Health and Wellbeing Board

Date **Thursday 23 July 2015**
Time **9.30 am**
Venue **Robinson Room, The Glebe Centre, Murton SR7 9BX**

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. Election of Chairman
2. Appointment of Vice-Chairman
3. Apologies for Absence
4. Substitute Members
5. Declarations of Interest
6. Minutes of the Special Meeting held on 14 May 2015 (Pages 1 - 8)
7. Children & Young People's Overview and Scrutiny Review of Self Harm by Young People - Report of Overview & Scrutiny Officer (CYP), Assistant Chief Executive, Durham County Council (Pages 9 - 36)
8. Children and Young People Mental Health and Emotional Wellbeing Update - Report of Chief Operating Officer, North Durham & Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (Pages 37 - 56)
9. Health and Wellbeing Board Annual Report 2014-2015 - Report of Strategic Manager, Policy, Planning and Partnerships, Children and Adults Services, Durham County Council (Pages 57 - 88)
10. Joint Health and Wellbeing Strategy Delivery Plan 2015-18 - Report of Strategic Manager, Policy, Planning and Partnerships, Children and Adults Services, Durham County Council (Pages 89 - 132)
11. Health Protection Annual Assurance Report 2013-14 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 133 - 144)
12. Smokefree County Durham Tobacco Control Alliance Update - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 145 - 156)

13. Winter Plan and System Resilience Update - Report of Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 157 - 162)
14. Better Care Fund Update - Report of Integration Programme Manager - Joint Funded, Children and Adults Services, Durham County Council and Clinical Commissioning Groups (Pages 163 - 176)
15. Section 256 Year End Update 2014-15 - 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 & Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 177 - 180)
16. Joint Health and Wellbeing Strategy 4th Quarter 2014/15 Performance Report - Report of Head of Planning and Service Strategy, Children and Adults Services, Durham County Council (Pages 181 - 214)
17. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration
18. 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)

19. Pharmacy Applications - Report of Director of Public Health, County Durham, Children and Adults Services, Durham County Council (Pages 215 - 218)
20. 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
15 July 2015

To: The Members of the Health and Wellbeing Board

Durham County Council

Councillors L Hovvels, O Johnson and J Allen

R Shimmin	**Corporate Director of Children and Adult Services, Durham County Council**
A Lynch	**Director of Public Health County Durham, Durham County Council**
N Bailey	**North Durham Clinical Commissioning**

	Group
Dr D Smart	**North Durham Clinical Commissioning Group**
Dr S Findlay	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
J Chandy	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
S Jacques	**County Durham and Darlington NHS Foundation Trust**
A Foster	**North Tees and Hartlepool NHS Foundation Trust**
M Barkley	**Tees. Esk and Wear Valleys NHS Foundation Trust**
C Harries	**City Hospitals Sunderland NHS Foundation Trust**
J Mashiter	**Healthwatch County Durham**

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

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DURHAM COUNTY COUNCIL

At a Meeting of **Health and Wellbeing Board** held in Committee Room 2, County Hall, Durham on **Thursday 14 May 2015 at 9.30 am**

Present:

Councillor L Hovvels (Chairman)

Members of the Board:

Councillors M Nicholls and T Smith, and J Chandy, Dr S Findlay, A Lynch, C Harries, J Mashiter, R Shimmin, Dr D Smart, E Lovell and P Newton.

Also in attendance:

Councillor J Allen

The Chairman informed the Board that Dr Mike Lavender, Public Health Consultant was currently in Nepal as part of an earthquake recovery programme. He would be working with Save the Children and Childreach Nepal. He is knowledgeable about the rural village geography, both these are skills in high demand given the recent earthquakes. The Board wished him their best wishes in the work he was carrying out.

1 Apologies for Absence

Apologies for absence were received from N Bailey, M Barkley, A Foster, S Jacques and Councillor O Johnson

2 Substitute Members

Councillor T Smith for Councillor O Johnson, P Newton for M Barkley and E Lovell for S Jacques.

3 Declarations of Interest

Mr J Chandy declared an interest in Item No. 17.

4 Minutes

The Minutes of the meeting held on 11 March 2015 were confirmed by the Board as a correct record and signed by the Chairman.

With reference to Item No. 16, the Director of Public Health County Durham reported that the minute should read fluoridation and not fluoridisation. She advised that she was taking forward this issue with colleagues in the Tees area and would require a joint approach.

5 Update Report on the Outcome of the Children's Centre Review

The Board considered a report of the Head of Children's Services, Children and Adults Services, Durham County Council that gave an update on the outcome of the Council's Cabinet on 18 March 2015 relating to the Review of Children's Centres in County Durham (for copy see file of Minutes).

The Associate Director of Marketing & Communications, County Durham and Darlington NHS Foundation Trust (CDDFT), said that he had received feedback from mothers who use the breastfeeding clinics within the Children's Centres. As new mothers were encouraged to take up breastfeeding to give their children the best start in life, he asked what would happen to those services. The Head of Children's Services confirmed that there had been full consultation on the changes and services would change and would be more accessible for local people. The Head of Children's Services emphasised the need to plan out the timetables so the communities are aware of the activities taking place.

The Chief Clinical Officer, Durham, Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) added that this would be an opportunity to make services more available by integrating the services within primary care settings. He went on to say that the CCG had inherited premises from the former Primary Care Trust and encouraged partners to contact CCG Finance Directors if they wished to make use of the available venues.

The Chairman said that it was important that the right outcome was achieved for children, young people and their families and that a better model would be delivered moving forward.

Resolved:
That the report be noted.

6 Children's Services Update

The Board considered a report of the Head of Children's Services, Children and Adults Services, Durham County Council that provided an update on the national and local developments in relation to children's social care services (for copy see file of Minutes).

The Chairman thanked the Head of Children's Services for her report and congratulated the service on the successful Innovation Fund bids.

The Chief Clinical Officer DDES CCG referred to Child Sexual Exploitation (CSE) and work with GPs, and asked if it was as integrated as it could be. The Head of Children's Services explained that all partners are working together. She added that proactive information sharing was an area that needing addressing as well as the need to spot early signs of exploitation e.g. unexplained injuries or access to early contraception.

Councillor T Smith asked how neglect was defined and if there were specific guidelines. The Head of Children's Services explained that there were national definitions but that neglect is where there are impacts on a child's health and wellbeing. She emphasised that it was important to get the message across that people needed to ask for 'early help' which does not necessarily mean they will progress to a statutory care plan.

The Corporate Director of Children and Adults Services, Durham County Council (DCC) said that it was important to develop services around 'early help' to support families. GPs are also key as many of the families will be known to practices.

Resolved:

(i) That the report be noted.

(ii) That further updates in relation to the transformation of Children's Services on a six monthly basis be received.

7 Guidance for the Operationalisation of the Better Care Fund in 2015-16

The Board considered a report of the Integration Programme Manager – Joint Funded, Children and Adults Services, Durham County Council and Clinical Commissioning Groups that updated on the requirements and recommendations set out in the Better Care Fund (BCF) Operationalisation Guidance released on the 20th March 2015 (for copy see file of Minutes).

The Corporate Director of Children and Adults Services, DCC said that concern had been expressed nationally and locally about targets as many foundation trusts had seen volume increases over the winter period. There are monitoring arrangements imposed on local systems for the BCF through NHS England.

The Chief Clinical Officer DDES said that the target set for County Durham was challenging but noted that Darlington and Tees had seen reductions.

Resolved:

(i) That the report be noted.

(ii) That the agreement of the quarterly BCF performance report for submission to NHS England to the Corporate Director, Children and Adult Services, Durham County Council, the Chief Clinical Officer's ND and DDES CCG and the Chief Operating Officer, DDES CCG's be delegated in consultation with the Chair of the Health and Wellbeing Board.

8 Clinical Commissioning Group Planning Progress Update and Final Commissioning Intentions 2015-16

The Board considered a joint report of the Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups and Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that updated on progress of the refresh of North Durham Clinical Commissioning Group (ND CCG) and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) two year operational plans (for copy see file of Minutes).

The Clinical Chair of North Durham CCG advised that a shared approach across both CCGs had been taken and that quality premium indicators chosen were challenging to achieve.

The Associate Director of Marketing & Communications CDDFT advised that the outcomes of the Securing Quality in Health Services (SeQIHS) project would be available from September and would be influential in taking forward secondary care services.

The Head of Planning and Service Strategy CAS DCC said that it was important to work together to ensure that strategies were aligned to provide a whole system approach and that the performance indicators would be included in the Health and Wellbeing Boards performance framework.

Resolved:

(i) That the report be noted.
(ii) That the final CCG commissioning intentions 2015/16 be noted.
(iii) That the CCG Quality Premium Indicators be agreed.

9 Health Premium Incentive Scheme 2014-15

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council that provided an update on the Health Premium Incentive Scheme for public health 2014-15 (for copy see file of Minutes).

The Director of Public Health County Durham stated that the performance indicators under this scheme would be challenging to achieve.

Resolved:

(i) That the progress and pilot phase of the Health Premium Incentive Scheme be noted.
(ii) That the submitted local indicator as per paragraph 9, be noted.
(iii) That the uncertainty regarding incentive payment value be noted.
(iv) That the delayed timescale for payment be noted.
(v) That the Director of Public Health, County Durham would contact Public Health England to seek clarity on the methodology of the Health Premium Incentive Scheme 2014-15 be noted.

10 Approach to Reducing Diabetes in County Durham - National Diabetes Prevention Programme Demonstrator Site and CCGs' Diabetes Service Developments

The Board considered a joint report of the Director of Public Health County Durham and Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups that highlighted the initiative launched by NHS England in collaboration with Public Health England and Diabetes UK “to be the first country to implement at scale a national evidence-based diabetes prevention programme” as part of the NHS Five Year Forward View. Durham

County Council public health service was invited to register an expression of interest and has subsequently been chosen as one of seven demonstrator sites for this programme. The report also highlighted the impact and costs of diabetes to the Clinical Commissioning Groups (CCGs) and the development being progressed to establish a new diabetes service model (for copy see file of Minutes).

The Chief Clinical Officer DDES CCG highlighted that the cost of diabetes would increase considerably and, as it was preventable for some patients, a better way of supporting people to manage their condition was required. He highlighted that the cost of diabetes medication varied considerably, with no substantial difference in outcomes. He added that providers were working together to look at a new model of community based care to support people in the community without the need for secondary care interventions.

The Director of Primary Care, Development and Engagement, DDES CCG advised that the uptake was co-dependant on take of the Checks4Life programme. Work was underway with Public Health to engage general practices that were not hit hitting their targets. New commissioning arrangements were being looked at and motivation techniques were being created for newly diagnosed type 2 patients to encourage change.

Councillor Smith asked how we target lifestyle changes and asked if we had statistics on those who had changed their lifestyle e.g. success stories. The Director of Primary Care, Development and Engagement said that they signpost patients to make the right choices and use other services to correctly direct patients to the help they needed. The Chief Clinical Officer said that their focus was on prevention and recognised that it was a huge challenge to change behaviour.

The Director of Public Health County Durham advised that children and young people were a key priority. Programmes were in place to tackle childhood obesity and DDES CCG were testing different ways in which to work with partners including GPs, schools and dentists. Progress would be reported to a future meeting.

The Head of Planning and Service Strategy queried if we were sending a strong enough message about diabetes. He said that social marketing could mirror the messages sent out such as those used for smoking and domestic violence. The Director of Public Health County Durham said that they did need specific social marketing and that perhaps a collaborative message from the region could be developed. The Corporate Director of Children and Adults Services suggested that the Board write to Public Health England about a national campaign.

Councillor Nicholls said that he had seen the effects of diabetes and agreed that people should be taught about the serious consequences of losing limbs and the other health problems associated with it.

Resolved:

(i) That the selection of the Durham County Council public health service commissioned Check4Life and Just Beat It programme as one of seven demonstrator sites for the development of the National Diabetes Prevention Programme be noted.

(ii) That the future intention is to procure a diabetes prevention programme across England be noted.
(iii) That local delivery forms part of the Check4Life programme in County Durham be noted.
(iv) That the preliminary findings from the check4Life and Just Beat it programmes and their implications be noted.
(v) That the strategy group established by the CCGs to develop a diabetes service model be noted.

11 County Durham Dual Needs Strategy

The Board considered a report of the Director of Public Health County Durham, Durham County Council to provide the Health and Wellbeing Board with the refreshed copy of the County Durham Dual Needs Strategy for endorsement. This strategy builds on the existing strategy but has now been updated to account for the changes from the Health and Social Care Act 2012 (for copy see file of Minutes).

The Director of Operations, Durham and Darlington, TEWV commended the strategy as it would give people with complex needs the support they needed.

Resolved:
(i) That the Refreshed Dual Needs Strategy be endorsed.
(ii) That to receive the first year action plan and update reports on delivery of the strategy at future meetings be agreed.
(iii) That the joint commissioning opportunities to ensure the needs of those with dual needs are met be noted.

12 Feedback from County Durham's Health and Wellbeing Peer Challenge

That Board considered a report of the Strategic Manager – Policy, Planning & Partnerships, Children and Adults Services, Durham County Council that provided an update on the Local Government Association's (LGA) Health and Wellbeing Peer Challenge in County Durham (for copy see file of Minutes).

It was explained that there were four areas of best practice the LGA wanted to share with the Sector in relation to community engagement, Area Action Partnerships, the voice of the child and the relationship with Scrutiny.

The Corporate Director of Children and Adults Services said that it was testament to all of the hard work undertaken by the Board over the last couple of years.

The Chairman once again thanked all involved in this piece of work.

Resolved:
That the feedback on the Health and Wellbeing Peer Challenge and the development of an action plan to be considered at the Development Session in July 2015 be noted.

13 Healthwatch County Durham - Update

The Board considered a report of the Chair, Healthwatch County Durham that gave an update on the organisation, activities and outcomes of Healthwatch County Durham during the period October 2014 to March 2015 (for copy see file of Minutes).

The Chair of Healthwatch highlighted the strands of work and priorities. Engagement activities had seen a move away from drop in sessions in libraries and had been successful in leisure centres and hospitals where engagement with patients could take place.

The Healthwatch England special inquiry into unsafe discharge from hospital was highlighted and would form a strong focus locally. The Chair invited partners to engage with Healthwatch to take this forward.

The Associate Director of Marketing & Communications, County Durham and Darlington NHS Foundation Trust said that he would welcome the opportunity to talk to Healthwatch in relation to the Trust's discharge policy.

The Corporate Director of Children and Adults Services said that there was a broader issue for public health and engagement was different depending on age groups. She welcomed the opportunity to bring together best practice and by working collaboratively.

The Director of Public Health advised that Healthwatch may be able to access European Health funding for technology solutions to support better engagement including the use of social media.

The Head of Planning and Service Strategy added that it was worth pursuing by working together. It was also agreed that it would be of benefit to do this through the County Durham Partnership where all agencies could look at best practice and gaps in practice.

The Chair of Healthwatch concluded that she would be happy to take this work forward with partners.

Resolved:

(i) That the activities and outcomes of Healthwatch County Durham's work in gathering views, advising people and speaking up for health and social care service users be noted.

(ii) That Healthwatch County Durham Community Interest Company is now operating as an independent social enterprise be noted.

14 Health and Wellbeing - Area Action Partnership Links

The Board considered a report of the Area Action Partnership Coordinator, Assistant Chief Executive's office, Durham County Council that provided an update in relation to the work taking place to enhance the interface between Area Action Partnerships (AAPs) and the Health and Wellbeing Board to improve the alignment

of AAP developments and investments and the Board's priorities (for copy see file of Minutes).

The Strategic Manager – Policy, Planning & Partnerships, CAS DCC reported that there had been a lot of good partnership working with AAPs and the Corporate Director of Children and Adult Services suggested that partners take back details to their own organisations about what is happening at a local level.

The Director of Public Health County Durham said that AAPs were a major vehicle to be utilised as they had an extensive reach within the local community. She referred to the community based approach in terms of diabetes and thanked the AAP for the support provided.

Resolved:

(i) That the work that is taking place be noted.
(ii) That the improved alignment of work of the AAP's to the Health and Wellbeing Board be noted.
(iii) That work will progress through the Community Wellbeing Partnership.
(iv) That the AAP/public health supported projects in 2014/15.

15 Any Other Business

The Strategic Manager – Policy, Planning & Partnerships, Children and Adults Services, Durham County Council advised the Board that the 'Big Tent' event would take place on the afternoon of the 4 November 2015. It was hoped to engage a key note speaker to the event and workshops would take place discussing for example, diabetes and housing. Any suggestions about the day should be fed back to the Strategic Manager.

16 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 paragraphs 1 & 2 of Schedule 12A to the said Act.

17 Pharmacy Applications

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council 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 2015 (for copy see file of Minutes).

Resolved:

That the Board note the Pharmacy Relocation Applications received.

Health and Wellbeing Board

23 July 2015

Children & Young People's Overview and Scrutiny Review of Self Harm by Young People

Report of Ann Whitton, Overview & Scrutiny Officer (CYP), Assistant Chief Executive, Durham County Council

Purpose

1. The purpose of this report is to present the key messages and recommendations of the Children and Young People's Overview and Scrutiny Committee working group review report on Self Harm by Young People attached at Appendix 2. A copy of the full report is attached at Appendix 3.

Background

2. The Children and Young People's Overview and Scrutiny Committee added Self-harm by Young People to its work programme following its refresh at their meeting in June 2014. This was because the committee were concerned about the number of young people in County Durham who self-harm, especially those who do not come into contact with any support services. The committee wanted to raise awareness and understanding of self-harm among young people and adults.

3. The terms of reference for the review were agreed by the Committee at its meeting held on 25th September 2014. The objective of the review is to raise awareness of self-harm by young people to young people and adults involved in their lives and to investigate how early intervention and support can be increased following five key lines of inquiry:

    - What policies and practices does Durham County Council have in place to help, support, prevent and intervene early where looked after children and young people self-harm?
    - How reliable/accurate performance data is and what does it tell us about self-harm in this area compared to regional and national data.
    - What services are available in the community for young people with anxieties or mental health problems to talk to people and how accessible are these services?
    - How are schools addressing students' issues that may lead them to self-harm? What prevention and early intervention methods do they use?
    - How can awareness of self-harm be increased among young people, parents and carers and what are the signs to look out for?

4. The committee set up a working group of 14 members and gathered evidence over six meetings from key parties including:

    - Public Health.
    - Children & Adult Services.
    - North of England Commissioning Support Unit.
    - Durham Dales, Easington and Sedgefield Clinical Commissioning Group.
    - North Durham Clinical Commissioning Group.
    - Child & Adolescent Mental Health Services.
    - School Nurses.
    - Investing in Children.
    - Disc Lesbian, Gay, Bisexual and Transgender Young People's Group.
    - Representative from Framwellgate School Durham.
    - Representative from Educational Psychologists Team.
    - Representatives from Sunderland pact Support Group.
    - Representative from Mental Health North East.
    - Youth Leader and Young People from Bowburn Youth Club.

5. The review makes seven recommendations. They relate to:

    - Internet safety.
    - Development of information pages for parents/carers.
    - Update and refresh of school policies on emotional health and wellbeing; and a reminder to governors of services that can be bought in which address emotional health and wellbeing.
    - Consideration of how to engage with parents and carers to advise on the importance of good mental health and the warning signs.
    - Consideration to a single multi-agency pathway and registry of self-harm.
    - Consideration to the role youth workers/leaders can play in providing emotional and wellbeing support to young people in schools.
    - Consideration to providing basic mental health and emotional wellbeing awareness training to all staff who regularly come into contact with young people.

6 The report was presented to Cabinet at their meeting on 15 April 2015 and a systematic review that will give detail of progress made on the report's recommendations will come back to Children and Young People's Overview and Scrutiny Committee at their November meeting.

Recommendation

7 The Health and Wellbeing Board is recommended to:

- Receive the Children and Young People's Overview and Scrutiny Committee review report on Self harm by Young People.
- Note the key messages and recommendations.

Contact: Tom Gorman, Corporate Scrutiny & Performance Manager, Durham County Council
Tel: 03000 268027
Ann Whitton, Overview & Scrutiny Officer, Durham County Council
Tel: 03000 268143

Appendix 1: Implications

Finance
No implications

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
The review focuses specifically on age as a protected characteristic looking at self-harm in children and young people. The review also looked at lesbian, gay, bisexual and transgender young people as a group who are proportionately more predisposed to self-harm than compared with peers of the same age. The review report takes into consideration Equality and Diversity; an Equality Impact Assessment has been carried out and is available on request.

Accommodation
No implications

Crime and Disorder
The review report received information on the impact of alcohol on young people's offending.

Human Rights
No implications

Consultation
No implications

Procurement
No implications

Disability Issues
The report addresses the mental health and emotional wellbeing of young people

Legal Implications
No implications

APPENDIX 2 - KEY MESSAGES

- Performance data relates to a very small number of young people who self-harm. This data is limited in County Durham which is the same regionally and nationally.
- DCC and partners do have plans, policies and strategies in place which address mental health and emotional wellbeing.
- Looked after children in County Durham are well served and have access to lots of services
- Identified vulnerable groups are more likely to self-harm
- Some adults over react to self-harm which places a barrier between them and the young person
- Young people look for support online before speaking to trusted adults but online sites are not always helpful.
- There are lots of services that provide support to young people with mental health and emotional wellbeing problems but there is no single multi agency pathway or registry of self-harm.
- Lots of services are commissioned to support young people who self-harm but most of these services are targeted or specialist services that require a referral.
- CAMHS Primary Mental Health Workers work in schools, GP surgeries and the wider children's workforce to provide prevention and early intervention services.
- A single point of contact for mental health services would ensure that all incidents are logged and picked up by the appropriate service in a timely manner.
- From 2015 health visiting and school nursing services will become part of Public Health function of the Council.
- Currently all schools receive relatively the same service from School Nursing Service but different schools have different needs and therefore the service should be tailored to fit the needs within the school.
- Each school's response to self-harm is different
- Best practice suggests a whole school approach to good mental health and emotional wellbeing.
- Not all schools have the capacity or resources to offer the same package of emotional wellbeing to students.
- Young people need to be aware of e-safety
- Governing bodies should be encouraged to refresh and update their policies and procedures on emotional wellbeing
- Internet safety is a major concern and should be addressed at all levels in school, in the community and at home.
- All adults who come into contact with young people should have mental health and emotional wellbeing training.
- Parents and schools need to have a mutual level of communication in relation to their children's mental health and emotional wellbeing.
- It is important to listen to what young people are saying and not trivialise or minimise what they are saying
- Young people prefer to talk to other young people
- Self-harm needs to be talked about to dispel myths and break stigma.

RECOMMENDATIONS

A. That in relation to internet safety, Cabinet place restrictions to limit internet access on personal computers in Council run buildings including libraries to ensure that sites which glorify self-harm and relevant social chat sites are prohibited access. In addition that Cabinet write to the Mental Health Minister to ask for search engine sites to recognise their moral social duty to filter search results.

B. That the Cabinet give consideration to developing specific pages for parents/carers giving information on preventing self-harm and how to support their children. Also that the pages are designed by or with direct involvement of young people who have knowledge of self-harm and emotional health and wellbeing such as help4teens.co.uk.

C. That the Cabinet highlight to school governing bodies:

   i. The necessity to refresh and update all emotional health and wellbeing policies on a regular basis specifically those that relate to self-harm.

   ii. The range of emotional health and wellbeing services that can be bought in to support children and young people especially those provided for free by Public Health.

D. That Cabinet request the Corporate Director of Children and Adult Services, the Director of Public Health, the Local Safeguarding Children Board, the Joint Health and Wellbeing Board and the Children and Families Partnership give consideration as to how to engage with parents of children to advise on the importance of good mental health and the warning signs to look out for in relation to risk taking behaviours.

E. That through discussions at the Health and Wellbeing Board, appropriate commissioners and providers give consideration to the establishment of a single point of contact for services that offer mental health service and support which would ensure that all incidents are logged and picked up by the appropriate service in a timely manner and in doing so create a single multi-agency pathway and registry of self-harm.

F. That Cabinet give consideration to how youth services leaders/workers, school nurses and health visitors can have a role in schools in relation to emotional health and wellbeing support to young people.

G. That Cabinet give consideration to providing all adults (School Staff, Children's Home Staff, Youth Services Staff) who come into contact with young people on a regular basis receive basic mental health and emotional wellbeing awareness training.

Children and Young People's Overview and Scrutiny Review Self-Harm amongst Young People

Children and Young People's Overview and Scrutiny Committee

Please ask us if you would like this document summarised in another language or format.

العربية (Arabic) (中文 (繁體字)) (Chinese) اردو (Urdu)

polski (Polish) ਪੰਜਾਬੀ (Punjabi) Español (Spanish)

বাংলা (Bengali) हिन्दी (Hindi) Deutsch (German)

Français (French) Türkçe (Turkish) Melayu (Malay)

Overview & Scrutiny

03000 268143

 Braille  Audio AAA Large Print

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Chair's Foreword

There are increasing pressures put upon our young people today, whether it is exam pressure, parental expectations, body image, social media or relationship issues. This is why we all should be aware of how to notice any changes in behaviour of the young people in our lives and make sure they are able to confide in someone who they trust.

The review received information on how reliable and accurate performance information is; how looked after children are supported; services available to young people in the community; how schools address self-harm and how can awareness of self-harm be increased among young people, parents and carers.

I would like to thank all those who have contributed to this review, fellow Councillors and Co-optees from Children and Young People's Overview and Scrutiny Committee, especially Councillor Christine Potts the Vice Chair for her support. I would also like to extend thanks to officers from Children and Adult Services, Public Health, North of England Commissioning Support Unit, North Durham and DDES CCGs, Framwellgate School Durham, DISC LGBT Group, Sunderland Pact Group, Mental Health North East, DJ Evans Boys Club Bowburn, Investing in Children and of course the many young people from County Durham who have help us in this review.

Councillor Jan Blakey
Chair Children and Young People's
Overview and Scrutiny Committee

Background & Methodology

Introduction

1. The Children and Young People's Overview and Scrutiny Committee decided to carry out the review following concern about the number of young people in County Durham who self-harm, especially those who do not come into contact with services. Nationally available data showed that hospitalised admissions due to intentional self-harm in County Durham were higher than average. The committee wanted to raise awareness and understanding of self-harm among young people and adults.

2. Young people who self-harm go to great lengths to conceal their scars and bruises from friends, carers, parents and teachers. They try to keep their actions secret, being aware of the stigma of self-harm but the burden of guilt weighs heavy and impacts on their relationships with family and friends and can make them feel worse.

3. Self-harm is not a core problem but is a sign and symptom of underlying emotional difficulties and is used as a way of coping. Young people who have self-harmed have said that by performing acts of self-harm they feel as if they are in control. They cannot control what is happening around them but they can control what they do to themselves. Emotional wellbeing is a significant factor in a person's health which impacts on their ability to work. In a young person this would affect their educational attainment would in turn reduce their aspirations and opportunities.

Purpose

4. The purpose of this review is to raise awareness and understanding of self-harm by young people and in doing so highlight to young people, parents and carers where support can be found.

Terms of Reference

5. The terms of reference for the review were agreed by the Committee at its meeting held on 25th September 2014. The objective of the review is to raise awareness of self-harm by young people to young people and adults involved in their lives and to investigate how early intervention and support can be increased following five key lines of inquiry.
    - What policies and practices does Durham County Council have in place to help, support, prevent and intervene early where looked after children and young people self-harm?
    - How reliable/accurate performance data is and what does it tell us about self-harm in this area compared to regional and national data.
    - What services are available in the community for young people with anxieties or mental health problems to talk to people and how accessible are these services?
    - How are schools addressing students' issues that may lead them to self-harm? What prevention and early intervention methods do they use?

