March 2014	No older people with autism identified through DCC older persons service. MAIN working with one older person.	To be determined
		Develop responses to identified issues	**Denise Elliott**	Sept 2014	Support available to individual identified. Training available to service providers who may work with older people.	To be determined
8.	Younger adults with autism have access to social activities and achieve greater social inclusion	Work with voluntary sector partners, KK2 and the MAIN Project, to develop socially inclusive activities across Co Durham	**D. Shipman** (CAS)	Sept 2014	3 projects to facilitate social inclusion all operational.	Events across Co Durham up and running by Sept 2014

Health and Wellbeing Board

5 November 2014

Integrated Personal Commissioning

Report of Rachael Shimmin, Corporate Director, Children and Adults Services, Durham County Council

Nicola Bailey, Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1. The purpose of this report is to inform the Health and Wellbeing Board of the intention to submit a bid on behalf of Durham County Council and North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups, to be part of the national Integrated Personal Commissioning programme.

Background

2. Integrated Personal Commissioning (IPC) is a new voluntary approach to joining up health and social care for adults with complex needs and also, health, social care and education for children.

3. The approach is endorsed by; the Association of Directors of Adult Social Services, Think Local Act Personal, The Local Government Association and NHS England.

4. The approach consolidates a shift in power to people who use services, enabling them to shape care that is meaningful and effective for them by bringing together the totality of expenditure at an individual level to achieve three key goals:

    - That people with complex needs and their carers have a better quality of life and can achieve the outcomes that are important to them.
    - The prevention of crises in people's lives which can lead to unplanned hospital or institutional care, by keeping them well and supporting self-management.
    - The better integration and quality of care.

5. The IPC approach is based on; what matters to people and their families, co-production, partnership working, flexibility and creativity within a common framework for both care and financial models.

Durham submission

6. A submission is being developed for Durham which focuses initially on developing an IPC approach for the cohort of people within our complex needs model work.

7. The intention being that this could be expanded as the model develops to include other group's i.e. young people going through transitions, frail elderly people.

8. The deadline for submission is 7 November 2014. The submission is required to be signed off by the Chair of the Health and Wellbeing Board.

Next steps

9. NHS England is anticipating that approximately ten sites will be selected from the submissions in December 2014.

10. Support would commence in January 2015 to assist in the development of both the financial and care models required to progress IPC, the intention being that by April 2015 implementation would commence on a shadow basis.

11. Additionally there will be some money available to support the process but as yet it is unknown exactly what this will be.

Recommendations

12. The Health and Wellbeing Board is recommended to:

- Support the submission of a bid.
- Delegate authority to Cllr Lucy Hovvels as Chair of the Board to formally sign off the submission.
- Receive updates on the outcome of the submission.

Contact: Jane Robinson, Head of Commissioning, Durham County Council
Tel: 03000 267357

Appendix 1: Implications

Finance
To be determined - Finance to support the process is available but as yet it has not been made clear how much this will be or for what purpose.

Staffing
No implications.

Risk
There are no risks associated with the submission of the bid. Detailed risk assessments regarding the implementation of IPC would be done as part of the implementation process.

Equality and Diversity / Public Sector Equality Duty
No implications.

Accommodation
No implications.

Crime and Disorder
No implications.

Human Rights
No implications.

Consultation
Ongoing with all relevant partner organisations.
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Procurement
No implications at this stage.

Disability Issues
IPC would support people with complex needs.

Legal Implications
There are no risks associated with the submission of the bid.

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Health and Wellbeing Board

5 November 2014

Winterbourne View Concordat and Action Plan Implementation in County Durham

Report of Jane Robinson, 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 the Health and Wellbeing Board (June 2013 and November 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. This has been completed.
    - Review of those people by 31 May 2013. This has been completed
    - Development of plans to move people to appropriate local placements. Work in this area is underway and ongoing.
    - Transfer to community based settings by June 2014. Work is on-going in this area.

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. Operating under the banner of the 'Complex Needs Project Group', initial scoping work led to an Issues & Options paper which was considered early in 2014. The group are currently working to develop an accommodation-based service, and having jointly agreed the service model are exploring options at a location in East Durham.

6. The primary focus has widened from the ten people with Learning Disabilities on the Winterbourne register, and now includes those currently in hospital accommodation with a broad range of complex needs who require community-based services.

7. Alongside the Complex Needs Project Group, detailed work has been undertaken in relation to children and young people and people with forensic needs. Local capacity for clients with forensic needs has increased, but there remains an identified gap in the market for those individuals who challenge or are not fully compliant with services.