- How can awareness of self-harm be increased among young people, parents and carers and what are the signs to look out for?

6. The committee set up a working group of 14 members who gathered evidence over six meetings from key parties including:
    - Public Health
    - Children & Adult Services
    - North of England Commissioning Support Unit
    - DDES CCG
    - North Durham CCG
    - Child & Adolescent Mental Health Services (CAMHS)
    - School Nurses
    - Investing in Children
    - DISC Lesbian, Gay, Bisexual and Transgender Young People's Group
    - Representative from Framwellgate School Durham
    - Representative from Educational Psychologists Team
    - Representatives from Sunderland pact Support Group
    - Representative from Mental Health North East
    - Youth Leader and Young People from Bowburn Youth Club.

Information to Support the Review

National Policy & Research

7. The working group considered the national policy and key research documents listed below to be key drivers of good mental health.
    - No Health Without Mental Health 2011
    - NICE Guidance 116, 133 and QS34
    - Health and Social Care Act, 2012
    - Children and Families Act 2014
    - Closing the Gap on Mental Health 2014
    - Public Health Outcomes Framework 2011
    - Chief Medical Officers' Annual Report 2013
    - 0-25 Special Educational Needs and Disabilities Code of Practice
    - Managing Self Harm by Young People 2014

8. The key national policy driver is 'No Health without Mental Health' (2011) which is the Governments' Mental Health Strategy and indicates that self-harming by young people is not uncommon. However only a fraction of cases are seen in hospital settings, therefore all those in contact with young people should be aware of how and when to refer someone for further assessment and support.

9. The National Institute for Clinical Excellence (NICE) published in June 2013 a new quality standard to improve the quality of care and support for young people who self-harm. This guidance covers the management of self-harm and the provision of long term support for children and young people over the age of eight.

10. NICE guidance indicates that self-injury is more common than self-poisoning as an act of self-harm, although people who self-poison are more likely to

seek professional medical help. An individual case of self-harm might be an attempt at taking one's own life although acts of self-harm are not always connected to attempted suicide. Self-harm is viewed as a way of coping with overwhelming feelings or situations and can be a way of preventing suicide. This can be difficult for people to understand including people who work in the medical profession.

11. It has been reported that in some medical settings clinicians are not as compassionate when dealing with young people who have self-harmed. NICE have produced guidance CG133 and a quality standard (QS34) to address these issues.

12. Closing the Gap: Priorities for essential change in mental health (2014) identifies that changes will be made in the way front line services respond to self-harm in emergency room settings and sets out how GPs should respond when self-harm is disclosed. Furthermore the document details how the introduction of a new indicator that specifically addresses self-harm in the Public Health Outcomes Framework can help us understand the prevalence of self-harm and also how Emergency Departments are responding.

13. The Public Health Outcomes Framework (2013) includes a definition of a new indicator on self-harm which makes clear the priority given to the prevention and management of self-harm across local authority and NHS services. As well as reflecting attendances at emergency departments for self-harm, the indicator will also capture how many attendances received by psychological assessment.

14. The Annual Report of the Chief Medical Officer 2013, indicates that mental health problems in children and young people are common and specifically references the increase of self-harm particularly in adolescence and those with a mental disorder.

15. The Children and Families Act 2014 sets out to reform and improve services for vulnerable children and their families. The Act includes transformation of the system for children and young people with special educational needs and disabilities. These reforms include improving co-operation between all the services that support children and their families, particularly requiring local authorities and health authorities to work together.

16. Managing Self-harm by Young People (2014) by the Royal College of Psychiatrists explains that the patterns of self-harm in children and young people have grown with the increase of digital communications. The report discusses the vast array of social media sites and cites anonymity is often associated with bullying however they allow young people to explore difficult issues such as self-image concerns, anxiety and relationship worries.

Local Policy

17. From a local policy context the working group considered the following:
    - Council Plan 2014-2017
    - Sustainable Community Strategy 2014-2030

- Children, Young People & Families Plan 2014-2017
- Joint Health & Wellbeing Strategy 2014-2017
- Joint Health and Wellbeing Board Annual Report 2013
- Public Mental Health Strategy
- CAMHS Interim Strategy

18. The Council Plan sets out what the Council aims to achieve for the population of County Durham over the next three years. The 'Altogether Better for Children and Young People' priority theme has three policy objectives and the one that relates to this review is 'that children and young people make healthy choices and have the best start in life.' This objective indicates that good emotional health and wellbeing is crucial in the development of resilient healthy children and young people.

19. This objective is shared in the Children, Young People's and Families Plan and the Health and wellbeing Strategy which are key documents that set out partnership arrangements for the Children and Families Partnership and the Joint Health and Wellbeing Board. Within the objective the Children, Young People's and Families Plan has an outcome that children and young people become more resilient and specifically mentions the need for partners to work together to reduce the incidence of self-harm. The Joint Health and Wellbeing Strategy address the need to reduce the incidents of self-harm by young people and to improve the mental health and physical wellbeing of the population.

20. The Public Health Mental Health Strategy has a vision that individuals, families and communities within County Durham are supported to achieve their optimum mental wellbeing. There are five objectives under the heading prevention of mental ill health, objective three addresses the need to reduce the suicide and self-harm rate for County Durham. The strategy indicates that Self-harm is an expression of personal distress. It can result from a wide range of psychiatric, psychological, social and physical problems and self-harm can be a risk factor for subsequent suicide.

21. A Child and Adolescents Mental Health Services (CAMHS) Joint Interim Mental Health Strategy has been developed by local Clinical Commissioning Groups and Durham County Council as an interim measure whilst a more detailed piece of work is being undertaken to develop a three year Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan commencing in 2015. This interim strategy supports local delivery of the national No Health without Mental Health Strategy.

22. Work is continuing on developing a Mental Health, Emotional Wellbeing and Resilience Plan for County Durham. This encompassing plan will supersede the interim CAMHS Strategy and support the local delivery of the national No Health without Mental Health Outcomes Strategy. It will ensure that the needs of the local population are being met.

Evidence

What is Self-Harm?

23. The broad definition of self-harm is when a person harms or injures themselves. Young Minds publication 'Worried about self-harm?' indicates that self-harm is a way of dealing with very difficult feelings that build up.

24. Evidence from Public Health indicates that young people who self-harm go to great lengths to hide their scars and bruises from parents, carers and friends. They try to keep their actions secret but the awareness of the stigma of self-harm and the burden of guilt impacts upon their relationships with their family and friends which makes them feel worse and perpetuates the self-harming.

25. Self-harming actions might include:-
    - Cutting or scratching;
    - Burning;
    - Hitting or banging arms, legs or head;
    - Putting objects under the skin;
    - Deliberately taking overdoses of drugs, alcohol and other substances;
    - Taking risks with the intention of causing self-harm;
    - Self-strangulation.

26. Self-harm is usually a symptom of an underlying emotional problem which young people find difficult to cope with. The NSPCC publication *Your Guide to Keeping Your Child Safe* indicates there are links between self-harm and depression and often a young person who is being bullied, under too much pressure to do well at school, being emotionally abused, grieving, or having relationship problems with family or friends will self-harm. Often the physical pain of self-harm distracts from the emotional pain that is behind it. The document goes on to say that for some young people self-harming makes them feel as if they have some control of their life or that they feel they should be punished for something they have done. Managing Self-harm in Young People 2014 suggests that poor support and care breakdown may also be factors of self-harm and states that prolonged lack of communication promotes progression of self-harm into a vicious downward spiral.[1]

27. A report by Young Minds in partnership with the Cello Group suggests that more and more children and young people are using self-harm as a mechanism to cope with the pressures of life. Self-harm is often dismissed as merely attention seeking behaviour but it's a sign that young people are feeling terrible internal pain and are not coping[2]. With the correct support, access to services and change in circumstances most young people will overcome the need to self-harm but this is also very dependent on the individual and there will be some who continue to suffer mental health and anxiety problems into adulthood.

[1] Managing self-harm by young people, Royal College of Psychiatrists, 2014
[2] Talking Self Harm by Young Minds & Cello Group, 2012

28. A report published following a national inquiry in 2006 suggests that while there is no evidence to support that self-harm is addictive there is evidence to support that chemicals in the brain are released when a person is injured which acts like an opioid analgesic which makes the person calm. However the body may begin to expect a higher level of these chemicals that would require a greater level of harm to be inflicted to achieve the same effect.[3]

Performance Information

Key Findings

- Data is limited in County Durham which is the same regionally and nationally.
- Performance data relates to a very small number of young people who self-harm .

29. Definitive data on self-harm is difficult to obtain and statistics are unreliable as many incidents of self-harm are not reported, carried out in private and medical help is not usually sought. Reported data tells us how many young people were admitted to hospital as a result of self-harm but this relates mostly to self-poisoning incidents, (e.g., overdose) and as not all young people who self-harm end up in hospital there is no way of knowing how many young people actually self-harm.

30. Within the performance management information presented to Children and Young People's Overview and Scrutiny Committee there is a tracker indicator in relation to the number of young people aged 10 to 24 years who were admitted to hospital as a result of self-harm (the figure relates to a rate per 100,000 per population aged 10 to 24 years.) This performance tracker indicator has recently changed from 0-18 years to 10-24 years and the Council's Public Health team have requested that information is captured for both age ranges to enable them to consider the data across all children and young people. The information shown in the table below indicates hospital admissions as a result of self-harm data for young people aged 10 – 24 years pooled years; this data refers to episodes of admissions and not persons.

Hospital admissions as a result of self-harm 2007/08-2009/10	Hospital admissions as a result of self-harm 2008/09 – 2010/11	Hospital admissions as a result of self-harm 2009/10 – 2011/12	Hospital admissions as a result of self-harm 2010/11 – 2012/13
560.2	586.3	561.8	504.8

Source: Public Health England: National Child and Maternal Health Intelligence Network as accessed 1/12/14

31. Public Health England provide a snap shot of child health for County Durham, this information that was produced in March 2014, in relation to young people's mental health the report indicates that: In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is higher

[3] Truth Hurts – Report of the National Inquiry into Self Harm among Young People,2006

than the England average. Nationally, levels of self-harm are higher among young women than young men.

32. Nationally, prevalence of self-harm is lower than in County Durham, Public Health England Community Mental Health Profiles indicate that for 2012/13 emergency admissions for self-harm per 100,000 was 191.0 for England while figures for clinical commissioning groups in County Durham was much higher – Durham Dales CCG – 315.9 per 100,000 and North Durham CCG – 217.4 per 100,000.

33. Evidence from Public Health Portfolio Lead stated that unplanned attendances for self−harm are recorded through Hospital Episode Statistics (HES) activity in accident and emergency departments, minor injuries clinics, walk-in centres and other locations. In 2011/12 self‑harm accounted for 0.7% (119,000) of all recorded attendances across England. This data also indicates that around 60% of reported episodes were among women in the age group 15-24 years as shown in figure 1 below.

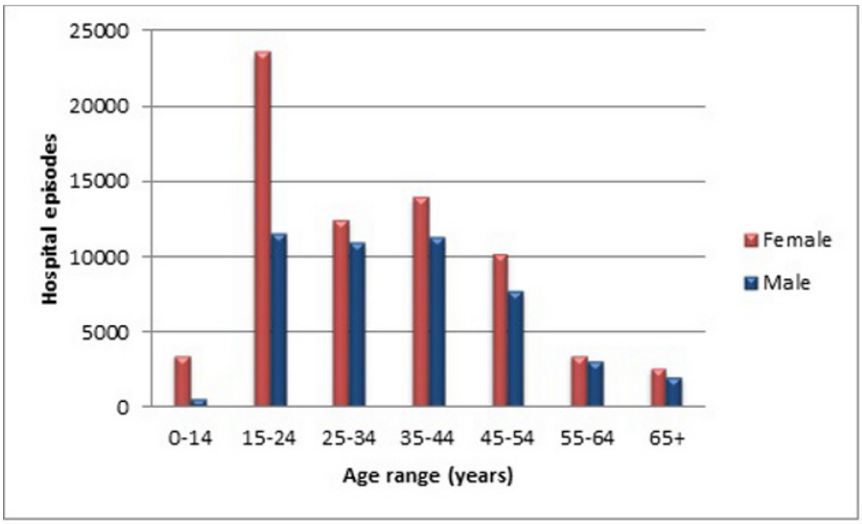

Figure1: First finished consultant episodes (FFCE) for self-harm by gender and age group 2011/12

34. HES data capture cases of intentional self-harm that result in a hospital admission. Therefore, this excludes people who intentionally self-harm and are treated in an emergency department but are not admitted.

35. Data on self-harm in County Durham is limited which is similar to the national and regional pictures. Hospital admission data only deals with a very small proportion of cases as most young people who self-harm will not come into any health services.

36. Emergency admissions rates for self-harm (all ages) for CCGs (2012-13) show North Durham CCG with the lowest self-harm rate across Durham, Darlington and Tees Area (figure 2).

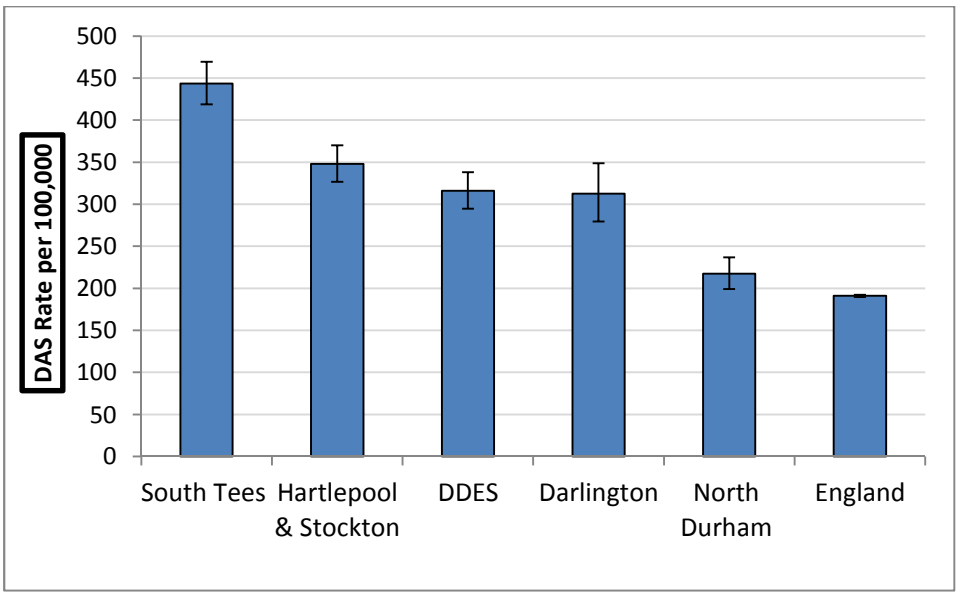

Figure 2: Directly age standardised rate per 100,000 with 95% confidence intervals emergency admissions self-harm 2012-13.[4]

37. The number of first finished consultant episodes (FFCE's) in County Durham for under 18 years are relatively low (227). Small variations in the number of FFCEs will affect relatively larger changes in crude rates. Self-harm crude admission rate per 100,000 for under 18 years in County Durham are higher than the North East, and have also shown variation over time. Rates have fallen since 2008 - 2009 (figure 3).

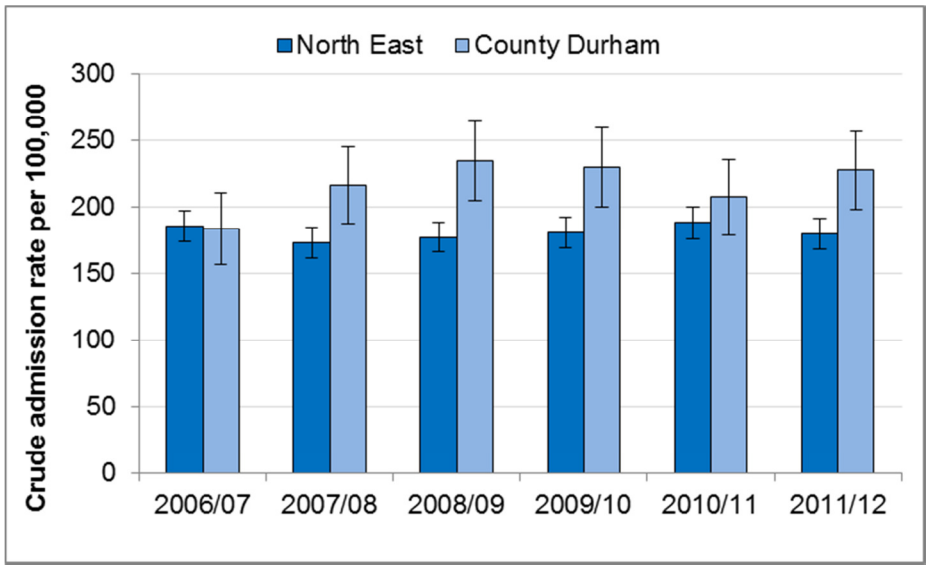

Figure 3: Self harm crude admissions rate per 100,000, aged under 18 years County Durham and North East, 2006-07 to 2011-12.

Looked after Children and other vulnerable groups

Key Findings

- Durham County Council and partners have strategies, plans and policies which address mental health and emotional wellbeing.

[4] PHE. Community Mental Health Profile. Accessed July 30th 2014.

- Looked after children in County Durham have good access to a wide range of mental health and emotional wellbeing services.
- Being in a vulnerable group does not mean the young person will self-harm but vulnerable groups are more likely to self-harm
- Young people suggest that many adults over react to self-harm and involve as many services as possible.
- Many adults are afraid of broaching the subject of self-harm in case this instigates the start of a problem.
- Young people look for support online before speaking to trusted adults but some online sites are not helpful and allow abusive comments.

38. Evidence indicates that vulnerable groups such as young people in residential settings, lesbian, gay, bisexual and transgender (LGBT) young people, young Asian women and young people with learning disabilities are more likely to self-harm. [5] In addition to this young women are four times more likely to self-harm than young men. Young LGBT people are four times more likely to suffer major depression related illness and three times more likely to suffer from generalised anxiety related disorder.[6]

39. Evidence from Child and Adolescent Mental Health Services indicated in terms of prevention, it was known that self-harm was not linked to suicide and therefore the challenge which was faced was to deliver the right service at the right time. Some incidents were 'one-offs', yet some would be the beginning of a cycle and therefore the correct pathway varied from person to person. 140 journeys through the service had been tracked and followed and from the information, it was obvious that some young people felt that the initial response to their incident was excessive.

40. Young people find it difficult to confide and share information in regard to self-harm due to the stigma associated with it and often look to the internet for support. However they should be warned about the potential dangers of online sites and be given information about trusted sites. Parents and carers find it difficult to control the sites young people access as most young people have access to the internet through their mobile phones.

41. Young people indicated that they found it difficult to communicate with some mental health workers and suggested that mental health users should be able to communicate in a way which is comfortable to them such as text messaging or via email. The young people indicated they did not always feel comfortable with face to face interviews with professionals especially when they were in business dress.

42. The third sector organisation Stonewall indicates that a lack of visibility of lesbian, gay and bisexual people in mental health services and poor measurement of access and outcomes for lesbian, gay and bisexual people has an impact on the mental health and experience of gay young people. The high incidence of attempted suicide, self-harm and homophobic bullying in

[5] The Truth about Self-Harm, Mental Health Foundation, 2008
[6] Why Schools are so important to Children's Mental Health, 2010 Accessed via www.youthspace.me 27/11/14

gay young people means mental health services must actively work to improve the health of lesbian, gay and bisexual people.

43. Young people from DISC LGBT group indicate that in their experience as soon as self-harm is mentioned there was an overreaction to involve parents, safeguarding or social services. The young people suggested that thought should be given before involving their parents as they may not want to involve their parents because self-harm could be a way of coping with parental problems. They suggested that in their opinion it would be better for an appropriate adult (teacher, youth worker, etc.) to build up a trusting relationship where the young person feels safe to explore what is to be done. Young people stressed the importance of truthfulness about confidentiality and that adults should not make promises if they cannot keep them.

44. The young people highlighted concerns over online safety and explained that they often go online to look for help and support but these sites are open for anyone to comment and some of the comments are upsetting and could incite more self-harm. It was suggested that more control is needed about good and bad sites to warn others about potential abusive or risky online sites.

45. Evidence indicates that there is no specific reporting method for self-harm in looked after children; however a joint therapeutic service called Full Circle deal with young people with mental health issues. The service consists of social workers, therapists and nurses who risk assess vulnerable young people and plan the best way of treatment.

46. A key point that was made by Looked after Children services, Educational Psychologists service and reiterated by the representative from Framwellgate School was that many adults are afraid of broaching the subject of self-harm for fear of inciting it in some way, but it is important that self-harm is addressed in a calm and sensitive and non-judgemental manner with compassion.

Services available in communities that address self-harm

Key findings

- There are lots of services that provide support to young people with mental health and emotional wellbeing problems but there is no single multi-agency pathway or a registry of self-harm.
- Lots of services are commissioned to support young people who self-harm but most of these services are targeted or specialist services that requires referral.
- CAMHS Primary Mental Health Workers work in schools, GP surgeries and the wider children's workforce to provide prevention and early intervention services.
- A single point of contact for mental health services would ensure that all incidents are logged and picked up by the appropriate service in a timely manner.
- From 2015 health visiting and school nursing services will become part of Public Health function of the Council.
- Currently all schools receive relatively the same service from School Nursing Service but different schools have different needs and

therefore the service should be tailored to fit the needs within the school.

47. Self-harm is indiscriminate and can affect anyone which makes commissioning services challenging. Evidence from North of England Commissioning Unit (NECU) suggests that self-harm is difficult to target as there is not a consistent method for gathering data due to the secretive nature of self-harm.

48. Information provided to the working group from North Durham and Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Groups (CCGs) indicates that mental health is a priority in their clear and credible plans and a crisis and self-harm service had recently been commissioned.

49. Commissioners provided the working group with a list of services to support young people who self-harm however most of these services are targeted and specialist services where young people would need a referral. A registry of self-harm would provide a measure of the numbers affected by self-harm which could be used to bench mark against other local authorities and regions.

50. Tees, Esk and Wear Valley NHS Foundation Trust provide Child and Adolescent Mental Health Service (CAMHS) advised that at tier 2 (targeted), Primary Mental Health Workers (PMHW) work in schools and GP surgeries; pilot schemes were also being run in South Durham youth centres to determine how to develop the service for young people. CAMHS work with the wider children's workforce and provide short term interventions, prevention and early intervention; they work with families and cover a range of community bases to provide these interventions. CAMHS have open access which allows anyone to contact them. Tier 3 CAMHS offer a specialist service where additional support is needed from a multi-disciplinary team. Pathways are centred on the young person and interventions are either individual or family centred dependent on circumstances.

51. The CAMHS Crisis and Liaison project is funded by North Durham and DDES CCGs until December 2015 and is fully operational across County Durham. It is open seven days a week from 8am until 10pm and from January 2015 it will be trialling a 24/7 approach. The project offers mental health assessment within the home, A&E, police custody and community settings. CAMHS remain involved with the young people until the acute episode is resolved and ensure that they are linked into ongoing multiagency care if appropriate (72 hour model) The service is embedded in accident and emergency with A&E teams contacting them as and when required and response time is within the hour. This helps the young person get back into the home environment as quickly as possible. Support is also given to the parents/carers for as long as required.

52. One of the difficulties of providing a multi-agency support network in relation to information sharing was often technology where different systems were used which may not link together. Some services were not certain of which pathway to direct a patient when dealing with less serious incidents where preventative support would benefit the individual. A single point of contact for

services offering mental health services would ensure that all incidents are logged and picked up by the appropriate service in a timely manner.

53. In relation to transitions CAMHS work with young people to develop a transitional plan when moving from CAMHS to Adult Mental Health Services (AMHS). However, young people indicated that the transition from in-patient care to outpatient care could be just as traumatic for them as moving from CAMHS to AMHS and could be overlooked.

54. From 2015 health visiting and school nursing services will become part of Public Health function of the council. This could be an opportunity to ensure that established support from Health Visitors continues into primary school. It was also suggested that in cases where parental issues were impacting on a young person's emotional and mental wellbeing adult services should become involved.

55. Evidence indicates that the school nursing service provides a universal service to schools and is accessible to pupils from the ages of 5 to 19 years. Each nurse is allocated a secondary school and a number of primary feeder schools they provide health and wellbeing drop-in session within each secondary school. In some hot spot areas they offer drop in sessions for parents in primary schools. Drop in sessions are a good opportunity to pick up on and encourage access to health support around emotional health, but due to capacity sessions are not as regular, however if a school has concerns school nurses can be contacted and will arrange to attend urgently as required.

56. The school nurses are also used as advocates in supporting young people in telling their parents/carers how they are feeling and often signposting young people to other appropriate services. The service is available term time only but it was accepted that the services should be available throughout the year. Currently all schools received relatively the same service but different schools had different needs and therefore the service should be tailored to the needs within the school.

How are schools address self-harm

Key Findings

- Each school's response to self-harm is different
- Best practice suggests a whole school approach to good mental health and emotional wellbeing.
- Not all schools have the capacity or resources to offer the same package of emotional wellbeing to students.
- Young people need to be aware of e-safety
- Governing bodies should be encouraged to refresh and update their policies and procedures on emotional wellbeing
- Internet safety is a major concern and should be addressed at all levels in school, in the community and at home.

57. Framwellgate School Durham, which is an Excel Academy Partnership Trust, provided information on how they address and manage self-harm in school with students, parents and carers. The school provides good practice in

pastoral care for its students. Tutor groups are small with a mix of students in age and ability which is tried and tested over many years in the school. Students have the facility to anonymously email staff if they have emotional wellbeing problems.

58. The school has a dedicated non-teaching pastoral team who provide support to students, parents, carers and teaching staff in order to address issues which are causing barriers to learning including self-harm. In addition the school offers a range of services to both students and their families some of which include:
    - Achievement Centre – the centre provides support and access to services which help students overcome difficulties they may have with engaging with learning. Students accessing Achievement Centre services may have medical, emotional or social needs. Staff help students develop strategies to overcome their difficulties through individualised learning plans and a wide range of support programmes.
    - Counselling Service
    - Internet Safety & Awareness Training
    - Equality and Diversity Workshops
    - Restorative Conferences
    - Mental Health Workshops

59. It should be noted that most schools offer a range of services to address emotional wellbeing which come under their safeguarding procedures. All schools receive the same amount of funding and they prioritise their spending in relation to the needs of their students. Schools can buy in services to meet their requirements and the Council's Public Health team provide mental health support services free of charge to schools, these include programmes such as Relax Kids, Mindfulness and If U Care, Share.

60. Governor Support Services provides information on services that are available for schools and governing bodies to purchase. The working group suggested that a full list of available services should be circulated to all local authority maintained school governing bodies for their information

61. Durham County Council offers schools through the Educational Development Service a range of assistance which can include:
    - Curriculum and Professional Development (CPD) for school staff around emotional and mental health of young people
    - Advice on the involvement of services
    - Advice for referrals and schools to contact other agencies
    - Advice to schools on relevant and appropriate curriculum content to cover such issues in PHSE sessions
    - Development of an area on the Durham Learning Gateway for staff around risk taking behaviours which will include self-harm, as well as e-safety; alcohol; sex and relationship education.

    Unfortunately, there is no evidence to indicate how often these services are accessed.

62. Evidence received from the Educational Psychologist team indicate the proactive work which is undertaken with schools especially secondary behavioural, emotional and social difficulties special schools carrying out therapeutic work. This may be offered as part of the school's learning agreement but can differ from school to school. The educational psychologist team offer a variety of training, therapeutic support and interventions to schools on a traded basis – which is open to all schools in the county. School counsellors work with their schools, with individuals and small groups offering weekly therapeutic input. The service supports students and staff and hopes to build capacity in schools and resilience in pupils to progress their emotional development and cope with difficult situations when they arise. It is important for schools to recognise and act upon changes in student's behaviour to look at what this is saying and try to get at the root cause of any problem the student may be facing.

63. It was suggested that schools have guidance on how to manage students' emotional wellbeing including mental health but for many schools guidance needs updating and refreshing.

64. Evidence from the Student Support Manager at Framwellgate School Durham suggests that it was important to work with students who are experiencing emotional and behavioural problems in a slow and steady manner to build the student's confidence and trust but to address issues such as confidentiality at the start of the process.

65. Evidence from young people suggests that youth leaders/workers could work in schools to provide emotional health and wellbeing support which could include support to students on risky behaviours. However, it would be wrong to assume that all young people could be reached in this way via youth workers. The young people advised that in their experience youth leaders and workers have given them tremendous support on many issues including relationship worries and anxieties, parental issues and worries about school. The young people trust the youth workers/leaders implicitly.

66. Social media and the internet is a great concern and plays a major factor in young people's lives as they have 24/7 access to internet sites via many devices. It is important that young people are made aware of internet safety from both points of view – victim and perpetrator. Young people accessing online support need to know that the site they are accessing is safe and the advice on the site is correct. Perpetrators need to be aware that they cannot hide behind a cloak of anonymity as technology is getting better all the time and IP addresses can be accessed. Members of the working group were extremely concerned about e-safety and suggested that internet access in council run buildings should be restricted to block access to some sites.

67. The working group carried out an exercise to see which self-harm sites could be accessed via desk top personal computers (PCs) in County Hall and other council premises. Safe internet sites that provided information on how to self-harm safely could be accessed via County Hall server. However other sites such as Youtube, chat rooms and Tumblr could not be accessed via PCs in County Hall but could be accessed from library PCs. The working group was

concerned that young people using libraries could access these sites and suggested that all public access PCs in council run buildings should have restrictions on access to certain sites.

Raising awareness of self-harm

Key Findings

- All adults who come into contact with young people should have mental health and emotional wellbeing training.
- Parents and schools need to have a mutual level of communication in relation to their children's mental health and emotional wellbeing.
- It is important to listen to what young people are saying and not trivialise or minimise what they are saying
- Young people prefer to talk to other young people
- Self-harm needs to be talked about to dispel myths and break stigma

68. Sunderland Pact is a parental support group for parents whose children have self-harmed. The group was started in March 2014 following a training course to educate parents about self-harm provided by Northumberland and Tyne and Wear NHS Foundation Trust at Monkwearmouth Hospital. After this five week, one hour course parents were left with no other means of support but felt that the group had helped them and they wanted the support to continue therefore they decided to set up their own support group.

69. The group is totally independent of NHS or CAMHS funding, the meeting room is provided by a supermarket free of charge. Members were interested to learn if there were similar sessions for parents in County Durham. There are currently no self-harm education sessions in County Durham but Tees, Esk and Wear Valley NHS Foundation Trust CAMHS has advised that they hope to have a very similar group up and running for parents and carers known to their services in the new year. Groups will be run in the three community team locality areas and from this they hope to establish drop in support groups in each locality. CAMHS has advised that they intend to continue the training sessions as long as there is a need to do so.

70. Parents advised that in their opinion it was important for teachers to receive training to spot emotional problems in young people to ensure issues were dealt with before they escalated out of control. It was suggested that this type of training should occur during their teacher training so they are fully equipped to deal with such issues when in post. They also felt strongly that parents should know the warning signs to enable them to help their children.

71. Evidence from a young person who had self-harmed and was now working with Mental Health North East to help other young people and suggested that when young people are seeking support they would often prefer to speak to people of their own age who had some experience of similar problems and anxieties.

72. Evidence from parents indicates that in their situations there had been long periods in-between referral times and suggested that the referral process should be more fluid. However it should be noted that these parents were

from out of the area and evidence from CAMHS indicates that referral times are coming down.

73. Parents suggested that self-harm needs to be spoken about both in and out of school which will help young people deal with their emotions and for adults to understand not to trivialise or minimise how young people are feeling during the stressful times of their lives. By talking about self-harm will help to dispel any taboos and myths about this subject, this was also suggested by residential staff and student support manager who had provided evidence to the group.

74. Information provided from young people indicates that support is often sought from youth workers who gave advice rather than telling the young person what they should do. The young people respect, trust and value youth workers and suggested that youth workers could be brought into schools to help to provide support and assistance to young people with emotional health and wellbeing problems. Young people made a further suggestion was that some sort of cognitive behaviour therapy be used to help young people devise coping strategies.

Conclusions

75. Definitive data on self-harm for County Durham is limited which is similar to both the regional and national position. The data only reflects the numbers of young people who attend hospital, however there are many more young people who self-harm but do not seek any kind of medical assistance and are not included within the data. Commissioners expressed frustration at the inconsistent methods of gathering data in relation to self-harm which makes it difficult when designing services. However a registry of self-harm would provide a greater indication of the number of young people self-harming and could be used as a benchmarking tool with other local authorities.

76. Although looked after children and young people were identified as a vulnerable group who may self-harm looked after children and young people in County Durham do have access to a very wide range of services from foster carers to psychiatrists. However it does not necessarily follow that because a young person falls into a vulnerable group they will self-harm, exposure to risks or being considered vulnerable does not mean that a young person will self-harm it could make them more resilient to pressures put upon them.

77. There is a fine balance between addressing self-harm and overreacting to a risk taking behaviour. Some incidents of self-harm are considered to be 'one-offs' but for some it could be the beginning of a cycle and therefore the correct pathway is varied from person to person. Young people suggested that there are times when adults over react by involving as many services as possible which they find more stressful.

78. The importance of good mental health and emotional wellbeing is considered in many Council and Partnership strategies and plans as identified in paragraphs 17 to 21. Work is also continuing in the preparation of a Young

People's Mental Health, Emotional Wellbeing and Resilience Plan. The Local Safeguarding Children's Board

79. There are many services commissioned to provide help and support to young people who self-harm. Yet these are targeted and specialist services that require a referral to access them, although some may be accessed through self-referral. Universally, young people have access to school nurses, GPs, teaching staff and youth workers. Young people the working group visited indicated that from this selection of professionals it is youth leaders/workers they would prefer to talk to and suggested that perhaps they could work in schools liaising with young people about emotional health and wellbeing.

80. The internet hosts a range of sites which provide good and bad information. Parents and carers should have a conversation with their child to inform them of the dangers of the internet. As a local authority we also have a duty of care for those young people accessing information via personal computers in council buildings.

81. Schools have many constraints on their time and must cater for the needs of all their students. Best practice suggests a whole school approach in relation to mental health and emotional wellbeing of students.

82. All schools receive relatively the same amount of funding and it is up to each school to prioritise how it spends its budget. Some schools have a greater focus on pastoral care of its students which could be attributed to having more students with emotional wellbeing needs. All schools provide safeguarding provision to its students which include counselling services, access to CAMHS, School Nurses and Educational Welfare and Psychology Services.

83. Internet safety for children and young people is a key concern for parents, carers and teachers alike. It is important that young people understand and are aware of the dangers when surfing the internet especially when seeking help and support for their anxieties and worries.

84. Parents need to be aware of the warning signs which may suggest their child is experiencing mental health or emotional wellbeing issues, including the signs to look out for should they suspect their child is self-harming.

85. Young people have indicated they value the relationship they have with youth workers/leaders and feel more comfortable speaking to youth leaders/workers when asking for advice in relation to risk taking behaviours including self-harm. The young people who took part in the review also suggested that they would prefer to talk to other young people rather than discussing problems with older adults.

Recommendations

86. Consideration of the review's findings has led the working Group to make the following recommendations which the Children and Young People's Overview and Scrutiny Committee will receive a systematic update at least six months following consideration of the report by Cabinet.

A. That in relation to internet safety, Cabinet place restrictions to limit internet access on personal computers in Council run buildings including libraries to ensure that sites which glorify self-harm and relevant social chat sites are prohibited access. In addition that Cabinet write to the Mental Health Minister to ask for search engine sites to recognise their moral social duty to filter search results.

B. That the Cabinet give consideration to developing specific pages for parents/carers giving information on preventing self-harm and how to support their children. Also that the pages are designed by or with direct involvement of young people who have knowledge of self-harm and emotional health and wellbeing such as help4teens.co.uk.

C. That the Cabinet highlight to school governing bodies:

   i. The necessity to refresh and update all emotional health and wellbeing policies on a regular basis specifically those that relate to self-harm.

   ii. The range of emotional health and wellbeing services that can be bought in to support children and young people especially those provided for free by Public Health.

D. That Cabinet request the Corporate Director of Children and Adult Services, the Director of Public Health, the Local Safeguarding Children Board, the Joint Health and Wellbeing Board and the Children and Families Partnership give consideration as to how to engage with parents of children to advise on the importance of good mental health and the warning signs to look out for in relation to risk taking behaviours.

E. That through discussions at the Health and Wellbeing Board, appropriate commissioners and providers give consideration to the establishment of a single point of contact for services that offer mental health service and support which would ensure that all incidents are logged and picked up by the appropriate service in a timely manner and in doing so create a single multi-agency pathway and registry of self-harm.

F. That Cabinet give consideration to how youth services leaders/workers, school nurses and health visitors can have a role in schools in relation to emotional health and wellbeing support to young people.

G. That Cabinet give consideration to providing all adults (School Staff, Children's Home Staff, Youth Services Staff) who come into contact with young people on a regular basis receive basic mental health and emotional wellbeing awareness training

Health and Wellbeing Board

23 July 2015

Children and Young People Mental Health and Emotional Wellbeing Update

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

Purpose of the report

1. The purpose of this report is to update the Health and Wellbeing Board on the implementation of County Durham Child and Adolescent Mental Services (CAMHS) Interim Joint Strategy and development of the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan, which will take into consideration the recent policy document on promoting children and young people's mental health and wellbeing (Future in Mind, 2015).

Background

2. The County Durham CAMHS Interim Joint Strategy was agreed by the Health and Wellbeing Board on 5 November 2014.

3. There was acknowledgement that the CAMHS Interim Joint Strategy would offer a holding position, while the whole system Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan is developed by the Children and Young People's Mental Health and Emotional Wellbeing (including CAMHS) Group.

4. The action plan within the Interim Joint Strategy focuses 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.

Future in Mind

5. Since the endorsement of the CAMHS Interim Joint Strategy, the Department of Health has published the 'Future in Mind Promoting, protecting and improving our children and young people's mental health and wellbeing' (March 2015).

6. 'Future in Mind' makes a number of proposals the government wishes to see by 2020. These include: tackling stigma and improving attitudes to mental illness; introducing more access and waiting time standards for services; establishing 'one stop shop' support services in the community and improving access for children and young people who are particularly vulnerable.

7. The report introduction includes a statement from Simon Stevens CEO of NHS England he stated *'Need is rising and investment and services haven't kept up. The treatment gap and the funding gap are of course linked'.* The report emphasises the need for a whole system approach to ensure that the offer to children, young people and families is comprehensive, clear and utilises all available resources.

8. The report also calls for a step change in the way care is delivered moving away from a tiered model towards one built around the needs of children, young people and their families.

9. The report followed the announcement of an additional £1.25bn investment. However, it is unclear how this will be allocated locally. Further guidance is expected from NHS England.

10. It identifies key themes fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people. Themes include:

    - Promoting resilience, prevention and early intervention
    - Improving access to effective support – a system without tiers
    - Care for the most vulnerable
    - Accountability and transparency
    - Developing the workforce

11. This report states that areas will be required to develop and agree a **Transformation Plan for Children and Young People's Mental Health and Wellbeing** which will concentrate on achieving these aspirations and clearly articulate the local offer.

12. In terms of local leadership, Future in Mind anticipates that the lead commissioner, in most cases CCGs, would draw up the Plan, working closely with Health and Wellbeing Board partners including local authorities. However, partners in County Durham have already supported that the Children and Young People's Mental Health and Emotional Wellbeing (including CAMHS) Group will lead the development of a local Plan, the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan, as noted in paragraph 3 above.

13. The North of England Strategic Clinical Networks (NESCN) is aiming to gather some local intelligence on how each CCG/ local authority and other partners are currently working to meet the 49 recommendations from the Future in Mind Report and to understand the current challenges and position of each local area. A self- assessment tool has been made available.

Update on the Implementation of CAMHS Interim Joint Strategy

14. The CAMHS Interim Joint Strategy action plan is **attached at Appendix 2**. Actions have been RAG rated.

15. Examples of progress include: refining of the governance around mental health; scoping in regard to the all age mental health needs assessment; pilot of the crisis and liaison / deliberate self-harm service, which will be evaluated as part of the CAMHS review which is being undertaken by the CCGs (detailed in the section below).

16. Work is in progress to cross reference actions with requirements in detailed in Future in Mind, which will need to be transferred into the new Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

CAMHS Review Update

17. An action with the CAMHS Interim Joint Strategy was for CCGs to undertake a review of children and young people's mental health and wellbeing services they commission, to identify potential improvement opportunities and inform commissioning decisions.

18. The CAMHS review was initiated following preliminary work which highlighted:

- A number of historic contract variations which had limited information or service descriptors.
- A number of service specifications were out of date - reviews had been postponed due to the proposed move to Cluster specifications through the Care Pathways and Packages process.
- Changes in local authorities funding contribution to the CAMHS budget.

19. Objectives of the review include:

- For each service area, gather information on access to service, activity levels, waiting times, discharge process and patient outcomes and experience – and where possible assess for added value (quality), pressures and gaps.
- Seek views of children and young people (also parents/carers) on their experience of current services and seek views of potential users of services; in order to gain an understanding of what more can be done to improve their mental wellbeing and those services commissioned.
- Identify changes to existing service specifications, quality/information requirements or identify if a full service redesign is required.
- Understand impact of funding changes.
- Propose recommendations to inform future commissioning plans.

20. In terms of engagement, the CCGs have commissioned Investing in Children to undertake an Agenda Day with young people to gather feedback on health commissioned services.

21. It is anticipated that information gathered as part of the CAMHS review will feed into wider work, and that there will be an opportunity for further engagement around how all of the wider services, including schools work together.

Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan Update

22. A multiagency group has been established to take responsibility for the development, implementation and oversight of the Children and Young People Mental Health and Emotional Wellbeing and Resilience Plan as part of the County Durham No Health without Mental Health Implementation Plan.

23. The Children and Young People's Mental Health and Emotional Wellbeing (including CAMHS) Group will develop the Children and Young People Mental Health and Emotional Wellbeing and Resilience Plan. This group is jointly chaired by Catherine Richardson, Portfolio Lead for Mental Health, Public Health and Stephen Cronin, Consultant Paediatrician, Associate Medical Director, County Durham and Darlington NHS Foundation Trust.

24. Terms of reference, for the group have been agreed and Task and finish groups have been set up to explore:

    - Prevention
    - Early identification and intervention
    - Effective care, support, treatment and recovery

25. The governance structure chart for mental health which shows the links to the Health and Wellbeing Board and the Local Safeguarding Children's Board is **attached at Appendix 3.**

26. It is anticipated that a first draft of the Children and Young People Mental Health and Emotional Wellbeing and Resilience Plan will be developed by end of July 2015 which will then be formally consulted upon over a three month period. A timeline for the consultation process is **attached at Appendix 4.**

27. The Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan will be presented to the Health and Wellbeing Board for agreement on 3rd November 2015.

Implications and Risks

28. To be aware of the risk relating to the importance of managing the transition between the Interim Joint Strategy and the new plan; whilst factoring in recent policy guidance from the Department of Health and undertaking a full consultation process.

Recommendations

29. The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Note the work taking place to develop the Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan which will include recommendations from “Future in Mind”
- Receive a draft of the Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan at its meeting in September 2015, as part of the formal consultation process.

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Appendix 1: Implications

Finance
No implications

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
Consider draft Children and Young People Mental Health, Emotional Wellbeing and Resilience Plan at its meeting in September 2015, as part of the formal consultation process

Procurement
No implications

Disability Issues
No implications

Legal Implications
No implications

Appendix 2: CAMHS Interim Joint Strategy

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	CYP MH,EW&R Group - meetings scheduled and membership identified; Terms of Reference developed	CCGs/DCC		July 2014
	Gain a more complete picture of local needs by refreshing the mental health needs assessment, identifying vulnerable groups	Scoping document for County Durham all age mental health and emotional wellbeing Health Needs Assessment available; 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 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 inform plan 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

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
1.2 Improve mental health in priority groups within County Durham	As part of mental health needs assessment identify local CYP vulnerable and priority groups	Scoping paper for needs assessment available	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	Lead named CAMHS practitioner identified; SEN Team are able to make formal requests for information to formulate EHCP assessments.	CCGs/DCC		September 2014
	Continue with nurturing attachment training as part of the fostering and adoption training programme	Training is ongoing	DCC		Ongoing
	Support a preventative approach for Looked After Children through LAC reduction strategy and adoption reforms incorporating pre-birth initiatives	New legislation from 1 May requiring therapeutic support for adopted children to address emotional wellbeing needs of both adopted and those adopting. Working group established to put in place plans and access new government funding. Pre-Birth Service report available Sept-14.	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	New integrated Drugs & Alcohol Service commenced 1-Apr-15; includes support for CYP; pathways in development with MH services; dual needs strategy includes support and interventions for children & families	DCC		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	Continue to identify and support young carers and provide early help to families with additional needs coordinated through One Point	Young Carers Workshop 17-Mar-15; action plan refreshed taking account of legislation; draft action plan presented to the County Durham young carers steering group	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.	PMHWs part of CAMHS review being undertaken by CCG; Task group 2 exploring actions re early intervention; Independent Review Officers and Full ; Circle in place – update on outcomes required	CCGs/DCC		Ongoing
2. More children and young people with mental health problems will recover					
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; PID completed; some project slippage resulting from delays in planning stakeholder engagement; CAMHS Agenda Day being explored; outputs of review will need to inform CYP MH, Emotional Wellbeing Plan	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	CCGs/TEWV		March 2015
	Ensure support/signposting is available in schools for people suffering from mental health issues	Mindfulness commissioned by Public Health – selected secondary schools; Relax Kids – approx.90 people trained to deliver nationally recognised training programme; Emotional Health & Psychological Wellbeing Service into schools; CAMHS input into schools;	CCGs/DCC		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
		school nursing currently under review, scope to explore emotional wellbeing support			
	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; need to explore baseline data on access and recovery rates	TEWV CCGs		Ongoing
	Ongoing monitoring of joint referral protocol between Full Circle and CAMHS and review	Ongoing monitoring, the protocol will be reviewed at next stakeholder meeting in November 2015.	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; update on CYPS pathway programme provided by TEWV	CCGs/TEWV		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	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 2016
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 wider plan	Needs assessment and CYP MH, Emotional Wellbeing and Resilience 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/LD health checks	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. Service user experience part of proposed MH Trust data set/information requirements; need to consider all providers	CCGs/TEWV		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
4.2 Improve access	Information on what support services are available		CCGs/TEWV		Ongoing
	Develop open access and drop in clinics	Action included in CYPFP – need to cross reference	CCGs/TEWV		March 2015
	Adopt a better use of technology within CAMHS e.g. Skype, texts appointment alerts	Action included in CYPFP - need to cross reference	CCGs/TEWV		March 2015
	Review web-based tool (previously commissioned by PCT) and make recommendation	Part of CAMHS review	CCGs		March 2015
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. Work ongoing.	DCC		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
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		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	'Scoping report for review on self-harm by young people, presented to O&S in Sept-14; working group established A group has been set up with representatives of Full Circle, CAMHS and Fostering managers to look at prevention of self-harm including guidance for foster carers. Joint training on self-harm between Full Circle, CAMHS and Crisis service.	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; interim review in progress; report to be submitted to commissioners when through internal processes.	CCGs/TEWV		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	Review pathway for paediatric self-harm admissions	Task and finish group to review pathway; 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	Guidance for school based staff being produced	DCC		March 2015
	Promote awareness of self-harm in Primary Care	Arrangements for development session for Practice Safeguarding Children Leads made; Protected Learning Time (PLT) for all GPs to be scheduled re early help / self-harm	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)	MASH live from 2-Mar-15	CCGs/DCC		Ongoing

Priority	Action(s)	Interventions / Activities / Progress	Lead organisation(s)	RAG Rating	Timescale
	Continue to work together to safeguard children and young people including those who are Vulnerable, Exploited, Missing, Trafficked (VEMT)	LSCB has established a strategic CSE sub group; locality meetings taking place fortnightly to manage individual cases; beginning discussions around information flows with GPs.	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

RAG Rating Key

Not commenced	**On track with minor issues**
Concerns / issues	**On track**

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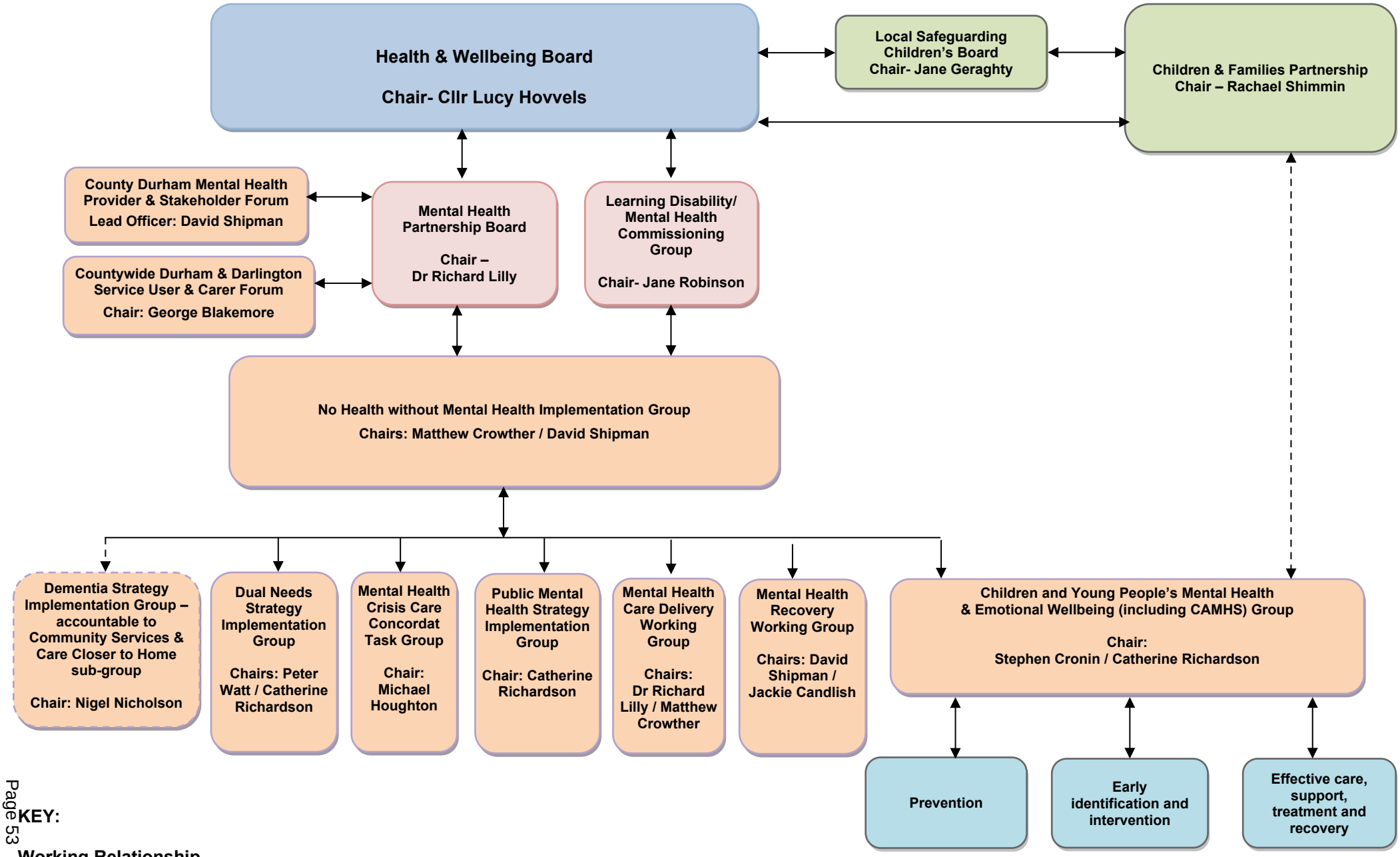
APPENDIX 3

County Durham Mental Health Partnership Board Governance Structure



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APPENDIX 4

Consultation Timeline for the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan 2015/18

Meeting	**Date**	**Purpose**
Mental Health Partnership Board	27th August 2015	Agree draft for wider consultation
DDES CCG Governing Body	8th September 2015	Consultation
Children and Families Partnership	21st September 2015	Consultation
ND CCG Governing Body	23rd September 2015	Consultation
Health and Wellbeing Board	24th September 2015	Consultation
Safe Durham Partnership	29th September 2015	Consultation
Local Safeguarding Children's Board	15th October 2015	Consultation
Mental Health Partnership Board	15th October 2015	Agree final version for HWB
Health and Wellbeing Board	3rd November 2015	Formal Agreement of plan
Safe Durham Partnership	16th November 2015	Endorsement
Children and Families Partnership	14th December 2015	Endorsement
Local Safeguarding Children's Board	17th December 2015	Endorsement
Cabinet	13th January 2016	Endorsement
Partner Management Boards including: North Durham CGG Durham Dales, Easington and Sedgefield CCG	TBC January – February 2016	Endorsement

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Health and Wellbeing Board

23 July 2015

Health and Wellbeing Board Annual Report 2014-15

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

Purpose of Report

1. The purpose of this report is to present the Health and Wellbeing Board with the Health and Wellbeing Board Annual Report 2014-15 (attached as Appendix 2) for agreement.

Background

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

3. The first Health and Wellbeing Board Annual Report was agreed by the Health and Wellbeing Board in July 2014 and was endorsed by Durham County Council's Cabinet in October 2014.

4. This is the second Health and Wellbeing Board Annual Report, which outlines the achievements of the Board during its second year of operation. It also includes details of locality health and wellbeing projects which are supported by the Health and Wellbeing Board, commitments and engagement activity of the Board and information on the Local Government Association Health and Wellbeing Peer Challenge which took place in February 2015.

Achievements during 2014/15

5. The Annual Report outlines a number of achievements of the Health and Wellbeing Board over the past year, which include:

    - Agreeing the first Joint Health and Wellbeing Strategy and Delivery Plan, and undertaking subsequent reviews, which have been informed by the Joint Strategic Needs Assessment, The Annual Report of the Director of Public Health County Durham, and feedback from engagement and consultation.

- Hosting a 'Big Tent' engagement event in October 2014 as part of the consultation process for the refresh of the Joint Health and Wellbeing Strategy.