8. The joint commissioning issues are being dealt with through the Learning Disability Joint Commissioning Group, chaired by the Head of Commissioning for Durham County Council, Jane Robinson. 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. The need to identify capital investment to develop specialist provision is also being considered, and consideration is currently being given to a local bid for funds from the Integrated Personal Commissioning Programme. The task group described in paragraph 5 is now established, and the group operates on the understanding that the services proposed will be jointly funded.

9. At the time of both of the previous reports to the Health and Wellbeing Board, 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 and the work on organisational change and future service design and commissioning is at an early stage. The need for an explicit 'road map' for all authority areas has been raised by the Corporate Director at national level.

10. For the ten individuals named on the Winterbourne Register, initial plans are in place to either identify suitable placements locally or to develop new services where required. Detailed individual work including a jointly commissioned package with Darlington Borough Council for two of the individuals is underway. It is expected that the remaining individuals will either be accommodated in existing services or the new service currently being developed by the Complex Needs Project Group.

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

12. Advocacy services remain 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. We have engaged with a broad range of service providers to undertake detailed assessments of individuals so that we can identify appropriate services at a fair and transparent cost.

15. Progress will be reported back to the Department of Health via the most recent Learning Disability Self-Assessment Framework, which is currently underway and which should be completed by January 2015

16. To ensure that Winterbourne View work remains a priority for Health and Wellbeing Board the Department of Health have issued guidance in July 2014, see **Appendix 2**.

17. The practical guide identifies five key enablers to guide Health and Wellbeing Board's in leading a robust and effective local response, as follows;

    - Engaging with individuals, families, carers and advocates
    - Building a comprehensive understanding of assets, needs and priorities
    - Encouraging change in commissioning behaviour
    - Driving integration and co-ordination
    - Delivering the front strategic plan

18. The guide also came with a survey template asking each Local Authority area to evidence how the Winterbourne activity and broader Learning Disability issues have been fed into the Health and Wellbeing Board agenda.

19. The survey asked whether the Health and Wellbeing Board has an identified Learning Disability Champion. Given that Cllr Morris Nicholls as Portfolio Holder for Adult Services, has had a long and in depth involvement with the Learning Disability Engagement Forum (previously the Partnership Board), it would be appropriate for Cllr Nicholls to take on this 'figure head' role, subject to the endorsement of the Health and Wellbeing Board.

20. The Health and Wellbeing Board is recommended to:

- Receive 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.
- Receive further progress updates, including a detailed action plan in relation to any significant 'resource shifts' from hospital to community-based services.
- In line with guidance dated July 2014 from the Department of Health, the Health & Wellbeing Board endorses Cllr Morris Nicholls as the champion responsible for Learning Disabilities.

Contact: **Jane Robinson, Head of Commissioning, Durham County Council**
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 boards: leading local response to Winterbourne View

A practical guide for health and wellbeing boards

July 2014

Key points

- Leading local response to Winterbourne View is an important role for all health and wellbeing boards, irrespective of whether the local area has inpatient care placements.
- Boards will want assurance appropriate person-centred, community-based services are in place to meet the needs of any local people in this vulnerable group; to limit problems arising, manage any problems that do arise, and prevent future institutional admissions.
- Assimilating the joint plan into the JSNA and JHWS process can have significant benefits.
- Approaches used for integrated working and joint commissioning, for example the Better Care Fund, may be relevant for other complex, multi-agency issues.

Health and wellbeing boards can play a significant role in leading local response to Winterbourne View – making a real difference by helping reshape local services to improve health outcomes for children and adults with learning disabilities and/or autism who have mental health conditions or behaviour that challenges.

The abuse scandal at Winterbourne View brought into focus the need to permanently transform care and support for people in this vulnerable group. Local partners need to be working together with a sense of urgency to find solutions that are right for each individual. Local leaders – working through their health and wellbeing boards – can play a crucial role as champions for progress.

At a glance

- **Audience:** This guide is aimed at all health and wellbeing board members, and in particular councillors and commissioners.
- **Purpose:** To provide practical information and guidance on the significant role health and wellbeing boards can play in leading local response to Winterbourne View.
- **Development:** This resource was developed by a working group including NHS Confederation, the Local Government Association, NHS England, Regional Voices and the Winterbourne View Joint Improvement Programme.

Supported by

Local Government Association

NHS CONFEDERATION

regional voices for better health

NHS England

There is an opportunity for health and wellbeing boards to not only help achieve a sizeable and permanent reduction in the numbers of local people who are inpatients in secure hospitals or assessment and treatment settings, but to create a lasting legacy of local, personalised, community-based support for individuals and their families.

Commitments in the Winterbourne View Concordat and Department of Health's Transforming Care report include:

- health and care commissioners to review all current placements and support those people inappropriately placed in inpatient / hospital settings to move into community-based support
- every area to develop a locally agreed joint plan for high-quality care and support, focused on prevention and sustainability, to reduce reliance on inpatient care for this group.

Background

Transforming care and support services for people with learning disabilities or autism, who have mental health conditions or behaviour that challenges, necessitates a significant shift in the planning and practice of local commissioners. The presumption should be that services are local and integrated around the needs of the individual, and that people remain in their local communities. This approach requires more focus on community-based services, prevention and early intervention. Health and wellbeing boards (HWBs) can play a significant role in leading local change.

Recent learning disability census data identified 3,250 people with a learning disability and/or autism with a mental health condition or behaviour that challenges, who are in secure hospitals or assessment and treatment settings. Many people in this vulnerable group have been inpatients for a long time: 60 per cent for a year or more, and 18 per cent for five years or longer.

Furthermore, around one in five inpatients are in units over 100km from home. For more information see: **www.hscic.gov.uk/catalogue/PUB13149/ld-census-initial-eng-sep13-rep.pdf**

Case study: Gavin's story

Gavin spent many years in assessment and treatment units between the ages of 20 and 35 years. With appropriate support he is now able to live independently in his own community. He has a community learning disability nurse who visits him once a month and uses a direct payment for nine hours of support each week, including help with housework, washing and cooking. Since 2011, Gavin has been a councillor for Selby Town Council. To read more about Gavin's story see: **www.local.gov.uk/web/guest/place-i-call-home/-/journal_content/56/10180/5969117/ARTICLE**

The Winterbourne View Joint Improvement Programme (WVJIP), led by the Local Government Association and NHS England, is working with and supporting local areas to transform services, building on and sharing current good practice. For more information on improvement activity and support options, see: **www.local.gov.uk/place-i-call-home** and **www.england.nhs.uk/ourwork/qual-clin-lead/wint-view-impr-prog/**

At the request of local areas, the WVJP has clarified and defined key individuals included within the remit of the programme, see: **www.local.gov.uk/place-i-call-home** and published status reports for each HWB area identifying progress across a number of key issues, including funding and commissioning. See: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/5765518/ARTICLE**

Key questions health and wellbeing board members might ask

1. Does the board know how many local people in the vulnerable group are currently in hospital, within the local area and outside it; and does this number equate with the latest data available from NHS England?
2. Is the board aware of the planned discharge date for all vulnerable individuals, so as to ensure the required support is in place for their return to the local area?
3. Is the board working in a proactive, co-productive and collaborative way with individuals and their families, carers and advocates to identify and understand their assets, needs and priorities?
4. Will there be effective commissioning procedures and processes in place by June 2014 that will lead to a permanent reduction in the number of local vulnerable people in secure hospitals or assessment and treatment settings?
5. Will any individual on discharge from inpatient care be appropriately supported in a local, personalised, community-based setting?
6. Is the board exploring all possible integration and joint commissioning options to best deliver expanded and improved person-centred community provision?
7. Is there effective partnership working across the whole local system, including with providers, to provide appropriate local services to meet the identified needs and future anticipated needs of any local people in the vulnerable group?
8. Are appropriate services in place for prevention and early intervention for children, young people and families, including well targeted support for individuals at early risk?
9. Has the joint strategic plan been assimilated into the JSNA and JHWS process to enable a more strategic approach to commissioning services for children and adults in this vulnerable group?
10. Are there well developed, suitable and effective safeguarding procedures and processes in place locally, used appropriately?
11. Is the board clearly communicating what is being done to change how health and wellbeing services are designed and delivered?

Enablers for leading local response

This resource sets out five key enablers to guide HWBs in leading a robust and effective local response to Winterbourne View. Linked local case studies can be viewed in the appendix.

- Engaging with individuals, their families, carers and advocates
- Building a comprehensive understanding of assets, needs and priorities
- Encouraging change in commissioning behaviour
- Driving integration and coordination
- Delivering the joint strategic plan.

1. Engaging with individuals, their families, carers and advocates

Effective engagement with individuals, their families, carers and advocates, working in co-productive partnership in the planning, design, inspection and review of local community services is important. HWBs will want to ensure decisions are always made with an individual and their family's best

interests as the guiding principle. With a seat on the board, local Healthwatch has an integral role, but their efforts could be supplemented to achieve engagement more widely and deeply. Some local voluntary and community organisations are likely to have expertise in proactive and meaningful engagement. Local Learning Disability Partnership Boards (LDPBs), Autism Partnership Boards (APBs), and local mental health networks will have valuable knowledge that can be accessed. Community-based providers offer another helpful route to engagement. It will be beneficial to actively involve these local partners as local plans are developed.

'HWBs will want to ensure decisions are always made with an individual and their family's best interests as the guiding principle.'