- Agreeing the County Durham Better Care Fund plan, which supports seven work programmes to integrate health and social care initiatives locally.

- Supporting the Wellbeing for Life Service to help people to live well, and build on their capacity to be independent, resilient and maintain good health for themselves and those around them.

- Agreeing the Dementia Strategy for County Durham and Darlington 2014-17, to enable people to live well with dementia.

Commitments of the Health and Wellbeing Board

6. The Health and Wellbeing Board has made a number of commitments since it was established in April 2013, including signing up to the Disabled Children's Charter and signing the NHS Statement of Support for Tobacco Control, to actively support local work to reduce smoking prevalence and health inequalities. Further examples of the commitments are detailed in the Annual Report.

Local Projects

7. Details of the local projects across County Durham, which aim to improve the health and wellbeing of people in their local communities, including those delivered by the Area Action Partnerships, are included in the Annual Report.

Local Government Association (LGA) Peer Challenge

8. The Annual Report includes a section on the LGA Peer Challenge, which took place between 24th and 27th February 2015, and provides an overview of areas which are strong, as well as four areas of best practice which the LGA would like to share with the sector.

9. The Peer Challenge team also identified four areas that the Health and Wellbeing Board may wish to give further consideration to. These areas will be considered as part of the Health and Wellbeing Board development session in July 2015, and an action plan will be developed to take forward any key areas.

Future work of the Health and Wellbeing Board

10. Details of the initiatives that the Health and Wellbeing Board will continue to take forward during the coming year are included in the Annual Report.

Next Steps

11. The Health and Wellbeing Board are requested to note the following key dates for the development of the Health and Wellbeing Board Annual Report 2014/15:

    - Durham County Council's Cabinet receives HWB Annual Report 2014/15 for endorsement - **16th September 2015**
    - Children and Young People's Overview and Scrutiny Committee receives HWB Annual Report 2014/15 for information – **5th October 2015**
    - Adult, Wellbeing and Health Overview and Scrutiny Committee receives HWB Annual Report 2014/15 for information – **7th October 2015**
    - Durham Dales, Easington & Sedgefield Clinical Commissioning Group Governing Body receives HWB Annual Report 2014/15 for information – **13th October 2015**
    - North Durham Clinical Commissioning Group Governing Body receives HWB Annual Report 2014/15 for information – **28th October 2015**

Recommendations

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

    - Agree the Health and Wellbeing Board Annual Report 2014/15 (Appendix 2)
    - Note the timeline and next steps as outlined in the report.

Contact: Andrea Petty, Strategic Manager – Policy, Planning and Partnerships.
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Appendix 1: Implications

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

Staffing – No direct implications.

Risk – No direct implications.

Equality and Diversity / Public Sector Equality Duty – The key equality and diversity protected characteristic groups are considered as part of the process to identify the groups/organisations to be invited to the Health and Wellbeing Board Big Tent Event 2015.

Equality Impact Assessments have been completed for the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).

Accommodation - No direct implications.

Crime and Disorder – The JSNA provides information relating to crime and disorder.

Human Rights - No direct implications.

Consultation – Consultation on the priorities of the Health and Wellbeing Board is undertaken on an annual basis through the Big Tent Event and other engagement activities.

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

Disability Issues – The needs of disabled people are reflected in the JSNA and JHWS.

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

Support

Wellbeing

Health

Independence

Our vision:-

‘Improve the health and wellbeing of the people of County Durham and reduce health inequalities’

County Durham Health and Wellbeing Board Annual Report 2014-2015

Contents

1. Foreword

Welcome to the Health and Wellbeing Board Annual Report 2014/15. We are honoured to have been re-elected as Chair and Vice Chair of County Durham's Health and Wellbeing Board for a second year, and are privileged to have been supported by a group of partners who have continued to work together with the shared vision of improving the health and wellbeing of the people of County Durham and reducing health inequalities.

Over the last year we have made significant progress together, and through the Joint Health and Wellbeing Strategy and the Better Care Fund, the Health and Wellbeing Board will continue to work together to develop more joined up and integrated services, making the best use of resources.

Our Big Tent Engagement event was attended by over 240 people and feedback was incorporated into our Joint Health and Wellbeing Strategy. The event also saw the launch of the Crisis Care Concordat to demonstrate our commitment to supporting people in mental health crisis.

An Integration Programme role has been created to develop and implement the Better Care Fund across County Durham to support the further integration of services.

A Health and Wellbeing Peer Challenge has taken place and we are very proud that national research on the state of play with Health and Wellbeing Boards by the Local Government Association has indicated that Durham is clearly at the forefront of Health and Wellbeing Board progress and impact nationally.

The Board's success can be attributed to its clear vision, direction and shared strategy which is owned and valued by partners and influences the work of the Board as well as the commitment and drive of the partnership and the willingness to work together. This partnership approach has been central to the many achievements described in this report.

We achieved a lot in our first year, and have continued to do so throughout our second year. Together we will continue to drive forward the ambitious work of the Health and Wellbeing Board to improve health and wellbeing outcomes for the residents of County Durham.

Councillor Lucy Hovvels
Chair of the Health and Wellbeing Board

Cabinet Portfolio Holder for Adult and Health Services

(Cabinet Portfolio Holder for Safer and Healthier Communities, May 2014 - May 2015)

Dr Stewart Findlay
Vice Chair of the Health and Wellbeing Board

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

2. The Health and Wellbeing Board

The Health and Social Care Act 2012 required all upper tier local authorities to establish Health and Wellbeing Boards.

The County Durham Health and Wellbeing Board was established as a Committee of Durham County Council in April 2013. It provides a forum for organisations to develop joint strategies and challenge each other on better ways of working.

Functions of the Health and Wellbeing Board
The Health and Social Care Act 2012 gives the Health and Wellbeing Board specific functions as follows:

- To develop a Joint Strategic Needs Assessment, which provides an overview of the current and future health and wellbeing needs of the people of County Durham;

- To develop a Joint Health and Wellbeing Strategy, which is based on evidence in the Joint Strategic Needs Assessment;

- A responsibility and duty to encourage integrated working between commissioners of health services, public health and social care services, for the purposes of advancing the health and wellbeing of the people in its area.

The vision for the Health and Wellbeing Board, as laid out in the Joint Health and Wellbeing Strategy is to:

'Improve the health and wellbeing of the people of County Durham and reduce health inequalities'

Central to this vision is the belief that decisions about the services provided for service users, carers and patients should be made as locally as possible and involve the people who use them.

The vision is supported by the following strategic objectives:

- Children and young people make healthy choices and have the best start in life
- Reduce health inequalities and early deaths
- Improve the quality of life, independence and care and support for people with long term conditions
- Improve the mental and physical wellbeing of the population
- Protect vulnerable people from harm
- Support people to die in the place of their choice with the care and support that they need.

The work of the Health and Wellbeing Board is based on the Joint Health and Wellbeing Strategy which identifies priorities for joint action that will make a real difference to people's lives.

The Health and Wellbeing Board does not work alone to improve health and wellbeing, and acts as the 'Altogether Healthier' thematic partnership of the County Durham Partnership, which is the overarching strategic partnership in County Durham.

Each thematic partnership delivers the work of the County Durham Partnership and maintains close working relationships with the other thematic partnerships:

The County Durham Economic Partnership 'Altogether Wealthier' aims to make County Durham a place where people want to live, work, invest and visit whilst enabling our residents and businesses to achieve their potential.

- Thriving Durham City
- Vibrant and successful towns
- Sustainable neighbourhoods and rural communities
- Competitive and successful people
- A top location for business

The Children and Families Partnership 'Altogether better for children and young people' works to ensure effective services are delivered in the most efficient way to improve the lives of children, young people and families in County Durham.

- 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

The Health and Wellbeing Board 'Altogether Healthier' promotes integrated working between commissioners of health services, public health and social care services, for the purposes of improving the health and wellbeing of the people in the area.

- Children and young people make healthy choices and have the best start in life
- Reduce health inequalities and early deaths
- Improve the quality of life, independence and care and support for people with long term conditions
- Improve the mental and physical wellbeing of the population
- Protect vulnerable people from harm
- Support people to die in the place of their choice with the care and support they need

The Safe Durham Partnership 'Altogether Safer' tackles crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and seeks to reduce re-offending.

- Reduce anti-social behaviour
- Protect vulnerable people from harm
- Reduce re-offending
- Alcohol and substance misuse harm reduction
- Embed the Think Family approach

- Counter terrorism and prevention of violent extremism
- Reduce road casualties

The Environment Partnership
'Altogether Greener' aims to transform and sustain the environment within County Durham, maximising partnership arrangements to support the economy and the wellbeing of local communities.

- Deliver a cleaner, more attractive and sustainable environment
- Maximise the value and benefits of Durham's natural environment
- Reduce carbon emissions and adapt to the impact of climate change
- Promote sustainable design and protect Durham's heritage

Poverty
A partnership approach is being taken to address poverty across County Durham. Partners will seek to support the most vulnerable members of our community and address inequalities. Growing up in poverty has a significant impact on children and young people both during their childhood and beyond. Almost a quarter of children in County Durham are living in poverty compared to an England average of one fifth.

A Poverty Action Steering Group is in place, led by the Assistant Chief Executive of Durham County Council, to look at the wider impact of poverty. County Durham has the scope to provide a wide range of support and innovative and targeted interventions. To facilitate this and to ensure that the actions are as effective as they can be, partners are concentrating on developing joined-up intelligence and joined-up services with a focus on prevention.

This approach helps to ensure that people in need are signposted to and receive the correct support and that the assistance and schemes developed are based on a clear and detailed appreciation of the issues involved, for example, housing services are signposting people to debt and benefits advice and employability support, where this is deemed appropriate.

Membership of the Health and Wellbeing Board

Membership of the Health and Wellbeing Board reflects the requirements of the Health and Social Care Act 2012, and a range of additional organisations are included to ensure that the Health and Wellbeing Board is most effective in having the biggest impact on improving the health and wellbeing of local people and reducing health inequalities (Figure 1, page 22).

Although non-statutory, Health and Wellbeing Board membership in County Durham includes the local NHS Provider Foundation Trusts as voting members.

Governance and accountability

The Health and Wellbeing Board has a clear structure in place, enabling it to fulfil its statutory obligations to improve the health and wellbeing of the people of County Durham and reduce health inequalities.

The comprehensive supporting sub group arrangements carry out work on behalf of the Health and Wellbeing Board and show clear linkages to the work of the Health and Wellbeing Board. These governance arrangements are subject to an annual review to ensure they remain fit for purpose.

The Health and Wellbeing Board has wider interface arrangements with a number of multi-agency partnership groups, including other County Durham thematic partnerships, for example the Children and Families Partnership and the Safe Durham Partnership as well as the two statutory safeguarding boards (Local Safeguarding Children's Board and Safeguarding Adults Board).

Key information, including the annual report, is shared with Durham County Council Cabinet and Adults, Wellbeing and Health and Children and Young People's Overview and Scrutiny Committees to ensure there are mechanisms in place to provide information on the work of the Board.

Regular consultation on key strategies and service developments also takes place with Adults, Wellbeing and Health and Children and Young People's Scrutiny Committees. Regular updates on key issues are also provided to Scrutiny Committees.

University Hospital North Durham A&E department

3. Achievements of the Health and Wellbeing Board 2014/15 and local projects undertaken in 2014/15

This section details key achievements and developments that have taken place in 2014/15 to achieve the strategic objectives in the Joint Health and Wellbeing Strategy. It includes examples of local projects relating to health and wellbeing, many of which have been developed with Area Action Partnerships (AAPs). The Health and Wellbeing Board works closely with AAP co-ordinators to reflect the priorities of the Health and Wellbeing Board locally and recognises the impact of AAPs on health and wellbeing.

The Health and Wellbeing Board:

- Agreed the County Durham Joint Strategic Needs Assessment for 2014.
- Agreed the Joint Health and Wellbeing Strategy and supporting Delivery Plan.
- Hosted a 'Big Tent' engagement event as part of the consultation process for the refresh of the Joint Health and Wellbeing Strategy, which was attended by over 240 people. Further details are included at page 15.
- Endorsed the Director of Public Health County Durham's Annual Report 2014, which focuses on tackling social isolation and loneliness and has been used to inform various plans and strategies.

Examples of local projects that address social isolation and loneliness include:

- Aspire Learning Support and Wellbeing, which in partnership with Durham Alcohol Support Service is working in the Chester-le-Street area to support people in recovery from alcohol, many of whom are socially isolated.
- Derwent Valley Diners is a pilot project with Age UK to benefit older people, particularly those experiencing social isolation. The pilot seeks to improve older people's health and quality of life, and provides a nutritious meal being brought to their homes weekly by volunteers, who will provide regular social contact.
- Wheels to Meals scheme addresses the issue of nutrition and social isolation in older people in Weardale. The scheme uses community transport to collect people and take them to local restaurants then drops them home after taking a scenic drive back.
- Upper Teesdale Agricultural Support Services deliver a project to provide socially isolated men who are over 60 and living in Teesdale with hot meals and the opportunity to socialise and seek information, advice and guidance on a range of topics
- The Pioneering Care Partnership's Health Buddy Service provides trained volunteers who offer over 50s regular home visits for a chat, or help to attend local groups or appointments.

- Agreed the County Durham Better Care Fund plan which will support seven work programmes to integrate health and social care:

    - **Intermediate Care + short term intervention services** which includes intermediate care community services, reablement, falls and occupational therapy services
    - **Equipment and adaptations for independence** which includes telecare, disability adaptations and the Home Equipment Loans Service
    - **Supporting independent living** which includes mental health prevention services, floating support and supported living and community alarms and wardens
    - **Supporting carers** which includes carers breaks, carer's emergency support and support for young carers
    - **Social isolation** which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services
    - **Care home support** which includes care home and acute and dementia liaison services
    - **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.

  The Better Care Fund is aligned to the strategic objectives in the Joint Health and Wellbeing Strategy and supports the aim to provide people with the right care, in the right place at the right time. Implementation of the Better care Fund commenced on 1st April 2015. An Integration Programme Manager has been appointed to develop and implement the Better Care Fund across County Durham.

- Agreed the County Durham Implementation Plan of the 'No Health Without Mental Health' national strategy to bring together all the strands of mental health and wellbeing to better support people who need it. In order to ensure the work is coordinated and the priorities are progressed an Implementation Group has been formed.

Examples of local projects supporting people with Mental Health needs include:

- Open Art Surgery project which targets vulnerable people across the Durham AAP area, who are experiencing mental health problems, to engage in creative activity and social interaction. This includes people with dementia, adults with learning disabilities, people with multiple sclerosis, and men at risk of suicide, their families and carers.

- Teesdale YMCA's Enriching Rural Lives project which focuses on mental and physical health, delivering a range of workshops and support sessions to engage community members who are aged 10-85.

- Countywide CREE initiatives are in place to support mental health and emotional wellbeing. Many of these projects are based around allotments, community gardens and pigeon crees (hence the name) and provide support or signpost users to other services.

- Supported the Wellbeing for Life Service to help people to live well, and build on their capacity to be independent, resilient and maintain good health for themselves and those around them.

  The tender for the Wellbeing for Life Service has been awarded to a consortium of providers, comprising of the following organisations:
  - County Durham and Darlington Foundation Trust, Health Improvement Service
  - Durham Community Action
  - Pioneering Care Partnership
  - Durham County Council, Culture and Leisure
  - Leisureworks.

  The Wellbeing for Life service went live on 1st April 2015.

Examples of local projects supporting the Wellbeing for Life approach include:

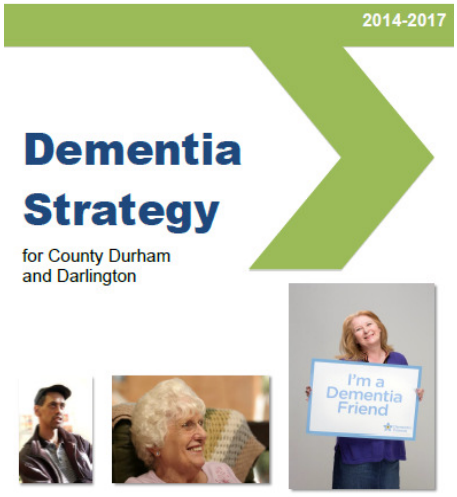
- Health Express in Shildon, that aims to increase knowledge and awareness of health issues in the local community and help people access health services and get support in better managing long term health conditions.

- As part of Health Express, students have teamed up with social housing provider Livin, to help residents stay fit and healthy through a series of activities. The initiative provides people with access to a range of health based initiatives and provides valuable work experience for local college students.

- Health Trainers will work closely with older residents in Brandon, Burnhope and Langley Park to help them set their own personal health plans. This will include support and advice on diet, nutrition, exercise, quitting smoking, reducing alcohol intake and improving how good you feel about yourself.

- Neighbourhood Networks is a community engagement pilot scheme, managed by Durham Community Action. The scheme is aimed at supporting older socially isolated residents to become more active and aware of local services which could be accessed to improve their quality of life.

- Agreed the Dementia Strategy for County Durham and Darlington 2014-17, to enable people to live well with dementia.



Examples of local projects supporting Dementia include:

- The Centre of Excellence project, that employs a Dementia Support Worker through the Alzheimer's Society to work in the East Durham area providing emotional, financial and medical support for families and sufferers of dementia

- A key area of the Dementia Strategy is the roll out of 'Dementia Friendly Communities', with Barnard Castle and Chester-Le-Street selected as the first two sites in County Durham focusing on improving inclusion and quality of life for people living with dementia. This has also been rolled out in the Mid Durham AAP area.

- Demonstrated commitment to supporting people in mental health crisis by signing up to a local declaration and agreeing a joint action plan. Gaps in the service and areas of good practice informed the action plan, which was developed across County Durham and Darlington in conjunction with both Health and Wellbeing Boards.

- Agreed the County Durham Interim Child and Adolescent Mental Health Services (CAMHS) Joint Strategy 2014/16, which was developed whilst more detailed work is undertaken to develop a three-year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan.

- Agreed the Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013-2018, to ensure the populations of County Durham and Darlington receive the best possible care, in the place where they want to receive it, when they are progressing towards the end of life.

  The Health and Wellbeing Board has prioritised end of life care as one of the six strategic objectives within the Joint Health and Wellbeing Strategy to ensure that the Council and Clinical Commissioning Group strategic commissioning plans are aligned to provide better outcomes for the residents of County Durham.

- Agreed the first County Durham Drug Strategy, which aims 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.

From April 2015 Lifeline began to deliver community based alcohol and drug misuse services jointly from recovery centres across the county, offering individuals and their families integrated drug and alcohol treatment journeys, and allowing people who are attending for treatment to benefit from the positive influences of people attending who are in recovery.

- Agreed the Strategy for the Prevention of Unintentional Injuries in Children and Young People in County Durham to reduce unintentional injuries in children and young people aged 0-19.

- Agreed the Healthy Weight Strategic Framework for County Durham, which has been developed by the County Durham Healthy Weight Alliance as a local response to 'Healthy Lives, Healthy People: A Call to Action on Obesity in England'. The strategy aims to achieve a sustained upward trend in healthy weight for children, young people and adults in County Durham by 2020.

  As a result, applications for take aways to be opened within a 400m zone of schools have been refused, to support children's healthy eating.

- Agreed the Safeguarding Framework which was developed jointly with the Health and Wellbeing Board, Children and Families Partnership and Safe Durham Partnership along with the Local Safeguarding Children Board and Safeguarding Adults Board.

SAFEGUARDING FRAMEWORK

June 2014

Example of a local project:

The Safer Homes scheme is aimed at reducing the risk to residents in their home from fire and crime. It supports people who are vulnerable due to a range of physical or mental health disabilities and lifestyle factors such as drinking or smoking.

- Agreed the first Pharmaceutical Needs Assessment, produced by the Health and Wellbeing Board, which was published in March 2015. The key conclusion from the assessment is that there are sufficient numbers of pharmacies in County Durham. The assessment will be used when considering future pharmacy applications.

- The Health and Wellbeing Board receive timely winter plans and system resilience updates to ensure that local health and care systems operate effectively in delivering year round services for patients.

Example of a local project:

The Warm and Healthy Homes programme is delivered in collaboration with British Gas through Warm Up North.
It aims to identify patients/clients with underlying health conditions who are living in a cold, damp home.

Once identified, a number of options can be offered to the patient/client appropriate to their circumstances.

Commitments of the Health and Wellbeing Board

Examples of commitments undertaken by the Health and Wellbeing Board include:

- Signed up to the Disabled Children's Charter to ensure the needs of disabled children are fully understood and services are commissioned appropriately. Evidence has been provided to Every Disabled Child Matters on the actions undertaken in County Durham.

  The commitments are being met in County Durham by ensuring that the needs of disabled children and young people are reflected in the Joint Strategic Needs Assessment, and by ensuring appropriate actions are identified in the Joint Health and Wellbeing Strategy. As part of the consultation on the review of these documents, a number of events took place including consultation with 'Making Changes Together' which is a group of parents of disabled children.

- Identified the Chair of the Health and Wellbeing Board and the Director of Public Health County Durham as mental health champions, whose role includes promoting wellbeing, and initiating and supporting action on public mental health.

- As part of the Winterbourne View Concordat and Action Plan, the Portfolio Holder for Adult Services was identified as a Learning Disability Champion to promote the needs of people with learning disabilities.

- Signed up to the National Dementia Declaration and Dementia Care and Support Compact to support the delivery of the National Dementia Strategy and improving care and support for people with dementia, their carers and families.

  In County Durham, one of the Better Care Fund work programmes is 'Care Home Support' which includes care home and acute and dementia liaison services. Intermediate Care + teams also have Community Psychiatric Nurse support to enable dementia clients to be included in the reablement pathway.

- Signed up to the Carers' Call to Action to ensure that the vision for carers of people with dementia is achieved.

  Another Better Care Fund work programme is 'Supporting Carers' which includes carers breaks.

- Signed up to the National Pensioners Convention's Dignity Code, which has been developed to uphold the rights and maintain personal dignity of older people.

  The Dignity Code was discussed at events with Residential Care Home Providers in 2014, who agreed to abide by the code.

- Signed the NHS Statement of Support for Tobacco Control to actively support local work to reduce smoking prevalence and health inequalities.

  A voluntary ban has been implemented across County Durham, encouraging play areas to become smoke free.

  The outdoor play area at Riverside Park in Chester-le-Street became the first park to become a smoke free zone.

Key Performance Achievements 2014/15
This section provides a summary of the key performance achievements of the Health and Wellbeing Board to describe the progress made against the strategic objectives in the Joint Health and Wellbeing Strategy.

Strategic Objective 1: Children and young people make healthy choices and have the best start in life

- Latest data shows that both under 16 and 18 conception rates are falling.
- The percentage of exits from young person's drug and alcohol treatment that are planned has achieved target and is above the national average.

Strategic Objective 2: Reduce health inequalities and early deaths

- Since 2000, all-cause mortality rates have continued to show a sustained downward trend.
- Patients receiving definitive treatment for cancer within 31 days of diagnosis has exceeded target and is better than national rates.

Strategic Objective 3: Improve the quality of life, independence and care and support for people with long term conditions

- Carers report a higher quality of life in Durham than North East and England averages and report higher satisfaction levels.
- A higher percentage of people remain in their own homes following rehabilitation services than North East and national averages.

Strategic Objective 4: Improve mental health and wellbeing of the population

- The proportion of adults in mental health services in paid employment and settled accommodation is better than national averages.

Strategic Objective 5: Protect vulnerable people from harm

- The number of children subject to a Child Protection plan has decreased and is below North East and England averages.
- The percentage of Children in Need referrals occurring within 12 months of a previous referral has reduced and is below North East and national averages.

Strategic Objective 6: Support people to die in the place of their choice with the care and support that they need

- The number of patients recorded on practice registers as in need of palliative care/support has increased, achieved target and is above national rates.
- The number of deaths occurring in the usual place of residence has increased and is above national rates.

4. Engagement

Central to achieving the vision of the Health and Wellbeing Board to **'Improve the health and wellbeing of the people of County Durham and reduce health inequalities'** is the belief that decisions about the services provided for service users, carers and patients, should be made as locally as possible and involve the people who use them.

Engagement within County Durham includes individual involvement, collective involvement and patient experience activities. A range of mechanisms are used by all partners to support their work in engaging with people about their health and social care needs.

The Health and Wellbeing Board's **Big Tent Engagement Event** is held every year to gather the views of a wide range of stakeholders, including service users, patients, GPs, carers, members of the voluntary and community sector as well as professionals from partner agencies, and elected members.

In October 2014, the event, which was attended by over 240 people, included a number of themed workshops relating to health, social care and the wider wellbeing approach such as long term conditions, physical activity and drugs and alcohol.

The event saw the launch of the Mental Health Crisis Care Concordat for County Durham and provided an update on the work taking place to address health and social care issues. It also gave attendees an opportunity to provide their views on how services should be developed through a series of presentations and themed workshops.

The Local Government Association supported the event and Dr William Bird, a national speaker, led the physical activity workshop.

Feedback from the event has been used to influence future priorities through the Joint Health and Wellbeing Strategy, as well as service reviews for specific plans and strategies.

Service User and Carer Forums support engagement, consultation and involvement with service users and carers from specific client groups, such as those with learning disabilities, mental health needs and older adults.

A specific event for people with learning disabilities, carers and organisations was held in November 2014, which focused on a number of themes, including social activities and health. The engagement tools used on the day were designed by the people with learning disabilities. The engagement approaches took into account the different needs of individuals with learning disabilities to enable people to have their say.

County Durham Adults Learning Disability engagement forum

There are fourteen **Area Action Partnerships** in place to give people in County Durham a greater choice and voice in local affairs. They allow people to have a say on services and give organisations the chance to speak directly with local communities. By working in partnership we help ensure that the services of a range of organisations are directed to meet the needs of local communities and focus their actions and spending on issues important to these local communities.

A designated Area Action Partnership representative has been identified as a link to the Health and Wellbeing Board. Updates on the work of the Area Action Partnerships are provided to the Health and Wellbeing Board on a six monthly basis.

Work has taken place to enhance the interface between Area Action Partnerships and the Health and Wellbeing Board to improve the alignment of Area Action Partnership developments and investments with the priorities of the Health and Wellbeing Board.

Further work will take place at a local level through Area Action Partnerships and will be progressed through the Community Wellbeing Partnership, which is a sub-group of the Health and Wellbeing Board.

AAP consultation event

Voluntary and Community Sector (VCS) organisations are represented on the Community Wellbeing Partnership which focuses on developing an asset based approach in communities and supporting people to help themselves through the Wellbeing for Life Service. VCS organisations are also consulted on the Joint Health and Wellbeing Strategy through the Big Tent engagement event.

Healthwatch County Durham voices people's concerns and provides feedback to service providers and commissioners. Through local engagement they collect vital data on how and why people use services in their area. Its place on the Health and Wellbeing Board means Healthwatch can represent the voice of people in decision making.

Regular reports are presented to the Health and Wellbeing Board on the engagement that has been held in relation to the three strands of Healthwatch work:

- *Listening* – to patients of health services and users of social care services to find out what they think of the services they receive.
- *Advising* – people how to get the best health and social care for themselves and their family.
- *Speaking up* – on consumers' behalf with those who provide health and social care services.

Healthwatch are also instrumental in being involved in projects and reviews and were involved in a patient journey consultation which focused on a dementia project and included people who care for those with dementia.