To raise public confidence in the quality of health and care provision for people in this vulnerable group, the HWB will want to communicate what is being done to change how health and wellbeing services are designed and delivered and be transparent about progress. HWB can publish and share their stocktake, status reports, and local area plan for example, and provide updates on how services are developing and numbers of inpatients in this vulnerable group decreasing.

For more guidance, see appendix: *Case study 1: Facilitating the involvement of individuals, their families, carers and advocates, in Salford.*

2. Building a comprehensive understanding of assets, needs and priorities

To support development of the joint strategic plan, the board could be asking whether there is a comprehensive picture of the assets, needs and priorities of local people in this vulnerable group.

The views and stories of individuals, their families, carers and advocates are particularly valuable as they provide first-hand accounts of their needs and experiences. They can help reveal local assets and innovative ideas for how to provide more local, personalised, community-based support. Some local areas may have already undertaken a needs assessment specifically for people in this group, which is a useful resource. Joint Health and Social Care Learning Disability Self-Assessments were completed in every local authority area in 2013 and the development of local registers for all people with challenging behaviour in NHS-funded care was a key action of the Concordat. Local LDPBs, APBs and mental health networks can have considerable expertise that is helpful to access, as do specialist learning disability community teams, specialist autism teams and community mental health teams.

Future need

Anticipating future need can help achieve better person-centred strategic planning, particularly important at transition points. People with learning disabilities or autism are living longer, and more young people are anticipated to transfer from children's services with complex needs and behaviour that challenges. At the other end of the age spectrum, more people with a learning disability or autism are affected by dementia, potentially resulting in an increase in challenging behaviour with age. The health inequalities and high prevalence of co-morbidities experienced by people with learning disabilities should also be recognised in the planning and development of services.

Priorities

For the joint plan to be effective, boards might consider identifying a small number of key strategic priorities which will have the most impact. This might take into account the different type and complexity of individuals' needs, the needs of carers, evidence of what works, budget constraints, and what is possible to achieve and influence in terms of service delivery.

For more guidance, see appendix: *Case study 4: Using a dementia care pathway for people with learning disabilities in Northamptonshire.*

3. Encouraging change in commissioning behaviour

HWBs can improve outcomes for the group concerned by encouraging a significant change in local commissioning behaviour – to focus consistently on high-quality care, as well as placing increased emphasis on prevention and sustainable local care and support solutions across all age groups.

A strategic whole-system approach

HWBs can support a strategic whole-system approach to local commissioning. The development of the joint strategic plans could be assimilated into the JSNA and JHWS process, since these are based on continuous strategic assessment and planning.

Strengthening local capacity

To reduce dependency on hospital-based services, it is important that HWBs ensure local commissioners strengthen local capacity through provision of local, personalised care and support in the community. This might include infrastructure that enables independent living such as personalised day support, supported accommodation, and specialist clinical support including clinical psychology and psychiatry, and skilled community care staff. To expand capacity and choice, commissioners might also consider innovations in clinical care and treatment, including assistive technology, telecare and telehealth. Boards can support a whole local system approach, looking beyond the boundaries of conventional health and care services to meet the wider wellbeing needs and aspirations of the vulnerable people concerned – encompassing the opportunities, activities, resources and relationships available in their local communities. Care reviews for people in out-of-area placements also can provide valuable insight, particularly as to why the placements happened.

Some people may need access to assessment and treatment settings as part of their care pathway. To significantly reduce average 'inpatient' time, boards will want to ensure that where such services are commissioned they are time limited, as close to home as possible, focused from the point of admission on planning for discharge into the local community, and involve regular care reviews.

Prevention and early intervention across the life course

Commissioning services across the life course, which anticipate and prevent as well as manage care, can help achieve better health outcomes. How support is managed for children and young people has implications for the individual and their families later in life. Early identification of risk factors and proactive intervention can prevent challenging behaviour developing and limit or avoid crises. The development of local crisis intervention services can help ensure that when crises do occur, people are supported to remain in their community. Effective transition planning will help ensure continuity of support and stop people slipping through the net, especially when they move from child to adult services.

Safeguarding

Boards will inevitably be concerned that there are suitable, well developed safeguarding processes and procedures in place locally, and used appropriately. They will also want to ensure close partnership working with local safeguarding children and adult boards.

Working closely with providers

HWBs will want to have considerable influence on the delivery as well as commissioning of services to achieve the level of integration required for transforming care of people in the vulnerable group. This necessitates a more inter-cooperative relationship with providers whereby they are more actively involved in design and development, and work more closely

with commissioners to get the outcomes needed. New provider entrants and existing provider reform can help expand local capacity, and increase pace of change. For more information, see: *Stronger together: how health and wellbeing boards can work more effectively with providers* **www.nhsconfed.org/hwb**

For more guidance, see appendix: *Case study 2: Supporting vulnerable individuals to stay in their own homes in Dudley* and *Case study 3: Making use of personal budgets to support independent living in Trafford.*

4. Driving integration and coordination

Integrated working and funding across the whole local health and care system will be necessary to ensure rapid, effective expansion and improvement in person-centred, community provision.

'Pooling resources and aligning these with strategic priorities in the joint plan can release significant additional funding capacity.'

Links to wider work

Proposals in the joint strategic plan for addressing needs and priorities can set the foundation for joined-up commissioning and be used to support stronger service integration. Boards may see opportunities in joint financing arrangements that could better meet these needs and priorities.

Integrating personal budgets (social care) with new personal health budgets (NHS) for vulnerable service users could promote greater service integration at the level of the individual. Boards may also want to consider utilising new funding mechanisms for integrated work, including the Better Care Fund.

For more information, see: **www.local.gov.uk/integration-better-care-fund**

Pooling resources and aligning these with strategic priorities in the joint plan can release significant additional funding capacity. It may also need the transfer of resources from some existing services and the decommissioning of others, and perhaps development of shared services with neighbouring local areas. Such arrangements will need careful management. More formalised accountability mechanisms may be required. Boards could make use of new forms of governance to secure more effective resource use, such as linking joint commissioning plans to an overarching Section 75 agreement. The WVJIP can provide work to support more flexible financial arrangements; for more information see: **www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/5615915/ARTICLE**

At different levels

HWBs will consider integration at several different levels: across funding organisations, including local authorities and the NHS (local health and specialised commissioning); across funding streams, such as criminal justice services; through coordinated care pathways across physical and mental health and wellbeing services; and on improving the transition between children's and adults' services. HWB may also wish to use existing work making links across regions where a cross or sub-regional response is required.

Build on existing work

There may be existing local integrated plans and care pathways based around particular work areas with this vulnerable group, e.g. pathways developed by the local LDPB or APB, or child and mental health services (CAHMS). In some local areas, liaison and diversion teams are being introduced to ensure people in this vulnerable group who are in prison or police custody have joined-up health care and support. These pathways can be used as a building block for closer integration

across wider services or to support maximisation of improved life outcomes from different parts of the system.

Working across HWB boundaries

Given likely low numbers of local people in this vulnerable group, and the highly specialised nature of some necessary care and support services, consideration might be given to working across HWB boundaries, e.g. undertaking a needs assessment jointly, sharing data, designing care pathways covering combined HWB areas to best meet needs, pooling resources to invest in shared specialist services to prevent inpatient admissions. For more information on HWBs working across boundaries, see: **www.nhsconfed.org/hwb**

5. Delivering the joint strategic plan

Alignment

Joined-up plans with consistent priorities and outcomes for this vulnerable group can strengthen coordination, prevent cross-purpose working, and avoid gaps or duplication across the whole local system. Alignment is important between the joint plan and other local assessments and plans.

A toolkit has been published by the Association of Directors of Adult Social Services (ADASS), designed to help local partners develop a local joint strategic plan, and to check that the right supports, services and reviews are in place. It also sets out key questions board members might ask to be assured appropriate local actions are being taken in response to Winterbourne View. See: *Getting Things Right: a response to Winterbourne View* **www.westmidlandsiep.gov.uk/index.php?page=863**

Oversight and accountability

Board members can use both 'soft' governance mechanisms, such as shared culture, common purpose and trust, and 'hard' mechanisms, to hold each other to account. The JHWS is the most important 'hard' mechanism and incorporating the joint plan within this process can have significant benefits. Overview and Scrutiny committees can be used to ensure understanding of the health and care needs of the vulnerable group concerned, that health inequalities experienced by them are being reduced, and health and care services are integrated around their needs. For further information, see: *A guide to governance for health and wellbeing boards* at **www.nhsconfed.org/hwb** and *Health and wellbeing boards: a practical guide to governance and constitutional issues* at **www.local.gov.uk/publications/-/journal_content/56/10180/3896494/PUBLICATION**

Again it will be important that HWBs communicate what is being done to change how services are being designed and delivered for this vulnerable group, and are transparent about progress.

Monitoring and reporting on outcomes

Boards will want to be assured that there are robust systems for monitoring performance as well as evaluating whether and how outcomes have changed as a result of what they are doing. Regular monitoring can enable early intervention when performance suggests quality standards or outcomes may suffer. Any monitoring like this may also involve the local authority's Overview and Scrutiny function.