Patient Reference Groups are the mechanism to engage with patients on specific services provided by GPs and for engagement with people who have specific health conditions.

Investing in Children Reference Groups are utilised for gathering the views of children and young people in relation to health and social care.

There are a number of Investing in Children reference groups, including:

- Emotional Health and Wellbeing
- Diabetes Group
- Disabled Children
- Local Community Groups

Investing in Children Agenda Day

Agenda Days are held that are led by young people and focus on the key issues affecting them.

The Bridge Young Carers group art day

The Health and Wellbeing Board have engaged directly with **young people** who requested to provide their feedback to Health and Wellbeing Board members on health issues which are important to them. An action plan was developed detailing how the issues are being taken forward.

The **Making Changes Together** group is the mechanism for engaging with parents of disabled children to ensure that the needs of disabled children are considered.

5. Local Government Association Peer Challenge

Peer Challenge is part of the Local Government Association's Health and Wellbeing System Improvement Programme's wider offer, where peers work as 'critical friends' and is designed to support the Local Authority and Health and Wellbeing Board in reflecting on, and improving practice.

County Durham's Health and Wellbeing Peer Challenge took place in February 2015. In four days the Peer Challenge team met Councillors, staff, partners, service users and carers through interviews and focus groups. A member of the Peer Challenge team also attended a Health and Wellbeing Board meeting.

The Peer Challenge team were looking for evidence in the following areas:

- A clear, appropriate and achievable approach to improving the health and wellbeing of local residents
- An effective governance system, with leadership that works well across the local system
- Local resources, commitment and skills across the system are maximised to achieve local health and wellbeing priorities
- Effective arrangements for evaluating the impact of the Joint Health and Wellbeing Strategy
- Effective arrangements for ensuring accountability to the public

Big Tent Engagement Event

Feedback from the Peer Challenge stated that County Durham's Health and Wellbeing Board is in a very strong place.

The Local Government Association have recently commissioned national research on the state of play with Health and Wellbeing Boards, and in terms of this research, feel that County Durham is clearly at the forefront of Health and Wellbeing Board progress and impact nationally.

The Peer Challenge team stated that the strength of partnership relationships was striking and they are clearly mature. They commented that distributed leadership had developed from well established relationships, trust and well managed organisations.

They also stated that a whole systems approach is clearly well-embedded and that the Joint Health and Wellbeing Strategy is clearly owned and valued by partners, has influence and is underpinned by the Joint Strategic Needs Assessment.

The Big Tent Engagement Event and Learning Disabilities Forum were commended as inclusive approaches for community engagement, along with engagement events by Investing in Children that ensure the 'voice of the child' influences the Health and Wellbeing agenda.

This is particularly notable as the Peer Challenge team's feedback report states that the 'voice of the child' is not well developed across the country.

IIC Agenda Day

Area Action Partnerships were described by the lead peer as "one of the best forms of localism I have seen in a long time" and that they clearly link to the Health and Wellbeing Board and allow for service models to be locally determined.

The clear governance arrangement between the Health and Wellbeing Board and Scrutiny was identified as among the best in the country.

The Peer Challenge team identified the following four areas of best practice that they would like to follow up and share with the sector:

- Community Engagement
- Area Action Partnerships
- 'Voice of the child'
- Relationship with Scrutiny

The Peer Challenge team identified the following areas that the Health and Wellbeing Board may wish to consider for the future:

- Stronger links to housing to ensure housing's contribution to health inequality and the wider determinants of health is maximised
- Reviewing the membership of the Health and Wellbeing Board in relation to the voluntary & community sector and housing.
- Ensuring the needs of carers are reflected in the Joint Health and Wellbeing Strategy
- Consider working across Health and Wellbeing Board boundaries e.g. to consider patient flows and service re-design.

An action plan will be developed by the Health and Wellbeing Board to take forward any key areas.

6. Future work of the Health and Wellbeing Board

There is a strong commitment from the Health and Wellbeing Board to continue to improve the health and wellbeing of the people in County Durham and reduce health inequalities.

Agreeing the refresh of the Joint Health and Wellbeing Strategy 2015-18 will enable us to progress key areas of work to help achieve that vision.

The Health and Wellbeing Board's work programme for 2015-16 will build on the progress made to date, and will include the following actions:

- Agree the refresh of the Joint Health and Wellbeing Strategy 2015-18 Delivery Plan to ensure that the Joint Health and Wellbeing Strategy is implemented and performance managed.
- Implement the actions in the Mental Health Crisis Care Concordat local action plan, which was agreed by both the County Durham and Darlington Health and Wellbeing Boards.
- Receive updates on the implementation of the County Durham Better Care Fund plan.
- Agree the approach to further develop health and social care integration and next steps.
- Agree the Cardiovascular Disease (CVD) Prevention Strategic Framework to prevent the disease, which is the second largest cause of death in County Durham.
- Agree the Dual Needs Strategy, which aims to identify people with dual diagnosis (drugs and/or alcohol misuse along with learning

  disabilities and/or mental illness, including dementia) and ensure they have access to coordinated and responsive services to meet their complex and changing needs.
- Agree the County Durham Physical Activity Delivery Plan, which will provide a greater range of opportunities to increase participation and activity levels in County Durham

- Agree the comprehensive three year Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan, which will also consider self-harm amongst young people.
- Receive an update on the work being undertaken across County Durham to address diabetes, as well as Public Health's role as a demonstrator site for the National Diabetes Prevention programme. The aim of the pilot is to be the first country to implement at scale, a national evidence based diabetes prevention programme.

- Support the implementation of the Oral Health Strategy to improve the oral health of children and young people across the county and reduce inequalities in oral health statistics.

- Agree the Urgent Care Strategy, which has strong ambitions to take a whole system approach, ensuring urgent care services are easier to navigate and are streamlined to avoid duplication.

- Endorse the Alcohol Harm Reduction Strategy, the vision of which is *"To change the drinking culture in County Durham to reduce the harm caused by alcohol to individuals, families and communities while ensuring that adults who choose to drink alcohol are able to enjoy it responsibly".*

- Sign up to St. Mungo's Broadway 'Charter for homeless health' to ensure that local services are accessible for people who are homeless.

- Receive updates on the progress in regard to the Joint Health and Social Care Learning Disability Self-Assessment Framework and the Learning Disability Self-Assessment.

- Receive updates on the Transfer of 0-5 Healthy Child Programme, which marks the final part of the overall public health transfer to local authorities from the NHS, and aims to encourage integrated working.

- Receive the Annual Reports of the Local Safeguarding Children Board and Safeguarding Adults Board.

- Consider the County Durham and Darlington NHS Foundation Trust Right First Time 24/7 Clinical and Quality Strategy.

Figure 1: County Durham Health & Wellbeing Board Membership (Correct at 31st March 2015)

COUNCILLOR LUCY HOVVELS
Chair of the Health and Wellbeing Board
Member Portfolio Holder (Safer and Healthier Communities) – Durham County Council

DR. STEWART FINDLAY
Vice Chair of the Health and Wellbeing Board
Chief Clinical Officer - Durham Dales, Easington and Sedgefield Clinical Commissioning Group

RACHAEL SHIMMIN
Corporate Director – Children and Adults Services – Durham County Council

ANNA LYNCH
Director of Public Health County Durham – Children and Adults Services – Durham County Council

ALAN FOSTER
Chief Executive – North Tees and Hartlepool NHS Foundation Trust

COUNCILLOR OSSIE JOHNSON
Member Portfolio Holder (Children and Young People's Services) – Durham County Council

COUNCILLOR MORRIS NICHOLLS
Member Portfolio Holder (Adult Services) – Durham County Council

JOSEPH CHANDY
Director of Primary Care Development and Engagement – Durham Dales, Easington and Sedgefield Clinical Commissioning Group

DR. DAVID SMART
Clinical Chair – North Durham Clinical Commissioning Group

NICOLA BAILEY
Chief Operating Officer – North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups

CAROL HARRIES
Director of Corporate Affairs – City Hospitals Sunderland

SUE JACQUES
Chief Executive – County Durham and Darlington NHS Foundation Trust

MARTIN BARKLEY
Chief Executive – Tees Esk and Wear Valleys NHS Foundation Trust (TEWV)

JUDITH MASHITER
Chair - Healthwatch County Durham

Also invited to attend – Non Voting
Ben Clark, NHS England Sub-Regional Team; Peter Appleton, Head of Planning and Service Strategy, Durham County Council; and Andrea Petty, Strategic Manager, Policy, Planning and Partnerships, Durham County Council.

7. Abbreviations and glossary

Area Action Partnerships (AAPs)	Groups set up to give people in County Durham a greater choice and voice in local affairs. The partnerships allow people to have a say on services, and give organisations the chance to speak directly with local communities
CAMHS	Child and Adolescent Mental Health Services
Clinical Commissioning Groups (CCGs)	Groups of GP practices, including other health professionals who will commission the great majority of NHS services for their patients
CREE	CREE projects are aimed at improving the mental health and wellbeing of residents by providing a social area and in a friendly and supportive environment. A lot of the projects are based around allotments, community gardens and pigeon crees (hence the name) and can offer support or signpost users to other support services.
Dementia	Dementia is used to describe a syndrome which may be caused by a number of illnesses in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. Individuals may develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering
Disabled Children's Charter	A formal document which the HWB signs to demonstrate its commitment to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions
Dual Diagnosis	Having both a diagnosis of learning disabilities/mental behavioral diagnosis and substance misuse problems
GP	General practitioner - also known as family doctors who provide primary care
Health and Wellbeing Board (HWB)	Statutory forum of key leaders from health and social care working together to improve the health and wellbeing of the local population and reduce health inequalities
Intermediate Care+	Provides one route into all intermediate care services, which prevent unnecessary admission to hospitals or premature admission to care homes, and promote independence and faster recovery from illness
Interventions	Services provided to help and/or improve the health of people in the county

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)	The 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
Local Government Association (LGA)	The LGA is a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. The LGA aims to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems
Long term condition	The Department of Health has defined a Long Term Condition as being "a condition that cannot, at present be cured; but can be controlled by medication and other therapies." This covers a lot of different conditions e.g. diabetes, chronic obstructive pulmonary disease (COPD), dementia, high blood pressure
National dementia declaration	Explains the challenges presented to society by dementia and some of the outcomes that are being sought for people with dementia and their carers
NHS	National Health Service
Reablement	Reablement is about giving people over the age of 18 years the opportunity, motivation and confidence to relearn/regain some of the skills they may have lost as a consequence of poor health, disability/impairment or accident and to gain new skills that will help them to develop and maintain their independence
Special Educational Needs and Disability (SEND)	Children who have needs or disabilities that affect their ability to learn. For example: • Behavioural/social (e.g. difficulty making friends). • Reading and writing (e.g. dyslexia). • Understanding things. • Concentrating (e.g. Attention Deficit Hyperactivity Disorder). • Physical needs or impairments
Social Isolation	A lack of contact with people
Stakeholders	Interested parties or those who must be involved in a service/project or activity
UTASS	Upper Teesdale Agricultural Support Services, supporting local residents with mental health needs

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County Durham Health and Wellbeing Board Annual Report 2014-2015

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Please ask us if you would like this document summarised in another language or format.

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CAS14300 Children and Adults Services, CMI Team 2015

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Health and Wellbeing Board

23 July 2015

Joint Health and Wellbeing Strategy Delivery Plan 2015-18

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

Purpose of Report

1. The purpose of this report is to present the Joint Health and Wellbeing Strategy Delivery Plan 2015-2018, attached at Appendix 2, for agreement.

Background

2. The Joint Health and Wellbeing Strategy (JHWS) 2015-18 was agreed by the Health and Wellbeing Board on 11th March 2015 and endorsed by Cabinet and CCG Governing Bodies in April and May.

3. Performance indicators and targets for the JHWS, where they relate to the health of children and young people, were also agreed at the Children and Families Partnership meeting on 11th March 2015.

JHWS Delivery Plan

4. The JHWS Delivery Plan includes more detailed actions outlining the work that will take place to achieve the Strategic Actions in the JHWS which includes target dates for when actions will be achieved.

5. Examples of key pieces of work included in the JHWS Delivery Plan 2015-18 are outlined below:

- Develop the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan
- Develop a Teenage Pregnancy and Sexual Health Delivery Plan
- Review the Child and Adolescent Mental Health Services (CAMHS) crisis self-harm pilot
- Implement the Healthy Weight Strategic Framework
- Implement with partners the Alcohol Harm Reduction Strategy
- Implement the Wellbeing for Life service within the 30% most deprived geographies of County Durham
- Implement the Care Act 2014
- Implement the Better Care Fund Plan with a focus on the seven local key work programmes including Intermediate Care Plus
- Implement the refreshed Physical Activity Framework

- Implement the Dementia Strategy for County Durham and Darlington
- LSCB to develop and deliver awareness sessions on child sexual exploitation to all taxi operators in County Durham

6. The JHWS Delivery Plan is monitored robustly and progress on the performance indicators is reported to the Health and Wellbeing Board on a six monthly basis. This allows partners the opportunity to challenge each other and ensure that services are delivered in a timely and effectively way to achieve good outcomes for service users, patients and carers. As well as providing performance highlights, the Health and Wellbeing Board also receives information on areas for improvement.

Recommendations

7. The Health and Wellbeing Board is requested to:

- Agree the Joint Health and Wellbeing Strategy Delivery Plan 2015-18.

Contacts: **Andrea Petty, Strategic Manager – Policy, Planning & Partnerships, Durham County Council**
Tel: **03000 267312**

Appendix 1: Implications

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

Staffing - No direct implications.

Risk - No direct implications.

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

Accommodation - No direct implications.

Crime and Disorder - No direct implications.

Human Rights - No direct implications.

Consultation - Consultations have taken place with over 240 key partners and organisations including service users, carers and patients as part of the refresh, to ensure the strategy continues to meet the needs of people in the local area and remains fit for purpose for 2015-18.

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

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

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

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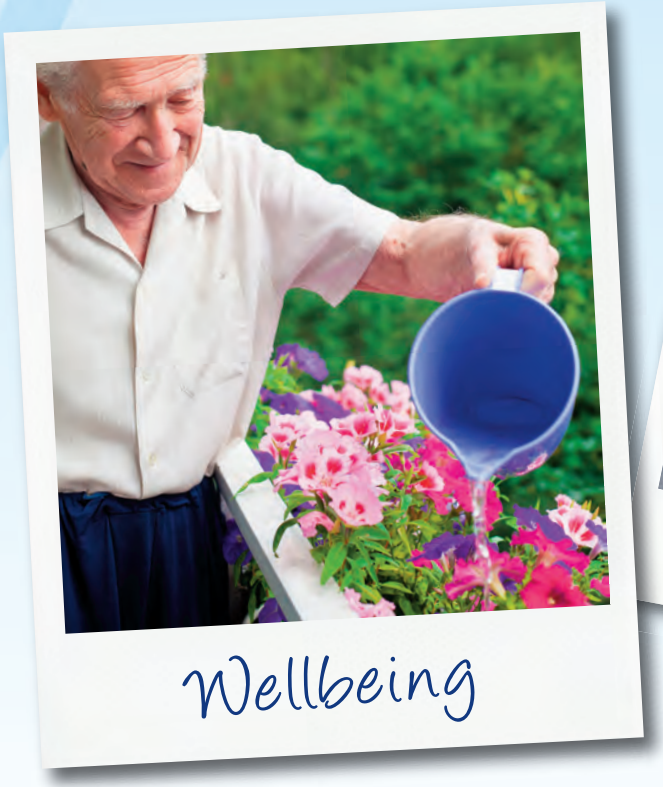
Support

Independence



Wellbeing

Health

County Durham Joint Health and Wellbeing Strategy 2015-2018

Delivery Plan

"Improve the health and wellbeing of the people of County Durham and reduce health inequalities"

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

Outcome: Reduced Childhood Obesity

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Improve support to families and children to develop healthy weight			Council Plan
• Provide advice and support to schools to enable them to work towards actions identified through the National School Food Plan, such as provision of free school meals, healthy packed lunches, growing clubs, after-school cooking lessons for children and parents	**DCC (Public Health)**	March 2016	CCG Operational / Strategic Plans
• Enhance Tier 2 weight management service to comply with NICE guidelines	**DDES CCG**	March 2016	
• Commission psychology input into weight management service	**DDES CCG**	March 2016	
Improve support to women to start and continue to breastfeed their babies	**DCC (Public Health)**		Council Plan
• Council buildings to be breastfeeding-friendly		March 2016	
• Inform One Point staff of the benefits of breastfeeding through information provided by public health		March 2016	

Outcome: Improved early health intervention services for children and young people

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Continue to improve the Mental Health and emotional wellbeing of children and young people and ensure interventions and services are effective and available to those who need it			CCG Operational / Strategic Plans Better Care Fund Plan
• Review health funded posts for Educational Psychologists and Advisory Teachers	**DCC (Public Health)**	April 2015	Children, Young People and Families Plan
• Implement recommendations from the review of universal, targeted and specialist Child and Adolescent Mental Health Services	**CCGs**	July 2015	
• Implement the Public Mental Health Strategy including identifying priority groups such as young carers and looked after children and focusing on: o Prevention o Promotion o Early Intervention o Recovery	**DCC (Public Health)**	December 2015	Council Plan
• Develop the Children and Young People's Mental Health, Emotional Wellbeing and Resilience Plan 2015/18 ensuring it captures the 49 recommendations of the national taskforce report 'Future in Mind'	**DCC (Public Health) / CCGs**	December 2016	
• Roll out resilience programmes across 20 schools, to support young people who have emotional and mental wellbeing needs	**DCC (Public Health)**	August 2015	
• Implement a children and young people mental health and emotional wellbeing network aimed at sharing good practice and building capacity within the wider workforce including schools and the voluntary and community sector	**DCC (Public Health) / schools / Voluntary and Community Sector**	June 2015	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan

Support the reduction of teenage pregnancies (under 18 conceptions) in County Durham by delivering interventions that are in line with evidence and best practice
• Undertake a comprehensive health needs assessment to ensure evidence based services are delivered across County Durham based on need
• Develop a model of delivery that will have an impact on teenage pregnancy and sexual health
• Develop the Teenage Pregnancy and Sexual Health Delivery Plan with a focus on:
  • Supporting young people to achieve and attain during school years to prepare them for relationships, sexual wellbeing and adulthood
  • Building resilience in children and young people to protect against engaging in risky behaviour
  • Raising self-esteem, aspirations and educational attainment of young people
  • Improving the outcomes for vulnerable young people including teenage parents and their children and those at risk of unplanned pregnancy
  • Supporting teenage parents to improve the outcomes for themselves and their children
• Review the 5-19 school nursing service and implement an improved service to ensure high quality service delivery which is value for money and meets the needs of children and young people:
  • Review complete
  • New specification in place
	DCC (Public Health)	July 2015
		August 2015
		March 2016
		May 2015
		April 2016
			Children, Young People and Families Plan
			Council Plan

Reduce the oral health inequalities faced by children within County Durham • Develop an Oral Health Strategy for County Durham	**DCC (Public Health)**	April 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan

Continue to implement the Healthy Child Programme
 	
• Implement statutory changes in relation to the 0-5 Healthy Child Programme, by:
  • Project-managing the transition to the council for the commissioning of health visitors and the Family Nurse Partnership
  • Planning the development of an integrated 0-19 Healthy Child Programme, working with One Point, to enable a whole systems approach to health improvement services and service delivery
	DCC (Public Health)	October 2015
		
		March 2017
			Council Plan

Implement the Early Help Strategy to better support families who have additional needs at an earlier point
 	
• Implement the Children's Social Care Innovation Project and the Early Help Strategy, by:
  • Creating 10 integrated early help and social work teams across the county to significantly increase the range, access, quality and effectiveness of services for the whole family across the continuum of need
  • Creating and developing third sector alliances in all areas of the county to bring about sustainable change for families
 	
  • Implement an intensive workforce development programme to support the new teams and the whole workforce
  • Provide significantly enhanced service user engagement to change the relationship between professional and service user
	DCC (CAS – Children's Services)
	
	DCC (CAS – Children's Services) / Voluntary and Community Sector
	DCC (CAS – Children's Services)
	DCC (CAS – Children's Services)
		November 2016
		
		November 2016
		
		November 2016
		November 2016
			Council Plan
			
			Children, Young People and Families Plan

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work together to reduce incidents of self-harm by young people			Council Plan
• Clarify safe and effective support pathways, and raise awareness of key professionals that can be involved in complex cases	**DCC (Public Health)**	July 2015	Children, Young People and Families Plan
• Evaluate the sheds model for young people	**DCC (Public Health)**	March 2016	
• Review the pathway for paediatric self-harm admissions	**CCGs**	March 2016	
• Implement the plan to reduce incidents of self-harm and improve health, educational and social outcomes for children and young people, enabling them to cope better with difficult situations	**ND CCG**	December 2016	
• Adopt a better use of technology by CAMHS services, for example Skype	**TEWV**	March 2016	
• Develop the knowledge and skills of school based staff to identify and support vulnerable young people engaging in self-harm behaviours	**DCC (Public Health)**	October 2015	
Implement the Special Educational Needs and Disability Strategy 2014-2018, based on the findings of the SEND Review, to enable joint commissioning of services and support for individual children across education, health and social care			Children, Young People and Families Plan Better Care Fund Plan
• Further develop the Local Offer to include feedback from service users and young people	**DCC (Education)**	March 2016	Council Plan
• Review the educational placement process for children with special educational needs, including those in the non-maintained and independent sector	**DCC (Education)**	March 2016	
• Develop a strategy and joint commissioning plan that meets the local needs of children and young people with autism spectrum disorder and assures local compliance with NICE Guidance	**CCGs**	March 2016	
Ensure health, social care and third sector organisations work together to identify and support young carers			Children, Young People and Families Plan
• Brief Senior Managers and undertake training with First Contact / Social Care Direct staff to ensure that children and adult services are aware of the Memorandum of Understanding for young carers to enable them to continue to work together to identify inappropriate caring roles	**DCC (Commissioning)**	September 2015	Council Plan
• Implement the young carers action plan to provide support to young people in their caring role, by reviewing the carer's card to give young carers access to a wider range of services		March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
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			Children, Young People and Families Plan Association of Police Officer (ACPO) Standards
• Support schools, colleges and youth settings to provide effective education on alcohol to children and young people as part of the resilience framework	**DCC (Public Health) / Durham Constabulary**	March 2016	
• Work with retailers to restrict the products that appeal to children and young people and to restrict advertising of such products	**Durham Constabulary / DCC (Trading Standards)**	March 2016	
• Develop support pathways for children and young people and for parents/carers who have alcohol problems	**DCC (Public Health)**	March 2016	
• Carry out test purchase operations and age verification compliance testing on both on and off-licence premises	**DCC (Public Health)**	March 2016	
• Provide targeted interventions and consistent messages to young people who already drink alcohol and around the hidden use of alcohol	**DCC (Public Health)**	March 2016	
• Develop an engagement network with children and young people aged 10-24 to provide an avenue for seeking information and giving young people a voice	**Durham Constabulary**	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Breastfeeding initiation	Tracker indicator - no target required		
Prevalence of breastfeeding at 6-8 weeks from birth	Tracker indicator - no target required		
Percentage of children aged 4-5 classified as overweight or obese	Tracker indicator - no target required		
Percentage of children aged 10-11 classified as overweight or obese	Tracker indicator - no target required		
Number of young people referred to CAMHS who are seen within 9 weeks	Tracker indicator - no target required		
Alcohol specific hospital admissions for under 18's (per 100,000 under 18 years population)	Tracker indicator - no target required		
Percentage of exits from young person's substance misuse treatment that are planned discharges	83%	Not set	Not set
Under 16 conception rate	Tracker indicator - no target required		
Under 18 conception rate	Tracker indicator - no target required		
Percentage of mothers smoking at time of delivery	18.2%	17.2%	16.6%
Infant mortality rate	Tracker indicator - no target required		
Emotional and behavioural health of Looked After Children	Tracker indicator - no target required		
Emergency admissions for children with lower respiratory tract infection	Tracker indicator - no target required		
Young people aged 10-24 admitted to hospital as a result of self-harm per 100,000 population	Tracker indicator - no target required		

STRATEGIC OBJECTIVE 2: REDUCE HEALTH INEQUALITIES AND EARLY DEATHS

Outcome: Reduced levels of tobacco related ill health

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement a comprehensive partnership approach to wider tobacco control actions to reduce exposure to second hand smoke, help people to stop smoking, reduce availability (including illicit trade), reduce promotion of tobacco, engage in media and education and support tighter regulation on tobacco	**Tobacco Control Alliance for County Durham**		
• Implement the Tobacco Alliance Action Plan		March 2017	
• Review and modernise stop smoking services to reduce tobacco related ill health, by:			
• Carrying out a review of the current stop smoking service		June 2015	
• Development of service specification and market testing		July 2015	
• Procurement of the service		Dec 2015	
• Implementing modernised service		March 2016	
• Train fire crews in level 1 brief intervention on smoking cessation and deliver during Fire and Rescue Service home fire safety visits	**County Durham and Darlington Fire and Rescue Service**	March 2016	
Implement local awareness-raising campaigns to support the Smokefree Families Initiative, by targeting specific age groups on the health issues related to second hand smoke and by encouraging smoke free play areas across the county			
• Link Smokefree Families Initiative to Wellbeing for Life Service and deliver targeted training sessions	**Tobacco Control Alliance for County Durham**	March 2016	
• Ensure council play areas have appropriate smoke free signage	**DCC (Neighbourhoods)**	March 2016	

Outcome: Reduced obesity levels

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement the Healthy Weight Strategic Framework to develop and promote evidence based multi-agency working and strengthen local capacity and capability			CCG Operational / Strategic Plans
• Develop a performance and reporting process in order to make relevant data available to all partners	**DCC (Public Health)**	March 2016	Council Plan
• Improve access to physical activity and encouraging greater use of the natural environment	**DCC (Public Health)**	March 2016	
• Implement with partners the Healthy Weight Strategic Framework, to develop and promote evidence-based multi-agency working and improve support to children and adults so that they can have a healthier lifestyle:			
◦ Develop a checklist of risk indicators which have an influence on behaviours and impact on healthy weight, to be taken into account when writing strategy / policy	**DCC (Public Health)**	March 2016	
◦ Develop and complete an equity audit / needs assessment of healthy weight provision	**DCC (Public Health)**	March 2016	
Implement a Food and Health Action Plan for County Durham			
• Facilitate development of new food growing projects and provide support to existing projects	**Durham Community Action**	March 2017	
• Enable networks to be developed via Community Growing sub group of Sustainable Food Partnership	**Durham Community Action**	March 2017	
• Evaluate participant impact utilising the Warwick Edinburgh Mental Wellbeing tool	**Durham Community Action**	March 2017	