To assess how the local area is doing, it will be important for HWBs to examine relevant data. NHS England publish a quarterly data collection for all NHS commissioners in order to help local areas monitor progress against the commitments outlined in *Transforming Care* and the *Concordat*. The data includes information about transfer arrangements for patients currently in inpatient care. See: **www.england.nhs.uk/2014/03/18/wvc-data/**

Additional resources for health and wellbeing boards

- The WVJIP has published a Core Principles document to support the commissioning of high quality and safe services which meet the needs of this group. See: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/5971490/ARTICLE**
- The Government's Transforming Care report and Concordat outline the commitments by partners to improving care and support for people with learning disabilities and/or autism and behaviour that challenges following Winterbourne View, see: **www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response**
- The Winterbourne View Concordat outlines four key milestone dates for local areas, see: **www.local.gov.uk/place-i-call-home/-/journal_content/56/10180/6015966/ARTICLE**
- As part of the WVJIP, a stocktake of progress against the Transforming Care and Concordat commitments was completed by all local authorities with local partners, with an analysis of findings and good practice examples published in October 2013. For more information, see: **www.local.gov.uk/web/guest/adult-social-care/-/journal_content/56/10180/5615959/ARTICLE**
- Letter from Norman Lamb, Minister of State for Care and Support, to chairs of health and wellbeing boards, May 2013. See: **www.england.nhs.uk/wp-content/uploads/2013/05/130517-Letter-to-HWBs.pdf**
- Inclusion North has published a short guide on the various Winterbourne View reports. These resources may be helpful for local engagement work. Also included is a set of questions from the Yorkshire and Humber Family Carers Network that families and people with learning disabilities might want to ask local board members and commissioners. See: **www.inclusionnorth.org/resources/information-packs/winterbourne-view**

Email: hwb@nhsconfed.org
www.nhsconfed.org/HWB

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Health and Wellbeing Board

5 November 2014

Transfer of 0 to 5 Commissioning Responsibilities for Health Visitors and Family Nurse Partnership

Report of Anna Lynch, Director of Public Health County Durham, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the progress regarding the transfer of 0-5 commissioning responsibilities (health visitors and family nurse partnership) to local government.

Background

2. Since 1 April 2013, NHS England has been responsible for commissioning the Healthy Child Programme (HCP) for 0-5 year olds, which is delivered by health visitors and the family nurse partnership. As of 1 October 2015, the commissioning responsibility for these service areas will transfer to public health teams in local government. This transition marks the final part of the overall public health transfer to local authorities from the NHS following implementation of the Health and Social Care Act 2012.

3. Nationally the process is being led by a '0-5 Healthy Child Programme task and finish group'. The national group includes representation from NHS England, Public Health England, the Local Government Association (LGA), the Society of Local Authority Chief Executives (SOLACE), the Association of Directors of Public Health (ADPH), the Association of Directors of Children's Services (ADCS), and the central government department for Communities and Local Government.

4. The national group is supported by six work streams, these are: finance, mandation, local authority and NHS preparedness, communication, information and IT.

5. To aid in the transfer process, the 0-5 Healthy Child Programme task and finish group has issued a timetable with key dates for the transition process.

Date	Action	Update
June 2014	NHS England Area Teams were requested to share information on existing contracts and funding, and seek engagement from local authorities and providers to help establish funding baselines.	NHS England notified us that the overall contract value (2014/15) for County Durham and Darlington is £10.8m.
July 2014	Local authorities and area teams were asked to submit joint information on funding ahead of indicative funding baselines for 2015/16 being identified and shared with local authorities for a period of local authority engagement in the autumn.	Received request 1 August. Meeting with NHS England on 28 August to discuss return. Submission 12 September. DPH signed off contract allocation but wrote to national team to highlight areas of concern
September-October 2014	22 September: Regional preparation events.	Public Health Consultant and Head of Commissioning attended Nothing new shared at this stage
October 2014	Local authority consultation on funding allocations.	Awaiting national group analysis of joint financial returns and feedback on how to progress consultation
December 2014	Local government funding settlement published including 0 to 5 part year funding (i.e. from October 2015).	
January 2015	Light touch self-assessment to be completed by each area to highlight any remaining areas of concern and barriers which need to be resolved at national / local level to enable a safe transfer.	
March 2015	Target date for expansion of Health Visitor numbers and Family Nurse Partnership places.	
1 October 2015	Transfer of commissioning responsibility from NHS England to local authorities.	

Current position – National perspective

6. There has been communication from the national task and finish group regarding mandated functions and contract transfer.

   Key points are:

   - For 2015/16 the transfer of commissioning responsibilities is to be effectively a 'lift and shift'. Government has indicated that it prefers a novation of the contracts, with stability of service the main priority. Guidance is expected shortly on the government's preferred approach to contracting and novation.

- Government has issued guidance regarding its plans for mandation. It is proposing (subject to parliamentary approval) to mandate five 'universal touch points':
    - Antenatal health promoting visits;
    - New baby review;
    - 6-8 week assessments;
    - 1 year assessment;
    - 2-2½ year old review.
- Government is planning to undertake a review at 12 months of the impact of the mandation, and has a 'sunset clause' at 18 months to enable Parliament to discuss the impact of the changes. The government believes that mandation will help ensure that the recent increases in health visitor capacity will be secured and will continue, as well as ensuring the best outcomes for children and families. Government has indicated that it expects the regulations to be in place by May 2015. There is an understanding that the draft regulations will be made available for comment in advance of parliamentary approval.

- As Government intends a stable service for 2015/16, there is no change in its commitment to deliver 4,200 additional health visitors. There will also be limited changes to the section 7a agreement, which outlines the functions which are delivered by health visitors.

- From 2016/17 onwards the 0-5 baseline will be added to the existing public health grant allocation to local government.

- The Government has stated that it expects contracts to be broken down in line with how providers allocate their staff between Local Authority areas. Government believes that by splitting the contracts in this way it should ensure that Local Authorities get sufficient resources behind any contracts to meet their mandation obligations (which will be communicated when agreed). Guidance indicates that these splits are to be agreed locally between Local Authorities.

Current position – Local perspective

Governance

7. A regional core group is to be established as of 20th October 2014. The purpose of this group is:
    - To take an overview of how transfer plans are progressing;
    - To feedback to a national 'preparations' group made up of PHE, LGA and NHS colleagues;
    - To disseminate key messages in connection with the transfer
    - To identify sector-led support where appropriate.

8. A 0-5 implementation / transition group is in place for the County Durham and Darlington area, with representation from the two local authorities as well as

NHS England who are the current commissioner and County Durham and Darlington Foundation Trust (CDDFT), the provider.

9. Alongside the external partnership group, a DCC project receiver board, chaired by the Director of Public Health County Durham, has been convened to manage the transfer. This group includes representation from public health, commissioning, finance, performance, contracting, human resources, and audit. The group is receiving legal support as required.

10. The Family Nurse Partnership (FNP) is a nationally licenced programme and is held to account by a local advisory board. All data for FNP is collated nationally and fed into the advisory board. The DCC public health lead is a member of the advisory board currently and will move into a co-commissioning role as of 1st April 2015. The FNP programme is currently operating at 80% capacity. Further information is available upon request.

11. The local health visitor trajectory is on an amber alert. The local trajectory indicates 171.9 whole time equivalent (wte) health visitors across County Durham and Darlington. As of August 2014 there were 163.39 wte in post. This is 8.51 wte away from target.
There are newly qualified post holders in the process of recruitment so numbers are expected to increase in October 2014.

Communications work stream

12. In addition to papers being written for stakeholders/boards, DCC as the new commissioner and NHS England as the current commissioner, have made a commitment to meet all front line health visitor/FNP teams to talk about the transfer of commissioning and to listen to concerns and answer questions. These meetings will take place at three time points: December 2014, April 2015 and August 2015. There will also be briefings written for parents/ families to reassure the population that the universal health visitor service will be maintained across County Durham.

Information / Data work stream

13. A regional event was held in September to discuss the information needs for local authorities. The following points were made at the event:

    - There are no direct IT requirements arising from this transition
    - Child Health Information Systems (CHIS) and Child Health Record Departments (CHRD) will remain within the NHS, CHIS until at least 2020.
    - Commissioners will not require direct access to CHIS systems or CHRD
    - The FNP Information System exists and is fit for purpose, no changes are needed. Data is reported quarterly via the FNP Advisory Board which DCC sits on.

Further guidance documents are expected in November 2014 regarding a self-assessment tool to measure local authority's readiness for the transfer and an indicator guide containing Key Performance Indicators which can be used as an appendix in new contracts.

Financial Return

14. The joint finance return, completed on 12th September 2014, included a financial summary as well as a narrative commentary. This document will be used to establish the local authority allocations which will then be consulted upon in October 2014 through to December 2014.

15. The national task and finish group directed that the returns should be completed and approved by both the NHS England Area Team and the local authority. The return template:

    - Included costs for the healthy child programme, health visitors and family nurse partnership in 2014/15 and 2015/16;
    - highlighted any other contracts which may transfer as part of the process;
    - identified the split of contract between local authorities (County Durham and Darlington)
    - highlighted risks and contract assumptions associated with our transfer;
    - Identified where local areas needed additional support.