Outcome: Reduced levels of alcohol and drug related ill health

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work together to reduce the harm caused by alcohol to individuals, families and communities in County Durham while ensuring that people are able to enjoy alcohol responsibly			Council Plan
• Implement with partners the Alcohol Harm Reduction Strategy 2015/18, to reduce the harm caused by alcohol to individuals, families and communities:			
• Undertake social marketing campaigns to raise awareness about the harms of alcohol	**DCC (Public Health)**	December 2015	
• Increase the awareness of Foetal Alcohol Spectrum Disorder (FASD) with people who are pregnant, their partners or those who are trying to conceive	**DCC (Public Health)**	March 2016	
• Encourage midwifery and obstetric services to ensure that all pregnant women are offered information and, if appropriate, advice about drinking during pregnancy, and social welfare services should implement support to help	**DCC (Public Health)**	March 2016	
• Train all health and social care professionals are trained in Identification and Brief Advice (IBA) for alcohol	**DCC (Public Health)**	March 2016	
• Promote, monitor and quality assure the take up of IBA amongst primary care, secondary care and social care	**DCC (Public Health)**	March 2016	
• Train fire crews in IBA for alcohol and deliver during Fire and Rescue Service home fire safety visits	**County Durham and Darlington Fire and Rescue Service**	March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement 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			Council Plan
• Implement with partners the County Durham Drug Strategy 2014/17, to prevent harm, restrict supply, minimise the impact and build recovery within communities and families:	**DCC (Public Health)**		
◦ Implement a social marketing plan to raise awareness of the harm caused by drugs through targeting schools, families and training professionals to be able to offer advice and support		March 2016	
◦ Provide specific targeted training and education to support individuals, professionals, communities and families to address the harm caused by drugs and sustain a future for individuals to live a drug-free and healthy life		March 2017	
Implement new specialist joint drug and alcohol service for children and adults			
• Implement the Dual Needs Strategy for individuals of all ages who have a learning disability, mental or behavioural disorder or dementia alongside a substance misuse issue	**DCC (Public Health)**	May 2015	
• Evaluate the Lifeline (joint drug and alcohol) service that went live in April 2015	**DCC (Public Health)**	September 2016	

Outcome: Reduced mortality from cancers and circulatory diseases

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work in partnership to develop effective preventative and treatment services for cancers			CCG Operational / Strategic Plans
• Raise the profile of cancer awareness and earlier diagnosis and encourage the uptake of cancer screening programmes from communities where take-up is low, through the Wellbeing for Life service	**DCC (Public Health)**	March 2016	Council Plan
• Review pathway to delivery improvements required in cancer 62 day performance improved diagnosis rates and mortality	**DDES CCG / NECS**	August 2015	
• Review diagnostics services to ensure resilience and capacity for increased demand during campaigns	**DDES CCG / NECS**	June 2015	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work in partnership to develop effective preventative and treatment services for circulatory diseases			Council Plan CCG Operational / Strategic Plans
• Implement a targeted approach to the Health Check programme in County Durham, by:			
• Expanding the locally developed version of health checks (Check4Life) to all GP practices in County Durham	**DCC (Public Health)**	March 2016	
• Implementing a call and recall system based on the GP practice clinical systems	**DCC (Public Health)**	March 2016	
• Identifying those people on the practice systems who are eligible for a health check and stratifying them by estimated CVD risk using information already available	**DCC (Public Health)**	March 2016	
• Targeting those individuals with the highest estimated risk of CVD and type 2 diabetes	**DCC (Public Health)**	March 2016	
• Following social marketing campaigns, targeting those at highest risk in areas of lower than expected take-up	**DCC (Public Health)**	March 2016	
• Appoint a Diabetes Specialist Nurse to deliver Primary Care Clinics, as part of service redesign	**DDES CCG**	July 2015	
• Implement an integrated model of care for diabetes	**ND CCG**	March 2016	
• Review current patient pathway for cardiac services including electrocardiograms (ECGs) and palpitations	**ND CCG**	March 2016	
• Develop a community service for diabetes moving services out of hospital into the community through the development of a lead provider model	**CCG's**	April 2016	
Implement an integrated and holistic Wellbeing for Life service to improve health and wellbeing and tackle health inequalities in County Durham	**DCC (Public Health)**		Council Plan
• Work with partners to develop specific interventions around social determinants of health, eg housing, adult education and learning and employment		September 2015	
• Implement the Wellbeing for Life service within the 30% most deprived geographies of County Durham, to address the factors which influence health and wellbeing, by working in partnership to ensure that the social determinants of health, eg housing and employment, are embedded into the service		September 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Reduce the inequalities between people with learning disabilities and the general population			CCG Operational / Strategic Plans
• Develop pathways to ensure that individuals with learning disabilities and behavioural problems have access to appropriate services to improve their physical health and wellbeing	**DCC (Public Health)**	March 2016	CAS Service Plan
• Implement the national Autism Strategy action plan, by supporting adults with autism to access preventative services and remain independent in their own home	**DCC (Commissioning)**	March 2016	
• Improve the uptake of Annual Health Checks for people with learning disabilities through sharing best practice and supporting practices to make reasonable adjustments for patient access	**ND CCG**	March 2016	
• Review uptake of an eye care service for adults and young people over 14 with learning disabilities	**DDES CCG**	December 2015	
• Hold 2 workshops to better inform work around hydrotherapy and the work of the Profound and Multiple Learning Disability (PMLD) pathway	**DCC (Adult Care)**	March 2016	

Outcome: Reduced excess winter deaths

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Integrate and roll out interventions to address the impact of fuel poverty on excess mortality and morbidity			Council Plan CCG Operational / Strategic Plans

• Implement with partners the Affordable Warmth Strategy Action Plan, to address the impact of fuel poverty and target people who have a health condition:
  • Deliver a briefing programme for health and social care staff
  • Manage 100 referrals a year from health and social care professionals
	DCC (Public Health)	March 2016	

• Review pilot boilers on prescription scheme for patients with diseases that are exacerbated by living in cold damp conditions	**DDES CCG**	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Mortality rate from all causes for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from all cancers for persons aged under 75	Tracker indicator - no target required		
Percentage of eligible people who receive an NHS health check	8%	8%	8%
Mortality rate from liver disease for persons aged under 75 years	Tracker indicator - no target required		
Mortality rate from respiratory diseases for persons aged under 75 years	Tracker indicator - no target required		
Potential years of lives lost through causes considered amenable to healthcare – DDES & ND	To be confirmed		
Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis	96%	96%	96%
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	85%	85%	85%
Male life expectancy at birth	Tracker indicator - no target required		
Female life expectancy at birth	Tracker indicator - no target required		
Successful completions as a percentage of total number in drug treatment – Opiates	9.4%	Not set	Not set
Successful completions as a percentage of total number in drug treatment – Non Opiates	41.7%	Not set	Not set
Alcohol-related admissions to hospital per 100,000 population	Tracker indicator - no target required		
Successful completions as a percentage of total number in treatment – Alcohol	39.5%	Not set	Not set
Four week smoking quitters per 100,000 smokers aged 16+	2,939	Not set	Not set

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Estimated smoking prevalence of persons aged 18 and over	Tracker indicator - no target required		
Proportion of physically active adults	Tracker indicator - no target required		
Excess weight in adults	Tracker indicator - no target required		
Percentage of women eligible for breast screening who were screened adequately within a specified period	70%	70%	70%
Percentage of women eligible for cervical screening who were screened adequately within a specified period	80%	80%	80%
Percentage of people eligible for bowel screening who were screened adequately within a specified period	Indicator under development		
Excess winter deaths	Tracker indicator - no target required		
Percentage of people with learning disabilities that have had a health check	Tracker indicator - no target required		

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

Outcome: Adult care services are commissioned for those people most in need

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement The Care Act to promote integration between care and support provision and health services			Council Plan
• Implement the specific requirements of the Care Act 2014 for adult social care, by:	**DCC (Adult Care)**		
◦ Implementing an integrated transitions team		September 2015	
◦ Reviewing the assessment process to take into account additional demand from self-funders		March 2016	
• Review the Care Act documentation for adult and young carers	**DCC (Commissioning)**	February 2016	
• Complete the review of specialist residential care, to ensure that there is capacity to deal with complex needs	**DCC (Commissioning)**	March 2016	
• Develop preventative services in conjunction with key partners to meet gaps in provision	**DCC (Commissioning)**	March 2016	
Support people with caring responsibilities to identify themselves as carers so they can access the information, advice and support that is available			
• Hold a consultation event with carers to identify the barriers for hidden carers (with support from Area Action Partnerships)	**DCC (Commissioning) / Area Action Partnerships**	August 2015	
• Hold 2 engagement forums per year to engage with carers, people with a learning disability and partners on issues that have an effect on their lives	**DCC (Adult Care)**	March 2016	
• Work with carers to understand carers views of respite	**DCC (Adult Care)**	March 2016	
• Hold 2 engagement forums per year to engage with carers and older people on issues that have an effect on their lives	**DCC (Adult Care)**	March 2016	

Outcome: Increased choice and control through a range of personalised services

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work together to give people greater choice and control over the services they purchase and the care that they receive			Council Plan Better Care Fund
• Increase the number of personal health budgets administered through the direct payments process, by working with health partners to join up social care and health budgets, increasing efficiency and offering more choice and control to the service user	**DCC (Commissioning)**	March 2016	CCG Operational / Strategic Plans
• Develop a regional approach to developing personal health budget protocols and procedures	**NECS on behalf of CCGs**	March 2016	
• Increase capacity in the operational teams, to enable closer working with local authority partners on managing the applications and administration requirements of personal health budgets	**NECS on behalf of CCGs**	March 2016	

Outcome: Improved independence and rehabilitation

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Develop a new model for Community Services for the Frail Elderly that incorporates a whole system review that cuts across health, social care and the third sector; whilst delivering person centred care and placing early identification, timely intervention and prevention at its core			CCG Operational / Strategic Plans
• Increase community services that provide support to people in their homes and in the community to enable patients to leave hospital sooner or avoid admission	**CCGs**	June 2015	
• Review and evaluate current frail elderly services to ensure continued quality and value taking learning from other areas to implement and improve	**DDES CCG**	June 2015	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Maintain people's independence at home and reduce unplanned admissions by expanding the use of self-management programmes and technology			CCG Operational / Strategic Plans
• Review Telecare Service	**DCC (Commissioning)**	June 2015	Better Care Fund Plan
• Agree scope for review of Handyvan/Handyperson service	**DCC (Commissioning)**	September 2015	
• Implement a new home equipment loans service	**DCC (Commissioning)**	July 2015	CAS Service Plan
• Identify opportunities for minor adaptations, through the assessment process, to support more people at home	**DCC (Commissioning)**	March 2016	
• Implement recommendations from wheelchair service review	**CCGs**	March 2016	
Improve people's ability to reach their best possible level of independence by implementing the Intermediate Care Plus Service and other effective alternatives to hospital and residential care admission	**DCC (Commissioning) / CCGs**		Council Plan
• Implement Intermediate Care Plus		March 2016	
• Increase the number of service users who are supported through a reablement service, to help them recover from illness or disability, re-learn skills necessary for daily living and improve their independence		March 2016	
• Help people to manage their own long term conditions through self-management programmes		April 2016	
Provide safe, high quality 7 day integrated services across the health and social care economy			CCG Operational / Strategic Plans
• Implement phase 1 of the extension of the DDES weekend opening scheme	**DDES CCG**	June 2015	
• Extend access to primary care at weekends through the development of a new service, providing a wrap-around service for the most vulnerable patients	**ND CCG**	September 2015	
• Implement the recommendations of the review of weekend opening	**ND CCG**	March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement the Urgent Care strategy to ensure that patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient			CCG Operational / Strategic Plans
• Improve ambulance performance issues and response times by implementing recommendations of Clinical Senate review of proposals to change staffing structure across Teesdale and Weardale	**DDES CCG**	March 2016	
• Agree divert policy and commission additional bed capacity within Gateshead Foundation Trust	**ND CCG**	April 2015	
• Implement contractual arrangements in relation to changes to Shotley Bridge UCC Injuries	**ND CCG**	December 2016	
• Review all urgent care services (in and out of hours and minor injuries)	**CCGs**	March 2017	
• Complete review of Urgent Care and unplanned discharge transport and implement recommendations	**CCGs**	March 2017	
• Roll out of the NHS 111 remote appointments booking process to all GP practices	**ND CCG**	March 2016	
• Incentivise Primary care to allow NHS 111 to remotely book appointments both during the week and over the weekend	**DDES CCG**	July 2015	

Outcome: Improved joint commissioning of integrated health and social care

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement the agreed framework for Clinical Commissioning Group decision-making in relation to continuing health care and integrated packages in mental health and learning disability, including personal health budgets			
• Refresh framework and formalise agreement through DCC and CCG	**DCC (Commissioning) / CCGs**	February 2016	
• Agree jointly commissioned services through the Joint Decision Making Validation Forum	**DCC (Commissioning) / CCGs**	March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement the Better Care Fund Plan to integrate health and social care services			Council Plan
• Implement the Better Care Fund Plan with partners to improve integration of health and social care services in County Durham, with a focus on the seven local key work programmes	**DCC (Adult Care) / CCGs**	March 2016	
Work together to ensure a more localised approach to enable Clinical Commissioning Groups to set priorities based on local evidence			CCG Operational / Strategic Plans
• Work with GP Practices to improve outcomes for patients through increasing access to primary care, appropriate referral and pathway management to reduce avoidable referrals and unplanned admissions to secondary care and more effective management of long term conditions	**ND CCG**	March 2016	
• Improve health and wellbeing outcomes for residents by working with Clinical Commissioning Groups and Public Health to identify key local areas of concern whilst collectively developing and evaluating programmes to address these	**Area Action Partnerships**	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Carer reported quality of life	Tracker indicator - no target required		
Overall satisfaction of carers with support and services they receive	48-53%	Not set	Not set
Percentage of service users reporting that the help and support they receive has made their quality of life better	90%	90%	90%
Proportion of people using social care who receive self-directed support	90%**	90%**	90%**
	***NEW definition in Adult Social Care Outcomes Framework*		
Adults aged 65+ admitted on a permanent basis in the year to residential or nursing care per 100,000 population	710.4	Not set	Not set
Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	85.7%	Not set	Not set
Emergency readmissions within 30 days of discharge from hospital	Tracker indicator - no target required		
Delayed transfers of care from hospital per 100,000 population	Tracker indicator - no target required		
Falls and injuries in the over 65s	Tracker indicator - no target required		
Hip fractures in the over 65s	Tracker indicator - no target required		
Proportion of people feeling supported to manage their condition	Tracker indicator - no target required		
Avoidable emergency admissions per 100,000 population	2,884 (Apr-Jun15) 2,864 (Jul-Sep15)	2,916 (Oct-Dec15) 2,756 (Jan-Mar16)	
Number of people in receipt of Telecare per 100,000	225	Not set	Not set
Prevalence of diabetes	Tracker indicator - no target required		
Antibiotic prescribing in primary and secondary care -	To be confirmed		

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
% of patients on a diabetes or COPD register that have received a flu immunisation **and** % of patients on a COPD register that have received Pneumovacc – DDES and ND	To be confirmed		

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

Outcome: Increased physical activity and participation in sport and leisure

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Provide a wide range of physical activity opportunities across County Durham to support more active lifestyles and contribute towards tackling 'lifestyle conditions'	**DCC (Neighbourhoods)**		Council Plan
• Implement the refreshed Physical Activity Framework		March 2016	
Establish a wide and large scale intervention approach across agencies to support increased participation in physical activity through culture change	**DCC (Neighbourhoods)**		
• Instigate a top leader's summit on the Physical Activity Framework development to seek wide ownership		July 2015	
• Establish an inclusive approach to the development of a new framework across sectors		March 2016	
• Agree and develop the mechanism/forum for the coordination of the Physical Activity Framework long term		March 2016	
• Establish a single metric for the measurement and evaluation of progress in tackling physical inactivity		March 2016	

Outcome: Maximised independence

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work together to support people who have dementia to live in their own home for as long as possible			CCG Operational / Strategic Plans
• Implement the National Dementia Strategy and other national, regional and local dementia initiatives giving particular attention to:			Better Care Fund Plan
• Producing a dementia health needs assessment	**DCC (Public Health)**	July 2015	Council Plan
• Implement the Dementia Strategy for County Durham and Darlington 2014/17, to support people who have dementia to live in their own home for as long as possible, help them to maintain independence and provide them with end of life / palliative care which ensures dignity and respect:			
• Review provision of memory cafes across the county to ensure that coverage is appropriate and the service is meeting the needs of both people living with dementia and their carers	**DCC (Commissioning)**	September 2015	
• Carry out the accreditation process for dementia friendly communities in both the identified pilot sites – Barnard Castle and Chester-le-Street	**Alzheimer's Society / AAPs / DCC (Commissioning)**	March 2017	
• Support practices that have not yet signed up to the Dementia Enhanced service or have a low uptake and share best practice	**DDES CCG**	March 2016	
• Undertake a review and complete a scoping exercise to understand the post-diagnostic dementia service provision in North Durham	**ND CCG**	March 2016	
• Establish communications task group to engage with dementia stakeholders	**DDES CCG**	March 2016	
• Train fire crews on 'Dementia Friends' to assist with early identification and referrals to relevant agencies	**County Durham and Darlington Fire and Rescue Service and Alzheimer's Society**	March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Develop and implement programmes to increase resilience and wellbeing through practical support			CCG Operational / Strategic Plans
• Undertake a review of Recovery College	**CCGs**	March 2016	Better Care Fund Plan
• Implement national and local requirements defined by the crisis care concordat	**CCGs**	March 2016	
• Improve ambulance response times for mental health patients	**ND CCG**	March 2016	
• Develop and implement CQUIN re physical health checks for mental health patients	**CCGs**	March 2016	
• Evaluate place of safety (adults and children) to determine further investment required	**CCGs**	March 2016	
Work together to find ways that will support the armed services community who have poor mental or physical health			CCG Operational / Strategic Plans
• Invite representatives from key organisations and services to the biannual County Durham Armed Forces Network to share research and information about their activities and services and take forward any identified recommendations as required	**DCC (Public Health) / DCC (Assistant Chief Executive's)**	September 2015 & March 2016	
• Implement the Durham County Council policy for reservists	**DCC (Public Health) / DCC (Assistant Chief Executive's)**	October 2015	
• Encourage practices to identify armed services community	**DDES CCG**	March 2018	
Ensure that people using mental health services who are in employment have a care plan that reflects the additional support needed to help them retain this employment			TEWV Quality Account
• Embed the recovery approach within secondary mental health services	**TEWV**	September 2015	
• Implement the recommendations of the review of the Care Programme Approach (CPA) to address employment needs	**TEWV**	October 2015	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Continue to improve access to psychological therapies			
• Review IAPT services	**CCGs**	March 2016	
• Review counselling services and implement new specification re: service improvements including information governance and data capture	**CCGs**	March 2017	

Outcome: Increased social inclusion

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Develop a more integrated response for people with both mental and physical health problems, in particular supporting people with common mental health problems (such as depression or anxiety)			CCG Operational / Strategic Plans Better Care Fund Plan
• Develop integrated care pathways to address physical and mental health needs where appropriate	**CCGs**	March 2016	
• Implement Health Trainer model aimed at people with poor mental health	**DCC (Public Health)**	March 2016	
• Introduce Community Psychiatric nurses into general practice to better integrate primary and secondary care mental health services and reduce demand on secondary care	**DDES CCG**	March 2016	
• Work with CDDFT to ensure parity and what the pathway looks like for patients who are residing in hospital for a period of time following life changing conditions such as cancer, stroke, cardiac arrest and other long term conditions	**ND CCG**	March 2016	
Work in partnership to identify those who are, or who are at potential risk of becoming socially isolated to support people at a local level and to build resilience and social capital in their communities			Council Plan
• Implement the 2014/17 County Durham Implementation Plan of the 'No health without mental health' national strategy, to improve mental health and wellbeing across all age groups within the county and to identify those at risk of social isolation:			
◦ Undertake an assessment of the mental health needs of the population of County Durham	**DCC (Public Health)**	December 2015	
◦ Develop a mental health navigation model and ensure that these are accessible for each general practice within County Durham	**CCGs**	March 2016	

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work in partnership to support the building of improved connectedness in communities in order to protect those most at risk of social isolation			CCG Operational / Strategic Plans
• Implement a volunteer service for mental health	**Social Care Reform Board / CCGs**	March 2016	Better Care Fund Plan
• Implement programmes with partners to address social isolation which will be community based and owned	**AAPs**	March 2016	
Work together to address the health and social needs of vulnerable people who come into contact with the Criminal Justice System			
• Ensure that young people with mental health needs who offend receive a robust, high quality service through the secondment of mental health professionals to CDYOS	**CDYOS**	March 2016	
• Implement the screening, by CDYOS, of all young people who offend for substance misuse and mental health needs, through the implementation of Asset Plus (the national assessment tool for young people who offend)	**CDYOS**	March 2016	

• Ensure all referrals to the Liaison and Diversion Service are screened by skilled multi-disciplinary professionals to determine whether assessment is needed for service users of all ages who have been identified as potentially having the following:
  • Mental Health / Learning Disability / Substance Misuse / Autism / Physical Health / Acquired Brain Injury / Physical Disability / Safeguarding issues
  • For children and young people there is the addition of – emerging symptoms and risk factors for Mental Health / ADHD / speech and language communication needs/child protection issue/looked after status
	NHS England Sub-Regional Team (Health and Justice)	March 2016	

Work together to reduce the health inequalities between the Gypsy Roma Traveller community and the general population	**DCC (Public Health) / CCGs**		
• Provide a targeted Health Trainer service for this community		April 2015	
• Produce health related information in a format appropriate for the community		April 2015	
• Provide cultural awareness training through an identified program		April 2015	
• Provide a specialist Health Visitor for the community		June 2015	

Outcome: Reduced self-harm and suicides

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Implement the multi-agency Public Mental Health Strategy for County Durham including the self-harm and suicide plan	**DCC (Public Health) / CCGs**	March 2017	CCG Operational / Strategic Plans
• Develop plan to make County Durham a Suicide Safer County		April 2015	Better Care Fund Plan
• Evaluate suicide bereavement services		December 2015	
• Implement Mental Health preventative services		March 2016	Council Plan
• Develop an accessible 24-hour support service to enable services and the community to access advice on locally based services appropriate to their needs		April 2015	
• Develop a bereavement support service pathway to ensure that accessible information and timely support is available		September 2015	
• Review and potentially expand current pilot of the Primary Care Suicide Model	**CCGs**	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Gap between the employment rate for those with long term health conditions and the overall employment rate	Tracker indicator - no target required		
Proportion of adults in contact with secondary mental health services in paid employment	Tracker indicator - no target required		
Number of people with severe mental illness who are currently smokers	To be confirmed		
Health related quality of life for people with a long term mental health condition	To be confirmed		
Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population	Tracker indicator - no target required		
Hospital admissions as a result of self-harm	Tracker indicator - no target required		
Excess under 75 mortality rate in adults with serious mental illness	Tracker indicator - no target required		
Percentage of people who use adult social care services who have as much social contact as they want with people they like	50%	50%	50%
Estimated diagnosis rate for people with dementia	Tracker indicator - no target required		

STRATEGIC OBJECTIVE 5: PROTECT VULNERABLE PEOPLE FROM HARM

Outcome: Provide protection and support to improve outcomes for victims of domestic abuse and their children

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work together to provide support to victims of domestic abuse from partners or members of the family • Pilot an integrated model to work with families affected by domestic abuse and conduct a robust evaluation to identify what works • Procure a countywide domestic abuse outreach service which supports individuals who have experienced domestic abuse and children who have witnessed it • Develop and roll out a multi-agency e-learning training package in relation to domestic abuse which includes signposting to the County Durham Domestic Abuse Referral Pathway to enable professionals to identify domestic abuse and support individuals experiencing it	Domestic Abuse and Sexual Violence Executive Group (DASVEG)	March 2016 October 2016 March 2016	

Outcome: Safeguarding children and adults whose circumstances make them vulnerable and protect them from avoidable harm

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Work in partnership to identify signs of family vulnerability and to offer support earlier			Council Plan
• Implement the first strategic plan for the new statutory Safeguarding Adults Board, in line with the requirements of the Care Act 2014:			
• Revise safeguarding policy and procedures to be compliant with the Care Act	Safeguarding Adults Board (SAB)	March 2016	
• Ensure that the 2015/16 business plan addresses Care Act requirements	Safeguarding Adults Board (SAB)	April 2015	
• Establish methods of consulting with the public to influence the development of the plan	Safeguarding Adults Board (SAB)	May 2015	
• Develop and deliver awareness sessions on child sexual exploitation and offer to all taxi drivers in County Durham	Safeguarding Adults Board (SAB)	January 2016	
• Deliver Child Sexual Exploitation Conference to year 9 pupils in north of county	LSCB	October 2015	
• All front-line Trading Standards, Licensing and Environmental Health professionals to undertake Level 1 and Level 2 child sexual exploitation training	Area Action Partnerships DCC (Environmental Health)	July 2015 July 2015	
Support families using a Think Family approach to address their needs at the earliest opportunity			Children, Young People and Families Plan
• Embed the phase 2 Stronger Families Programme by rolling-out the use of the Family Outcome Plan through delivering to partner agencies: • staff engagement sessions; • briefings; and • Learning Network events	DCC (Children's Services)	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Percentage of repeat incidents of domestic violence	Less than 25%	Less than 25%	Less than 25%
Proportion of people who use services who say that those services have made them feel safe and secure	90%	90%	90%
Number of children's assessments where risk factor of parental domestic violence is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental mental health is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental alcohol misuse is identified	Tracker indicator - no target required		
Number of children's assessments where risk factor of parental drug misuse is identified	Tracker indicator - no target required		
Number of children with a Child Protection Plan per 10,000 population	Tracker indicator - no target required		
Percentage of adult safeguarding referrals substantiated or partially substantiated	Tracker indicator - no target required		

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

Outcome: Improved End of Life Pathway

Strategic Actions/Sub-Actions	Lead	Timescale	Link to Relevant Plan
Ensure the care and provision meets the individual requirements of people identified with palliative needs and those living with increased need in their last year(s) of life and support is provided to families and carers			CCG Operational / Strategic Plans
• Incorporate requirements for quality monitoring of end of life care in residential and nursing home contracts	**DCC (Commissioning)**	(tbc in July 2015)	
• Commence implementation of the Improving Palliative Care and End of Life Commissioning Plan including agreeing changes to the core community contract in relation to Palliative Care rehabilitation	**DCC (Commissioning) / CCGs**	April 2015	
• Employ Palliative care consultants and specialist nurses to support 24/7 access to advice and face to face assessments	**CCGs**	March 2016	
• Re-Procure rapid response service	**CCGs**	March 2016	
• Recruit to specialist Lymphoedema Practitioner post as part of the existing specialist community Lymphoedema service provided by CDDFT	**ND CCG**	March 2016	
• Establish community based Lymphoedema clinics within the North Durham CCG area	**ND CCG**	March 2016	

PERFORMANCE INDICATORS

Indicator	2015/16 Target	2016/17 Target	2017/18 Target
Proportion of deaths in usual place of residence	Tracker indicator - no target required		
Percentage of hospital admissions ending in death (terminal admissions) that are emergencies	Tracker indicator - no target required		
Number and percentage of patients in need of palliative care/support as recorded in practice disease registers – DDES & ND	To be confirmed		

GLOSSARY

ABBREVIATION	DESCRIPTION
ADHD	**Attention deficit hyperactivity disorder** Attention deficit hyperactivity disorder (ADHD) is a group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness
CAS	**Children and Adults Services** Children and Adults Services bring together a number of council functions which contribute to the County Durham Partnership vision of Altogether Better Durham In particular, the relevant themes are: • Altogether better for children and young people • Altogether healthier • Altogether safer • Altogether wealthier
CCG	**Clinical Commissioning Groups** Clinical Commissioning Groups are clinically-led groups that include all of the GP groups in their geographical area The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients
CDDFT	**County Durham and Darlington NHS Foundation Trust** CDDFT is an integrated acute and community Trust providing healthcare across County Durham and Darlington and surrounding areas, in hospital, at home and in community settings
CDYOS	**County Durham Youth Offending Service** County Durham Youth Offending Service works with young people and partner agencies to prevent re-offending
COPD	**Chronic Obstructive Pulmonary Disease** Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

ABBREVIATION	DESCRIPTION
CQUIN	**Commissioning for Quality and Innovation** The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals
CVD	**Cardiovascular Disease** Cardiovascular disease (CVD) is a general term that describes a disease of the heart or blood vessels. There are four main types of CVD. They are: • coronary heart disease • stroke • peripheral arterial disease • aortic disease
DASVEG	**Domestic Abuse and Sexual Violence Executive Group** DASVEG is a multi-agency sub-group of the Safe Durham Partnership
DCC	**Durham County Council** Local authority which performs all council functions in the County Durham area
DDES	**Durham Dales, Easington and Sedgefield** The name of the Clinical Commissioning Group operating in the South and East and West of the County
GP	**General Practitioner** A General Practitioner is a medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients
IAPT	**Improving Access to Psychological Therapies** The Improving Access to Psychological Therapies (IAPT) programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders

ABBREVIATION	DESCRIPTION
ND	**North Durham** The name of the Clinical Commissioning Group operating in the North of the County
NICE	**National Institute for Health and Care Excellence** The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care
SEND	**Special Educational Needs and Disability** Children who have needs or disabilities that affect their ability to learn, for example: • Behavioural/social (eg difficulty making friends) • Reading and writing (eg dyslexia) • Understanding things • Concentrating (eg Attention Deficit Hyperactivity Disorder) • Physical needs or impairments
TEWV	**Tees, Esk and Wear Valleys NHS Foundation Trust** Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and eating disorders services for the 1.6 million people living in County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton and Richmondshire

North Durham Clinical Commissioning Group

Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

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County Durham Joint Health and Wellbeing Strategy

2015-2018

Delivery Plan

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CAS12030 Children and Adults Services, CMI Team 2015

Health and Wellbeing Board

23 July 2015

Health Protection Assurance Annual Report 2013-14

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 provide an overview to the Health & Wellbeing Board of health protection assurance arrangements in County Durham and updates on relevant activity from April 2013 to March 2014.

Background

2. In the context of health system reforms brought about by the Health & Social Care Act 2012, new health protection responsibilities are in place across the various bodies established in the new system (NHS England, Public Health England and Clinical Commissioning Groups). Also, specific additional health protection responsibilities have been allocated to local authorities as part of their remit for public health. The protection of the health of the population is one of the five mandated responsibilities given to local authorities as part of the Act. The national Public Health Outcomes Framework includes indicators in relation to health protection.

3. The Director of Public Health (DPH) for County Durham is responsible under legislation for the local authority's new public health functions. The DPH also has responsibility for "the exercise by the authority of any of its functions that relate to planning for and responding to, emergencies involving a risk to public health".

4. Durham County Council's new responsibilities for public health include ensuring that local arrangements to protect the health of the population are robust and fit for purpose. Threats to the health of the public include infectious diseases, chemicals and poisons, radiation and emergency response and environmental health hazards.

5. The main issues include:

   - Implementation of robust Emergency Preparedness, Resilience and Response of both major and smaller scale incidents
   - Robust Environmental Health services
   - Implementation and Quality Assurance of Immunisation Programmes
   - Implementation and Quality Assurance of Screening Programmes.

6. New arrangements were established in Durham during 2013-14 to support the assurance role and to ensure information and intelligence is available on a timely basis and is monitored. During 2013-14 there was a strong focus on bringing the new organisational arrangements fully up to speed. Arrangements were tested through a number of incidents such as the measles outbreak in England and Wales. The current assurance arrangement are detailed in paras 9 to 13 of this report.

7. The North East Public Health England centre continues to deliver the functions delivered by former Health Protection Agency staff pre the 2013 changes.

8. NHS England is responsible for commissioning all of the screening and immunisation programmes that were formerly the responsibility of Primary Care Trusts (PCTs).

9. Regular liaison between Directors of Public Health and the Centre Director of Public Health England, and the Head of Public Health for NHS England has been established via the monthly North East DPH meeting.

Assurance arrangements in County Durham

10. Public Health England (PHE) established the County Durham & Darlington Health Protection Group and this brings together organisations involved in protecting the health of the population (terms of reference for this group are available on request. A Durham County Council (DCC) Consultant in Public Health attends and provides assurance to the DPH in relation to general health protection issues. More detailed information regarding PHE's role is detailed in a briefing attached at Appendix 2.

11. NHS England established the Durham, Darlington and Tees Screening and Immunisations Oversight Board with sub groups that consider specific screening or immunisations programmes. The Oversight Board is attended by a DCC Consultant in Public Health who provides assurance to the DPH in relation to screening and immunisation programmes. The management of incidents and the quality assurance for screening programmes are reported separately to the DPH.

12. The arrangements detailed in paragraph 10 are under review due to the re-structure of NHS England locally to become a sub-regional office covering Cumbria and the North East. A draft assurance framework has been presented to the Directors of Public Health (DsPH) network and will be progressed by NHS England.

13. The DsPH for County Durham and Darlington established the County Durham and Darlington Healthcare Acquired Infections Assurance Group in 2013. This has wide membership from all provider organisations ((terms of reference for this group are available on request. This enables both DsPH to have a clear line of sight to all providers in County Durham and Darlington.
14. NHS England established the County Durham & Darlington and Tees Local Health Resilience Partnership in 2013. One of the responsibilities of the Local

Health Resilience Partnership (LHRP) is to provide the DPH with assurance that the health sector has well tested plans to respond to major incidents that contribute to multi-agency emergency planning. The current terms of reference are available on request although these are currently under review due to the NHS England restructure.

15. Durham County Council Internal Audit has supported the DPH in making her determination on the assurance to be provided on the health protection assurance arrangements.

Performance

16. Both PHE, NHS England and the lead nurse for healthcare acquired infections have produced annual reports for 2013/14 (these are the latest available). These are available on request from the DPH.

17. PHE's annual report covers the NE geography and includes details of the prevention and surveillance of communicable diseases, the control of specific diseases such as meningococcal meningitis and septicaemia, their response to communicable disease outbreaks and incidents; emergency preparedness, resilience and response, environmental issues and quality and health inequality issues in health protection.

18. The annual report is supplemented by quarterly reports to the DPH that detail outbreaks and issues in County Durham.

19. Overall, there are no issues that the DPH has concerns about in relation to the health protection function discharged by PHE. Communications are very robust and effective and PHE keeps the DPH well informed of contemporary issues impacting on the Durham population.

20. NHS England's annual report covers County Durham, Darlington and Tees and is supplemented by geographical data and information presented to the Screening and Immunisation Oversight Board. This information is also provided directly to the DPH. The data provided is not adequate to enable local variations to be identified and therefore hides health inequalities. This is being progressed with NHS England by DsPH.

21. Overall, the universal immunisation programme demonstrates high uptake rates across County Durham, higher than the NE and England averages for most programmes.

22. There are three cancer screening programmes (breast, cervical and bowel cancer), six antenatal and newborn screening programmes plans two further non cancer screening programmes (diabetic eye and abdominal aortic aneurysm screening) delivered to the County Durham population.

23. Performance for the three cancer screening programmes demonstrated good uptake rates for the County Durham population, higher than the NE and England averages.

24. Where data is available for the six antenatal and newborn screening programmes, performance for the County Durham population is good although there are data reporting issues with providers that NHS England expects to resolve. This will ensure that data is provided for all antenatal and newborn screening programmes in the future.

25. The providers delivering the diabetic retinopathy screening achieve the national quality standard attendance rate of 70% but no published data for the (Abdominal Aortic Aneurysm) AAA screening is available for 2013/14. The National Screening Programme has put in place a quarterly data collection process for 2014/15.

26. The annual report of the Lead Nurse for infection prevention and control details the range of support and interventions initiated to reduce healthcare acquired infections and reports in year activity details.

27. This information is reported directly to CCGs and action plans are put in place to address identified issues. These are reported to the CCGs' Governing Bodies as part of the quality reports.

Conclusion

28. The health protection functions delivered by a range of organisations in County Durham demonstrates good performance and effective arrangements are in place that assure the DPH that the health of the population is adequately protected.

29. Good communication exists between the commissioners of the various programmes and the DPH and remedial and corrective interventions are instigated when necessary. Escalation procedures are in place in the event the DPH needs to raise concerns.

Recommendations

30. The Health & Wellbeing Board is requested to:

- Note the content of the report.
- Note that the performance is generally higher than the NE and England averages for most immunisation and screening programmes.
- Note that the DPH is satisfied that effective assurance processes are in place and that issues or concerns can be escalated appropriately.
- Note that the DPH discharges the health protection responsibilities on behalf of the Secretary of State for Health and the local authority.

Contact: Anna Lynch, Director of Public Health, County Durham
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Appendix 1: Implications

Finance
No implications from this report

Staffing
No implications from this report

Risk
No implications from this report

Equality and Diversity / Public Sector Equality Duty
No implications from this report

Accommodation
No implications from this report

Crime and Disorder
No implications from this report

Human Rights
No implications from this report

Consultation
No implications from this report

Procurement
No implications from this report

Disability Issues
No implications from this report

Legal Implications
No implications from this report

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Public Health England

APPENDIX 2

Health Protection Assurance Document

PHE Centre North East: Health Protection Team

February 2015

1 Purpose of the report

1.1 This report describes the arrangements for delivering health protection services to the people of the north east. In the context of this report health protection covers the investigation and control of communicable disease and other chemical/environmental hazards, incident and outbreak management, access to specialist advice in relation to epidemiology, microbiology, chemicals, radiation, communications and EPRR.

1.2 The purpose of the report is to provide Directors of Public Health, the NHS England, Clinical Commissioning Groups and PHE with evidence that can be used for internal and external assurance processes.

2 Delivering the health protection team response.

2.1 The staff establishment for the HPT at 1 March 2015 comprised:

- 1 Deputy Director for Health Protection (DDHP)
- 4 Consultants in Health Protection (CHP)
- 4 Senior Nurses (SN)
- 6.8 Nurses/Practitioners

The HPT is supported by administrative staff that are part of the business management team supporting the PHE Centre (PHEC).

2.2 For the purposes of health protection the northeast is divided into four areas, north of Tyne (Northumberland, North Tyneside and Newcastle); south of Tyne (Gateshead, South Tyneside and Sunderland); Durham and Darlington (Durham and Darlington); and Tees (Hartlepool, North Tees, Middlesbrough and Redcar and Cleveland).

2.3 A consultant and a senior nurse are aligned to each of four areas and provide a first point of contact for all operational and strategic activities. They routinely attend multiagency meetings in relation to health protection issues and lead on incident and outbreak management. This arrangement pre-dates PHE and has been in place for over ten years. It provides partner organisations with a point of contact with two senior members of staff in the HPT who understand the specific issues of the areas they cover. Cross-cover arrangements are in

place between CHP and SNs for annual leave or absence from work. This arrangement ensures that Directors of Public Health in particular are able to build up an effective working relationship with their named CHP and senior nurse.

2.4 Enquiries, case investigation, contact tracing and follow up of notifications is performed principally by the nurses/practitioners with additional cover from senior nurses. This is done on a north east wide basis with referral of more complex cases, incidents and outbreaks to the identified patch consultant/ senior nurse (or identified cover if not available). Escalation criteria are in place to determine what is referred to senior staff.

2.5 The HPT operates a de minimis staffing quota of 50% during office hours. A consultant and senior nurse is available during office hours to provide additional resilience.

2.6 The HPT operates a two-tier on call service. Senior nurses, nurse/practitioners and public health trainees who are deemed to be competent to perform this role staff the first on call rota. Competence is determined by passing the Part 1 exam, successfully completing their three month HP attachment, undergoing a scenario test and annual refresher weeks with the HPT. The second on call rota is staffed by the DDHP, CHP and the Consultant Field Epidemiologist.

2.7 The majority of the interaction between PHE and local partners is through the HPT, but the delivery of the health protection response involves working jointly with other co-located PHE services such as the Field Epidemiology Service (FES), Centre for Chemicals, Radiation and Environmental Hazards (CRCE), Communications and EPRR colleagues. Strong links also exist with local and national microbiology services. This arrangement ensures that specialist advice is available to HPT staff and partner organisations when responding to health protection issues.

2.8 In addition to these locally based services the HPT has access to national and international expertise via the Centre for Infectious Disease, Surveillance and Control, (Colindale), Emergency Response Department (Porton) and CRCE (Chilton).

2.9 The strength of the structure and integrated working arrangements of the HPT in the north east was recognised as an example of good practice by the Health Protection Agency (predecessor organisation to PHE) and this has continued since the inception of PHE.

2.10 PHE also have embedded staff in NHS England providing specialist advice and services in relation to screening and immunisation.

APPENDIX 2

3 Ways of working

3.1 The HPT works to a set of national guidelines in relation to the control of infectious disease. These are supplemented by local Standard Operating Procedures (SOPs). The following multi-agency plans have been developed:

- Outbreak Control Plan (stipulation that DsPH are members of an Incident or Outbreak Control Team)
- Infectious Disease Plan
- Incident Response Plan
- STAC Plan
- Influenza Plan
- Operational Pandemic Flu Plan
- Radiation Plan
- Mass Casualties Plan
- Critical Care Escalation Plans
- Ebola Plan
- Mass Vaccination Framework

Consultants and EPRR staff are also actively engaged in supporting the development and testing of plans developed by other organisations and the LRFs.

3.2 In addition to formal plans, the HPT will routinely inform DsPH of any enquiry, case or incident that is considered to be of significance or could attract media or political attention.

3.3 The HPT and FES produce a range of stakeholder reports with varying degrees of frequency depending on what is being reported. As at January 2015, twenty reports were routinely produced on a weekly (4), monthly (3), quarterly (8) and annual basis (5). A further 10 reports are produced for use by HP staff to ensure that every effort is made to identify possible links between cases and to identify outbreak that might not be obviously linked to one source or exposure. In addition, the HPT produces an Annual Report in June each year summarising the most significant activities and issues of the previous year and providing data at a local authority level for all major infectious diseases. The Annual Report contains a comprehensive list of the stakeholder reports produced for the previous year.

3.4 The HPT supports and where necessary provides system leadership to multi-agency arrangements across the north east. These arrangements include:

- Attending Health and Wellbeing Boards and other local authority meetings to provide guidance, training, advice and information on HP matters.

- Providing consultant level support to Local Resilience Forums and other senior staff to support the sub-group structures of LRFs.
- Fulfil the STAC Advisor role in the event of a major incident.
- Administer the STAC Rota and provide updates and annual training for DsPH in support of their role of STAC chair.
- Provide consultant level support to the Local Health Resilience Partnerships.
- Act as Proper Officers for local authorities, and Port Health/Medical Officers for specific elements of public health law.
- Chair the 'Ways of Working Group' comprising of DsPH, NHS AT representatives, CCG representative and PHE.

3.5 Since April 2013 one CHP has been working on a contracted basis (the equivalent half a day per week) with the NHS Areas Teams to provide system leadership across the NHS/PHE specifically in relation to EPRR, Influenza and the development of multi-agency plans covering the north east.

3.6 The HPT is committed to improving the quality of the services it provides to the public and to partner organisations. It does this by:

- An annual quality improvement programme comprising audits and review. All staff including admin staff have an objective to participate in at least one audit/service review per year.
- Regularly contribution to national and international conferences through posters and presentations.
- Contributing to the evidence base through research and publications.
- Continuous customer satisfaction monitoring.
- Delivers the high level national PHE objectives locally.
- Annually sets more locally sensitive objectives to improve effectiveness and efficiency.

An evaluation of the success of these objectives is contained each year in the Annual Report.

3.7 The HPT recognises that other organisations also have statutory responsibilities to protect the public and works closely with them to ensure that this is done in a co-ordinated and coherent way. This involves:

- Full engagement and participation in Local Resilience Forums and associated sub-groups.
- Deputy Director for Health Protection sits on the Local Health Resilience Partnership.
- Consultants and senior nurses meet with Environmental Health colleagues in various forums to discuss and agree ways of working.

3.8 The North East HPT has a strong track record in developing, delivering and participating in training sessions. Such sessions range from ad hoc events in response to an emerging issue, to more planned updates such as STAC training and learning from incidents and outbreaks.

4 Conclusion

4.1 This document summarises the structure and ways of working of the HPT internally and externally with partner organisations. It describes the processes by which the team seeks to protect the public from communicable disease, support partner organisations in their responsibilities, provide assurance to DsPH in their role to protect local populations and offer system leadership where appropriate.

Paul Davison
Deputy Director for Health Protection
Health Protection Team
PHE Centre: North East
February 2015

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Health and Wellbeing Board

23 July 2015

Smokefree County Durham Tobacco Control Alliance Update

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 provide the Health and Wellbeing Board with an update on the recent "CLeaR thinking: Excellence in local tobacco control" peer assessment. This provides a position statement on the County Durham Tobacco Alliance's plans and ambitions and recommends further action where required. The review was led jointly by Public Health England, Action on Smoking and Health (ASH) and Cancer Research UK.

Background

2. County Durham has a long term ambition to reduce smoking prevalence to 5% by 2030.The ambition is driven by a vision statement to 'Make Smoking History' supported by a medium term five year tobacco control action plan 2013 - 2017. Partners on the alliance are committed to delivering actions based on the World Health Organisation's (WHO) six evidence based strands of tobacco control.

3. In March 2015 the alliance undertook the one day CLeaR Thinking:Excellence in local tobacco control. CLeaR (Challenge, Leadership and Results) is an improvement model which provides local government and its partners with a structured evidence-based approach to achieving excellence in local tobacco control.

4. The model comprises of a self-assessment questionnaire, backed by an optional challenge and assessment process from a team of expert and peer assessors. The purpose of the assessment is to test the assumptions organisations have made in completing the questionnaire and provide objective feedback on performance against the model.

5. A number of recommendations (CLeaR messages) and the peers' assessment, accompanied by detailed feedback on specific areas of the model (CLeaR results) are provided at the end of the review.

6. Within the three domains - challenge, leadership and results, the review looks at how County Durham performs in the following areas:

- Leadership
  - vision and Leadership
  - planning and commissioning,
  - partnership agency and supra-local,
  - innovation and learning

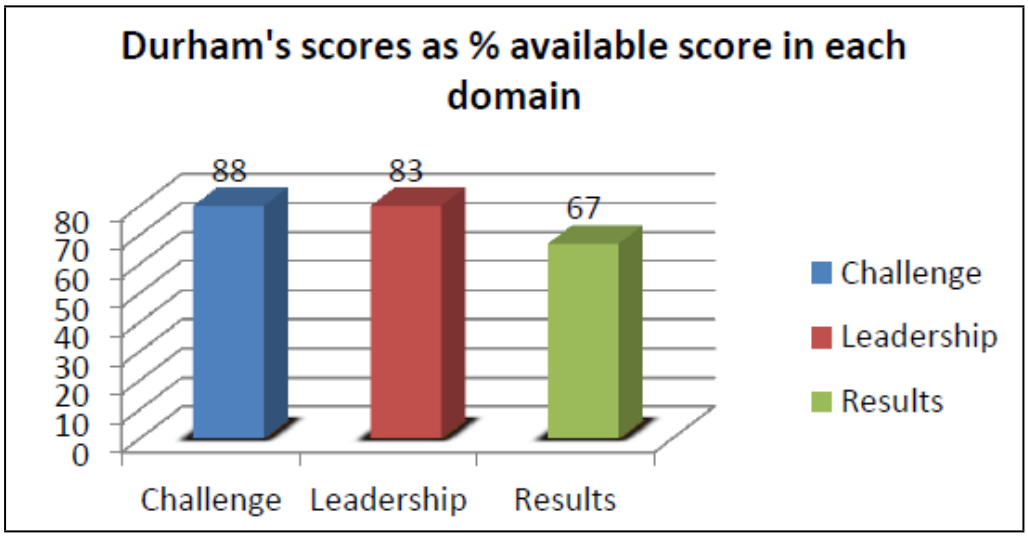
- Challenging services
  - prevention,
  - compliance,
  - communication and de-normalisation,
  - cessation,
  - prevention

- Results
  - quit data
  - priority indicators

Results

7. Overall the review team were impressed with the insight, leadership and strengths of how County Durham approached tobacco control and as a result scored high for two of the domains; challenge and leadership (table 1). The scores were lower for the results domain, however these results are based on ambitious priority indicators (reducing smoking prevalence in adults and young people, reducing smoking in pregnancy and reducing children's exposure to secondhand smoke) therefore these are expected to be low at this stage of the action plan delivery.

Table 1: County Durham scores



8. The detailed peer review summary in relation to each domain and recommendations for County Durham partner organisations are available in Appendix 2.

9. Subsequent to the peer review, the Tobacco Control Alliance has been awarded the 'challenging services achievement' award by Public Health England, one of four national awards recognising achievements in tobacco control work. Members of the alliance received the award in London on 7th July 2015 at a national conference.

Conclusions

10. The Tobacco Control Alliance undertook a challenge by taking part in the CLeaR assessment to improve how tobacco control is delivered in County Durham. The results in chart one of appendix 2 show the Alliance member's self-assessment results in comparison to those of the peer review team. The review team has produced a comprehensive report with suggested recommendations that will be translated into actions for the 2015/16 tobacco control plan.

Recommendations

11. The Health and Wellbeing Board is recommended to:

- Note the detailed feedback from the peer review in Appendix 2.
- Note the 12 high level recommendations for all partners attached as appendix 3.
- Note the leadership role of the Health and Wellbeing Board in challenging and supporting partners to progress relevant actions.
- Note the national award received by the County Durham Tobacco Control Alliance.

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Appendix 1: Implications

Finance
Current commissioned tobacco control activity is funded via the public health grant. Partner organisations contribute variable resource to the agenda.

Staffing
No implications.

Risk
No implications.

Equality and Diversity / Public Sector Equality Duty
No implications.

Accommodation
No implications.

Crime and Disorder
Illicit tobacco continues to be problematic in County Durham. Partnership work is addressing this.

Human Rights
No implications.

Consultation
No implications.

Procurement
No implications.

Disability Issues
No implications.

Legal Implications
No implications.

Appendix 2

Domain 1: Leadership

Vision and leadership

1. The Director of Public Health, Cllr Audrey Laing, Chair of the Alliance and Cllr Lucy Hovvels, Chair of the Health and Wellbeing Board demonstrated their clear vision, commitment, passion and leadership of the agenda. The panel were reassured to see that funding for local and regional level (Fresh) activity is being maintained in line with a renewed focus on achieving the 5% prevalence ambition for every community across County Durham.

2. Leadership qualities were clear at all levels of the partnership, at political, strategic, management and delivery levels. Coordination of the Alliance and the tobacco control commissioning agenda benefits greatly from an expert and experienced public health portfolio lead. The Alliance is clearly united behind a shared vision to make smoking history.

3. There was also evidence of distributed leadership through the Health and Wellbeing Board, Area Action Partnership teams and Health Networks. Tobacco control is clearly viewed as a cross cutting issue and embedded within strategic priorities at local authority level.

4. The review team noted Durham's early adoption of the Local Government Declaration on Tobacco Control. Durham has made a clear commitment to the World Health Organisation's Framework Convention on Tobacco Control and honouring its obligations under Article 5.3 as a government organisation. It is recommended that a clear written policy is put in place to evidence how the local authority will fulfil those obligations if approached by the tobacco industry or its affiliates.

5. Similarly, sign up to the NHS Statement of Support is welcomed and local NHS organisations will wish to consider putting in place similar policies. NHS organisations may also wish to consider whether all clinical leadership champions have been identified and fully engaged and whether their own delivery plans are consistent with joint ambitions to make smoking history.

6. Clinical leadership was less evident to the review team during the assessment visit. However, it was clear that the NHS was engaged in tackling smoking in pregnancy and that this was happening through the Baby Clear initiative in partnership with Fresh.

7. The recently initiated work to tackle smoking in mental health service users with the leadership of the Medical Director of the Mental Health Trust was noted as an example of the calibre of NHS leadership, engagement and commitment that is likely to deliver change.

8. Further work to build up clinical engagement and senior champions across the acute sector and with CCGs would further strengthen both partnership working and NHS delivery. Given the scale of Durham's ambition to reach 5% prevalence or less by 2030, all partners need to be fully engaged in planning to deliver this vision.

9. Formalising relationships with emerging clinical champions and requesting they be accountable for initiating and monitoring action in their organisations will be key.

Planning and commissioning

10. There is good evidence that planning and commissioning of tobacco control activity is based on structured processes, for example the JSNA and planned activity links into key local strategies such as the Health and Wellbeing Strategy and its delivery plan. It also links with Altogether Better, The Sustainable Community Strategy for County Durham 2010-2030.

11. Maintaining budget levels, alongside dedicated and sustained delivery capacity for tobacco control has been an asset for County Durham which it is hoped will be maintained.

12. The review team recognised that there had been some progress on the implementation of NICE harm reduction guidance in secondary care, however it was reported that it was not yet fully implemented as part of the local stop smoking service offer. Consideration should be given to progressing implementation of the guidance across all service areas where client need has been identified.

13. It was noted that the Foundation Trust is working towards full compliance with NICE secondary care guidance and offers a dedicated stop smoking service. Ongoing work will be required at Trust Board level to deliver a smokefree site. The identification of additional clinical champions, as highlighted above, should assist with this NHS focused work in addition to supporting partnership goals.

14. The Health and Wellbeing Board may wish to consider whether additional review, planning, investment and commissioning is required to support delivery of its 5% by 2030 vision. The ASH Smoking Still Kills Report due to be published in June 2015 will provide a useful strategic framework for action and advocacy.

Partnership, cross-agency and supra-local working

15. County Durham is the lead commissioner for Fresh Smoke Free North East on behalf of all North East councils, and therefore has links into supra-local activity around issues such as tackling illegal tobacco, marketing and communications, tobacco control commissioning and advocacy.

16. Durham clearly has a strong voice in the North East Make Smoking History campaign and the development of a joint ambition to achieve a 5% smoking prevalence target.

17. The evidence provided to the review team suggested all partners were enthusiastic about collaborative working to achieve better outcomes for communities and economies of scale.

18. During the workshop it was clear there was scope for wider engagement in the Alliance, including from NHS partners, but also from partners such as Trade Unions, the Police and Housing Associations. This engagement should be prioritised.

19. The Health and Wellbeing Board should consider requesting that all NHS partners present their detailed plans in relation to the NHS Statement of Support commitments. The Board may also wish to consider a joint workshop session with the Alliance and Fresh partners to map activity up to 2020 and 2025 that could deliver the 5% vision.

Domain 2: Challenging Your Services

Prevention

20. Prevention work is clearly framed in a wider context of denormalisation and changing the adult world by making tobacco use less desirable, accessible and affordable.

21. Interventions take a population level approach and are framed around the life course, from smokefree maternity interventions such as babyClear to smokefree programmes, advocacy on smokefree cars and standardised packaging, work to tackle access to tobacco including illegal tobacco, risk and resilience focused work in schools and implementation of regional quality smokefree standards in line with NICE guidance. This sits alongside work to support adult quitting.

22. There may be even greater opportunities to engage and involve health visitors, midwives and dental health professionals in plans to keep children, young people and their families smokefree.