Local financial risks

16. A number of local financial risks have been highlighted in the commentary narrative:

    - Financial allocations: The national financial allocation to be announced in December 2014 will not necessarily be the final amount the Council receives. The Government is indicating that if there are any changes in the assumptions made regarding the allocations or if the contracts differ post December 2014, then further local negotiations will be required. It will be part of the Council's due diligence process to ensure that any assumptions made in the returns or in negotiations are as accurate as possible, to ensure minimisation of the possibility of any late amendments to the final contract value which may impact on the ability of the authority delivering the contract.

    - The NHS England Area team is applying a 1.6% tariff deflator into the 2015/16 budget as per national agreements. This therefore means that the 15/16 budget is reduced compared to the 14/15 allocation. The risk to front line delivery is that the budget does not meet the demand for the service.

    - The NHS England Area team has been operating a CQUIN payment method to enhance the current contact at a value of 2.5% of the contract. This has been used historically to boost delivery. Within local

government there is no CQUIN payment option. The budget for the CQUIN value is not currently earmarked to transfer across to the council to prevent the contract value being reduced by 2.5% and therefore creating a risk for front line delivery.

- The NHS England area team has undertaken an exercise to determine the percentage of time spent on commissioning health visitors and the family nurse partnership. The methodology used demonstrates 10% (0.5 days a week) of their time, across six local authority areas and three foundation trusts. Financially this equates to £18,000 between the six councils which, through a fair shares process, gives each local authority £3,000. This £3,000 will not cover the commissioning cycle support time to manage the 0 – 5 commission effectively.

17. The Director of Public Health County Durham has written a letter jointly with the Chief Executive of DCC to Public Health England (PHE) and the Local Government Association (LGA) to highlight the above financial risks and seek a solution.

18. The projected total contract value for County Durham, predicted by CDDFT provider and NHS England is £9,371,000.00 for 2015/16. This is made up of £8,713,000.00 for the health visitor service and £658,000.00 for the Family Nurse Partnership programme.

Wider Risks associated with transfer

19. A full risk assessment has been produced as part of the project plan.

20. There are a number of key issues to highlight at this stage.

These are:

- Mandation: At this point in time, although we have received general information on mandation, we have limited clarity over the specific detail. Without the detail of the mandation, it limits our ability to plan effectively. Over the longer term it could impact on our ability to integrate and align services.

- Contracting split: The current contract held by NHS England covers County Durham and Darlington. Guidance has indicated that the split of the contract is to be determined on the staffing levels currently working in each locality. The current staffing levels on the ground do not reflect the population need and leave County Durham in a slightly disadvantaged position financially.

- Timescale: Although a high-level timetable for the transfer of commissioning responsibilities has been provided by the national task and finish group, already the timetable is slipping. The project team is working locally with partners to ensure that progress and preparation takes place for the transfer of commissioning responsibilities on 1 October 2015.

- Specialist health visitors: As part of the current contract, a small number (estimated at 7 across County Durham and Darlington) of health visitors are working to the Clinical Commissioning Groups (CCG) to deliver a specialist role delivering continuing care across Durham and Darlington. These health visitors are included in the health visitor trajectory. Going forward there will need to be discussion regarding the commissioning responsibility for these staff and their delivery specification.

Next steps

21. DCC is currently awaiting feedback regarding its challenge to the financial allocation currently being proposed. If no national directive is received on some of these issues, there will be local discussions to try and resolve them. Information from the national team regarding the financial consultation period and the self-assessment is also awaited.

22. In the interim, the council continues to make progress on the transfer with the current commissioner and provider to ensure a seamless transition and that services are protected. A key focus will be progressing the local communications plan to reassure staff and key stakeholders.

Recommendations

23. The Health and Wellbeing Board is requested to:

- Note the updated position in relation to the transfer of 0-5 commissioning responsibilities.

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Appendix 1: Implications

Finance
The proposed allocation for County Durham and Darlington in 2015/16 is £11,674,000. It is anticipated that Durham County Council will receive £9,371,000 (80%) of this budget allocation, however discussions are ongoing nationally and locally regarding the financial allocation.

Staffing -
Current staff will not be affected by the transfer of the commissioning responsibilities, however there are more general concerns regarding the recruitment and retention of health visitors in the county.

Risk
The transfer is being managed by a Durham County Council project board.

Equality and Diversity / Public Sector Equality Duty
Not applicable

Accommodation
It is anticipated that there will be no accommodation implications from the transfer and that staff will continue to be based within their existing locations.

Crime and Disorder
Not applicable

Human Rights
Not applicable

Consultation
There is a project board in place to enable consultation across the key partner organisations.

Procurement
The commissioning responsibilities will be transferring to the authority. It is anticipated that this will be a process of novation.

Disability Issues
Not applicable

Legal Implications
The project board is receiving legal advice as required.

By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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