23. There may also be opportunities for more effective delivery of the Smokefree Families programme when the Wellbeing Life service is fully integrated.

24. The CLeaR review team believe that there are opportunities to extend the smokefree playgrounds work to include smokefree sports grounds/touchlines for children and young people’s community sport.

Compliance

25. The review team noted work on tobacco regulation compliance including the offer of training in lieu of fixed penalty notices for taxi drivers smoking in their vehicles; intelligence led work to tackle underage sales; and extensive partnership working to tackle illegal tobacco.

26. There is evidence of a significant focus on illegal tobacco within trading standards that is taking a systematic and intelligence led approach to addressing the issue with encouraging results. Good partnership working in place, particularly with the Police and also with HMRC, however partnership working with HMRC remains a challenge.

27. The review team noted that three trading standards officers were delivering enforcement activity, supported by funding from the public health grant.

28. Opportunities exist for greater supra local working on illicit tobacco, especially on financial investigation, enforcement and intelligence liaison with HMRC. It is suggested that such opportunities will be most effectively and cost effectively achieved on a supra-local level.

29. Evidence from the North of England programme strongly suggests that regional trading standards capacity is required for effective intelligence and enforcement coordination. HMRC has consistently expressed a desire to work collaboratively at regional level to tackle the illicit trade due to the nature and level of the criminal activity involved and their own operational arrangements.

    It is suggested that a discussion could be taken forward through the NE Tobacco Regulation Forum in the first instance to explore this.

30. The CLeaR review team advise it would be useful to have a clear written local policy on engagement with the tobacco industry in relation to regulatory services, reducing contact to an absolute minimum around actual prosecutions and to reflect the commitments made in signing up to the Local Government Declaration and also wider Framework Convention on Tobacco Control 5.3 obligations.

31. Local intelligence on niche tobacco was evidenced and action appears appropriate to evidenced need.

Communications and de-normalisation

32. The County Durham Alliance works closely with Fresh Smoke Free North East to implement locally, regional and national campaigns such as Don’t Be the 1, Every Breath, Take 7 Steps Out, Keep It Out, Stoptober, New Year Quit and No Smoking Day. This work takes place as part of the Alliance tobacco control communications plan. Additional opportunities may be available to position tobacco control as a cross cutting priority within the wider public health service communications strategy.

33. The communications team is able to offer support around PR, marketing and communications. The support around Stoptober for example was excellent and there were examples of optimising a national campaign locally. The review team noted that amplification of national campaigns activity, such as Stoptober, is targeted at high deprivation/high smoking populations in the same way as regional and local campaigns activity.

34. It was noted that the historical links with the Foundation Trust have been maintained and that the communications team recognised the importance of targeting local authority and NHS staff as part of national PHE smokefree campaigns given that the majority of staff also reside within the County.

35. The local stop smoking service reports that marketing expertise is a gap. The service would benefit from the expert support within the public health communications team to review its current marketing and communications offer if capacity is available. Consideration could be given to training a broader range of local spokespeople to speak to the media on tobacco issues such as clinical champions, new strategic Alliance partners and community members who may be 'quit heroes' or young advocates for a tobacco free future.

Innovation and learning

36. There is evidence of sharing data, innovation and learning across County Durham.
    There was also good evidence of independent academic partner engagement in evaluation of delivery which impressed the assessment team.

37. There are opportunities for the Health and Wellbeing Board to take a greater role in scrutinising Alliance plans and data.

Quitting

38. The local stop smoking service is maintaining a high quality service, has some examples of good practice, and is actively working to reach more smokers in the local community. The Health Equity Audit of the service is exemplary and the review team was pleased to see its recommendations being implemented through task and finish groups.

39. It was highlighted that the smoking at time of delivery (SATOD) figure continues to fall and the further implementation of babyClear is continuing. The locality is to be congratulated for its leadership and success in the implementation of this programme in partnership with Fresh and the local NHS. The need to more fully engage all relevant NHS partners to assure the continued successful implementation of this work and its expansion to include the engagement of all health visitors, family nurse practitioners and fertility clinics is essential. The invitation (or confirmation) of a key NHS partner onto the Alliance to act as accountable officer or senior clinical champion for reducing smoking at time of delivery (SATOD) data is recommended.

40. The review team recommended that the local stop smoking service would benefit from undertaking some independent review process, for example a National Smoking Cessation Training Centre Audit.

41. The pragmatic and positive stances on tobacco harm reduction were welcomed by the assessment team. The team have a concern around references to pregnant women's use of e-cigarettes as a quit aid within the service. Whilst undoubtedly less harmful than smoking to a pregnant smoker, a service might be expected to recommend a licensed product and/or behavioural support as an alternative given that electronic cigarette products are currently unregulated/unlicensed.

Domain 3: Results

42. Adult prevalence rates are falling and reductions in smoking prevalence at time of delivery are particularly encouraging. Trend data on prevalence for routine and manual smokers is less clear in spite of great efforts to target this population through local stop smoking services and marketing and communications campaigns.

43. A continued focus on tackling health inequalities including through asset based community development approaches and harm reduction methods for heavily addicted smokers may deliver results in this group. Evaluation of this work will be of interest to the Alliance and the Health and Wellbeing Board.

Quit data

44. The quality of the service remains high albeit that there has been some drop off in throughput which is also reflected in national service data trends.

Local priorities

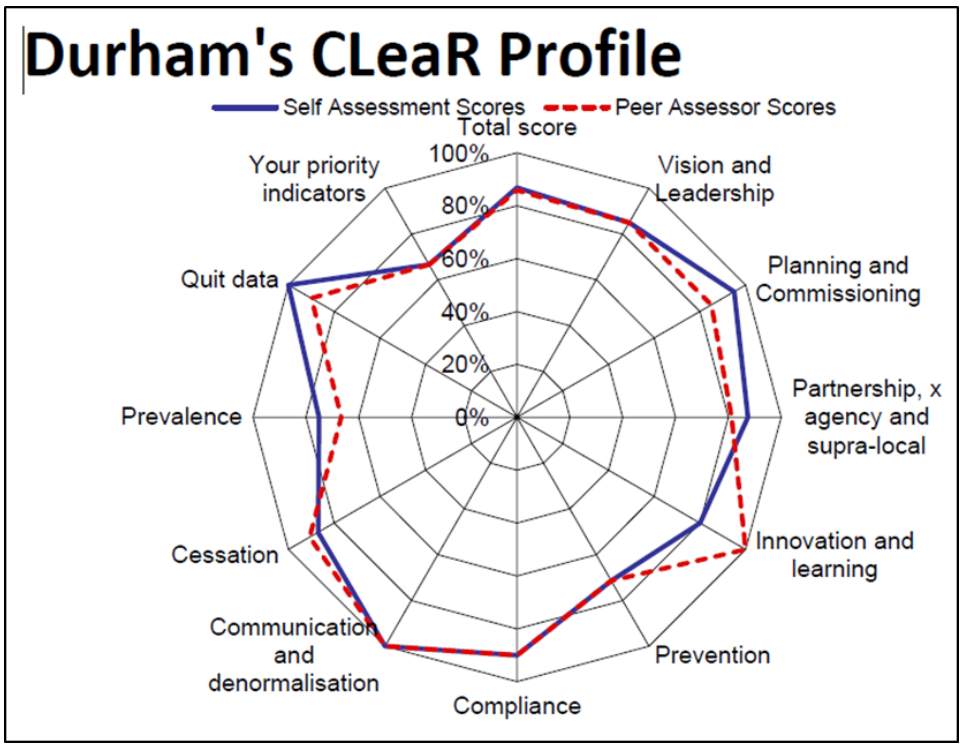
45. Reducing smoking prevalence in adults faster than the national rates is challenging but achievable with continued investment in comprehensive tobacco control. Investment levels may need to be reviewed to accelerate progress.

    The focus on reaching communities and groups where smoking rates are highest needs to continue within the context of the bold ambition of 5% adult prevalence in every community by 2030.

46. The Health and Wellbeing Board is well placed to lead this process, monitor plans that are put in place and hold partners to account for progress. The local authority's overview and scrutiny committee may also wish to consider its role in the process.

47. Chart one shows how the alliance self- assessed against the set of criteria (blue continuous line) and the peer assessment score (red dotted line). It is clear the self-assessment was very close to that of the review team.

Chart 1: Comparison of self-assessment and peer assessors scores



Appendix 3

High Level Recommendations

- Durham has made a clear commitment to the WHO Framework Convention on Tobacco Control and honouring its obligations under Article 5.3 as a government organisation. It is recommended that a clear written policy is put in place to evidence the process for how the local authority will fulfil those obligations if approached by the tobacco industry or its affiliates.
- NHS organisations may also wish to consider whether all clinical leadership champions have been identified and fully engaged and whether their own delivery plans are consistent with joint ambitions to make smoking history.
- Further work to build up clinical engagement and senior champions across the acute sector and with CCGs would further strengthen both partnership working and NHS delivery.
- Scope for wider engagement in the Alliance, including from NHS partners, but also from partners such as Trades Unions, the Police and Housing Associations. This engagement should be prioritised.
- The board may also wish to consider a joint workshop session with the Alliance and Fresh partners to map activity up to 2020 and 2025 that could deliver the 5% vision.
- Have a clear written local policy on engagement with the tobacco industry in relation to regulatory services, reducing contact to an absolute minimum around actual prosecutions and to reflect the commitments made in signing up to the Local Government Declaration and also wider FCTC 5.3 obligations.
- The stop smoking service would benefit from the expert support within the public health communications team to review its current marketing and communications offer if capacity is available.
- Consideration could be given to putting in place and training a broader range of local spokespeople to speak to the media on tobacco issues such as clinical champions, new strategic Alliance partners and indeed community members who may be ‘quit heroes’ or young advocates for a tobacco free future.
- There are opportunities for the Health and Wellbeing Board to take a greater role in scrutinising Alliance plans and data.
- The need to more fully engage all relevant NHS partners to assure the continued successful implementation of this work and its expansion to include the engagement of all health visitors, family nurse practitioners and fertility clinics is essential. The invitation (or confirmation) of a key NHS partner onto the Alliance to act as accountable officer or senior clinical champion for reducing smoking at time of delivery (SATOD) data is recommended.
- The stop smoking service would benefit from undertaking some independent review process, for example a National Smoking Cessation Training Centre Audit.
- The Health and Wellbeing Board is well placed to lead on the tobacco control process, monitor plans that are put in place and hold partners to account for progress. The local authority’s overview and scrutiny committee may also wish to consider its role in the process.

Health and Wellbeing Board

23 July 2015

Winter Plan and System Resilience Update

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

Purpose of the Report

1. The purpose of this report is to provide an update on system resilience funding and winter planning following a report produced and given to the Health and Wellbeing Board in January 2015. The role of the Systems Resilience Group (SRG) is to support and drive the delivery of operational resilience and capacity ensuring quality, performance and financial balance.

Background

2. The SRG is the forum where capacity planning and operational delivery across the health and social care system is coordinated for all urgent and emergency care services. Bringing together both elements of elective and urgent care within one planning process underlining the importance of whole system resilience and recognising that both parts need to be addressed simultaneously in order for local health and care systems to operate effectively in delivering year round services for patients.

3. In May 2015 a Winter Debrief was held with a wide range of stakeholders to examine how the health and social care system had managed over winter, feedback on what had worked and look at what could be improved for this coming winter. This report will seek to summarise these findings. It should be noted that the Health and Wellbeing Board received a report in January 2015 which detailed where the winter monies had been allocated.

Performance over Winter

4. NHS England attended the Winter Debrief and summarised the main points in terms of the performance of the system over this winter as:

- Higher patient acuity resulted in longer length of stay especially frail elderly.
- The impact was earlier and lasted the whole winter and the system struggled with flow through the system including discharge
- Limited mutual aid between providers.
- Escalation at times felt fragmented and there was variation in mitigating actions, triggers and command and control.
- It was a relatively mild winter with no major flu outbreak which leads to the question could the system have coped under a different scenario.

- The NHS111 service faced similar unprecedented demand, dealing with 4.6 million calls this winter –which is an increase of one million calls or 27% on last winter. NHS111 call handlers and support reduced unnecessary pressures on Accident & Emergency (A&E) and emergency ambulance services by directing people to the right place for their care such as GPs, walk-in centres or pharmacists. Of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to A&E.
- It is important to note that despite the pressures organisations consistently delivered core services and did not declare a Major Incident and provided a local and regional response to support the system.

Interventions that made a difference

5. There were a number of schemes across the region and more locally in County Durham and Darlington that seem to have received good feedback and made a difference to the patient experience and the flow of the urgent and emergency system. These include:

    - An increase in work force with particular reference to more senior decision makers fronting acute services, additional paediatric practitioners, occupational therapists/physiotherapists supporting timely discharge and hospital social workers.
    - Dedicated teams for specific groups of patients such as delirium patient assessment in A&E and triage of elderly patients for assessment and early supported discharge.
    - Extension of existing services supporting improved patient flow and timely discharge such as ambulatory care, see and treat and rapid assessment units.
    - Supporting discharges with more capacity in social care and equipment as well as schemes like help to home.
    - General Practitioner co-located in A&E evaluated well throughout the Region; however there are significant issues securing and sustaining the work force and there is a need to agree a process, induction and orientation to maximise the benefits.
    - Home Visiting Service supporting Primary Care evaluated well as a key admission avoidance scheme.
    - “Keep Calm” campaign.
    - Local media coverage throughout the winter monitoring period.
    - Daily teleconferencing via Surge Management Team.
    - Daily sharing of innovation via Surge Management Team.
    - Daily review of process via Surge Management Team.

Plans for 2015/16

6. There is already a draft timetable in place for production of winter plans for 2015/16 which will need to build on the learning from 2014/15. The main points to take forward are:

- Investment in whole system initiatives that ensure flow through system, feedback from schemes is aiding this and the SRG facilitates the discussions.
- Sharing learning and best practice such as the, 'perfect week' and ways of improving discharge – this has been done at SRG and will continue.
- Predictive modelling – 'stress test' plans under alternative scenario's - this will be done in the coming months with plans being signed off by October 2015 after an assurance process.
- Whole system management is essential and the North of England Commissioning Support Unit (NECS) Winter Surge Team can help with this in 2015/16.
- It should also be noted that providers of NHS Services, such as County Durham and Darlington NHS Foundation Trust, have been allocated funds for winter resilience in their 2015/16 base allocation in the anticipation that there will be no further monies centrally.
- NHS England have issued a list of eight high impact interventions which they believe will reduce pressure on NHS systems during times of Winter surge. These recommendations will be part of the criteria used to test the plans for 2015/16 (attached at Appendix 2).
- NHS England have also made a call for expressions for organisations and partnerships to become Vanguard sites for a further new care model focusing on urgent and emergency care. The Durham and Darlington Systems Resilience Group will be putting in a bid for this by mid-July 2015.
- The establishment of Urgent and Emergency Care Networks will also aid SRG work.
- It was also agreed at the Winter Debrief that the North of England Escalation Plans (NEEP) would be further refined to ensure a consistent approach. In addition the Regional Flight Deck would continue to operate with flight desk data enabling predictive modelling. Finally it was also noted that more work needed to be done with local authorities to improve delayed transfers of care as well as looking at the pathways into and out of nursing homes to ensure the best possible patient experience.

Recommendations

7. The Health and Wellbeing Board is recommended to:

- Note the contents of this report.

Contact: Kathleen Berry, Commissioning Manager, North of England Commissioning Support Unit
Tel: 0191 374 4163

Appendix 1: Implications

Finance
Providers have been allocated monies in their baseline for resilience

Staffing
No Implications

Risk
Contract variations are being put in place to ensure contractual accountability for appropriate use of the allocated funding

Equality and Diversity / Public Sector Equality Duty
No Implications

Accommodation
No Implications

Crime and Disorder
No Implications

Human Rights
No Implications

Consultation
No Implications

Procurement
No Implications

Disability Issues
No Implications

Legal Implications
No Implications

Appendix 2 - NHS England High Impact Interventions

1. No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7. Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the delayed transfer of care (DTOC) rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

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Health and Wellbeing Board

23 July 2015

Better Care Fund Update

Report of Jane Robinson, Head of Commissioning, 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 performance against the targets set within the Better Care Fund (BCF) requirements and the financial position relating to the plan. The report includes the performance report submitted to the Better Care Fund Support Team on the 29th of May 2015.

Background

2. The implementation of BCF commenced on the 1st of April 2015 following the agreement of the BCF plan by NHS England in December 2014. County Durham's allocation from the fund is £43.735m in 2015/16 and this funding has been invested in a number of projects and areas of service delivery set within the 7 schemes of the BCF.

3. The BCF planning process required partners to include 6 key performance indicators in their plans, 4 of which were set nationally (shaded below) and 2 to be locally defined. The key performance indicators agreed for County Durham are:

Percentage of admissions of older people (aged 65 and Over) to residential and nursing homes per 100,000 population.
Percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
Delayed transfers of care (delayed days) from hospital per 100,000 of the population (average per month)
Number of Non elective admissions to hospital
The number of carers who are very/extremely satisfied with the support or services they receive.
The number of people in receipt of Telecare per 100,000 population.

4. The 6 key performance indicators set within the BCF Performance Framework were previously agreed at the Health and Wellbeing Board on the 5th March 2014, but with the difference that only the metric related to non-elective admissions to hospital now directly links to the performance payment element of the BCF Funding.

5. The BCF planning process included an agreement that 5 quarterly reports would be presented to the Health and Wellbeing Board and this report is the first of the sequence of those reports.

6. Subsequently, in March 2015, NHS England released the BCF Operational Guidance which set out requirements for reports reflecting local areas performance against the targets to be provided to the BCF Support Team at 5 points in the programme and recommended that the reports are signed off by the Health and Wellbeing Board prior to submission.

7. A report was presented to the Health and Wellbeing Board in May 2015 recommending that the 'signing off' of the reports could be delegated to the Chair of the Health and Wellbeing Board and the Chief Officers of the partner organisations, as the two sets of dates for submissions did not correlate. This recommendation was supported and the report template submitted to the BCF Support Team on the 29th of May 2015, is attached at Appendix 2.

8. The required information for the template was refined to only include the position against the 6 national conditions (e.g. plans jointly agreed, better data sharing), budget allocations, the section 75 agreement and narrative regarding the implementation of the plan and performance. The financial and performance metrics were removed from the template and will be reported in line with the future dates set by the Support Team.

9. The BCF Operational Guidance confirms that the final quarter of 2014/15 is included within the performance payment programme, to be awarded in accordance with performance against the 3.5% reduction in non – elective admissions. Three further payments should be made in August 2015, November 2015 and February 2016 in line with performance against the target.

10. In addition to the performance element of monitoring, the BCF Plan requires that the identified funding is invested in line with the plan that identified efficiencies are achieved and the partners need to ensure that spending on the services does not exceed the identified budget.

Finance Update

11. The template attached at Appendix 3 sets out the financial position at the end of June 2015.

Performance Update

12. The performance against the 6 key metrics based on the end of the 2014/15 position is set out below and as can be seen performance is strong in 4 of the indicators, however, in two areas, the target for non-elective admissions, which is the only measurement now linked to the performance payment and admissions into care homes, performance is below target.

Non Elective Admissions to Hospital.

Indicator	Historical		Qtr 1	Qtr 2	Qtr 3	Qtr 4	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2015/16 Target
	2012/13	2013/14							
Non Elective admissions (average per 3 month period)	n/a	2999	2,970	3,012	3,146	**3,009**	Q1 2690 Q2 2690 Q3 2660 Q4 2660	↑	Q1 2887 Q2 3002 Q3 3018 Q4 2763

13. The number of non-elective admissions to hospital increased in 2014/15 by 1.5%. The performance element of the BCF for this period is based on the final quarter of 2014/15. The 3.5% reduction against the same period last year was not achieved. This performance reinforces the view expressed by the partners in the BCF Plan that the 3.5% target is ambitious and this final quarter performance would indicate that the performance funding element of the plan cannot be released by the CCG's for this period. This equates to c£810k of BCF funding that cannot be released to the pool at this stage and will need to be mitigated through re-prioritising spend and use of non-recurrent CCG funds.

14. A number of initiatives are ongoing to review and improve admission avoidance services across the CCG's, including

- The ongoing refinement of the Frail Elderly/Vulnerable Adults Wrap Around Service (VAWAS) services.
- DDES - GP weekend working including expansion to focus on care home patients and North Durham Clinical Commissioning Groups (ND CCG) planned care scheme in primary care working with patients at risk of admissions over the weekend.
- The Urgent Care review.
- ND CCG has set up a demand and activity management programme to focus on resolving the top 10 high admission areas.
- A review of paediatric admission avoidance services and the piloting of a paediatric admissions Commissioning for Quality and Innovation (CQUIN) in both CCG's.

Adults Aged 65+ per 100,000 Population Admitted on a Permanent Basis in the Year to Residential or Nursing Care

Indicator	Historical		2014/15	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2015/16 Target
	2012/13	2013/14				
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	809.7	736.2	820.9	726.6	↑	710.4

15. Between April 2014 and March 2015 there were 836 people aged 65 and over supported by the County Council and admitted on a permanent basis to residential and nursing care, an increase from 755 in the previous year. This results in a rate of 820 per 100,000 population, which has exceeded the target of 727 per 100,000 and is higher than the 2013/14 national (668), North East (804) and Statistical Neighbour (746) averages. Please note that the BCF target was set against 2013/14 baseline.

16. Factors which have contributed to an increased number of permanent admissions include:

- Increased pressures on the wider Health community in Durham, with Older People a particularly vulnerable group. There has been a 5.4% increase in presentations to Accident and Emergency (A&E) and a 2.4% increase in hospital discharge referrals.
- There is also clear evidence of increasing complexity of cases with an additional 21 people admitted to nursing care and 38 additional people admitted to specialist dementia care when compared to 2013/14.
- Despite the increase in those requiring permanent care, the actual number of residential/nursing beds purchased has continued to fall, with a 2.8% reduction in the numbers of Older People beds purchased when comparing 2013/14 with 2014/15.

17. Robust panels continue to operate to ensure that only those in most need, who can no longer be cared for within their own home, are admitted to permanent care.

Percentage of Older People (aged 65 and over) who were Still at Home 91 days After Discharge from Hospital into Reablement/Rehabilitation Services.

Indicator	Historical		2014/15	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2014/15 Target
	2012/13	2013/14				
Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85.4% (Oct-Dec 12)	89.4% (Oct-Dec 13)	89.6%	85.4%	↑	85.7%

18. Provisional data shows that of those older people discharged between January and December 2014, 89.6% (1,648 of 1,839) remained at home 3 months later. Performance has exceeded the 2014/15 target of 85.4% and is above the same period last year (87.6%).

Delayed transfers of care (delayed days) from hospital per 100,000 of the population (average per month)

Indicator	Historical		Qtr 1	Qtr 2	Qtr 3	Qtr 4	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2015/16 Targets
	2012/13	2013/14							
BCF Measure Delayed transfers of care (delayed days) from hospital per 100,000 population (average per 3 month period)	n/a	880.1	570.2 Apr-Jun	774.8 Jul-Sep	873.7 Oct-Dec)	452.3 Jan-Mar	Q1 - 838.5 Q2 - 838.5 Q3 - 838.5 Q4 - 808.3	↓	Q1 838.5 Q2 838.5 Q3 838.5 Q4 808.3

19. The number of delayed transfer of care per 100,000 population has achieved target in 3 of the 4 quarters in 2014/15.

20. The actual number of reported delayed days has fallen from 15,871 in 2013/14 to 10,288 in 2014/15, a drop of 24%. Durham's rate of delayed days per 100,000 population was 2,892 which is below the national rate of 3,832.

The number of carers who are very/extremely satisfied with the support or services they receive.

Indicator	Historical		2014/15	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2015/16 Target
	2012/13	2013/14				
The number of carers who are very/extremely satisfied with the support of services that they receive	47.9% (Statutory)	52.6% (Local Survey)	58.60%	48% - 53%	↑	48% - 53%

21. Figures from the 2014/15 national carers survey show that 58.6% of carers were either very or extremely satisfied with the care and report they receive, this exceed the 14/15 range target of 48-53%. The national survey is conducted every two years and in 2012/13 Durham performance was 47.9%.

22. The survey was sent to a sample of 1,288 adult carers. There were 591 responses received, achieving a 45.9% response rate.

23. National results have not yet been published for 2014/15, the latest national benchmarking from the 12/13 shows a national rate of 42.7%.

24. A local survey will be conducted in 2015/16.

The number of people in receipt of Telecare per 100,000 population.

Indicator	Historical		2014/15	2014/15 Target	Direction of Travel (14/15 vs 13/14)	2015/16 Target
	2012/13	2013/14				
The number of people in receipt of Telecare per 100,000 population	197	225.7	292	215	↑	225

25. The number of people receiving one or more items of telecare has continued to increase during 2014/15. As at 31st March 2015 292 people per 100,000 were in receipt of a telecare service which has exceeded the 14/15 target of 215.

26. No national benchmarking data is available.

Recommendations

27. The Health and Wellbeing Board is recommended to:

- Note the content of this report.

Contact: Jane Robinson, Head of Commissioning, Durham County Council
Tel: 03000 267357

Appendix 1: Implications

Finance
The BCF totals £43.735m for Durham, of which £3.241m is performance-related.

Staffing
No direct implications at this stage

Risk
Non-achievement of the non-elective admissions target will result in a reduction in the funds available to the BCF. Contingency plans are in place to mitigate any potential impact.

Equality and Diversity / Public Sector Equality Duty
As a public body, the Council must take into account the Equality Act 2010, a consolidating Act which brings together previous Acts dealing with discrimination. Decisions must be reviewed for potential impact on persons with "protected characteristics". Equality and Diversity Impact Assessments are carried out, as appropriate.

Accommodation
No direct implications

Crime and Disorder
No direct implications

Human Rights
No direct implications

Consultation
Any required consultation is undertaken through the Health and Wellbeing Board, Officer Group and within the respective partner authorities.

Procurement
No direct implications

Disability Issues
No direct implications

Legal Implications
Any legal requirements related to BCF projects and BCF programme management are reviewed and updated as appropriate

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APPENDIX 2

Cover and Basic Details
Q4 2014/15

Health and Well Being Board	County Durham
completed by:	Phil Emberson - Programme Manager
e-mail:	phil.emberson@durham.gov.uk
contact number:	03000 268245
Who has signed off the report on behalf of the Health and Well Being Board:	Rachael Shimmin, Nichola Bailey,Stewart Findlay, Neil O'Brien, Cllr

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

County Durham

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements	
Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Selected Health and Well Being Board:

County Durham

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	Yes	
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

County Durham

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	31,507

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.

The original target for non-elective admissions agreed by chief officers from the Council, the CCGs and the FT set in the first BCF Plan for County Durham was for a 1% reduction in non-elective admissions. This was reluctantly increased to 3.5% in the final plan on the clear direction of the Local Area Team. The narrative in the final plan made reference to local data which suggested that the 3.5% was ambitious and a range between 1% and 3.5% was more realistic. This narrative was based on local performance information and plans .

Our most recent data shows that in common with many Trusts across the Country we are in fact seeing an average 1.6% increase in non-elective admissions in County Duham due to the significant pressure on our acute trust and our quarter 4 2014/15 performance return reflects this pressure.

The partners are committed to maintaining our joint approach and ambitions to reducing non-elective hospital admissions and we will continue to review and develop our plan and services in line with those requirements. A detailed risk sharing agreement is in place and contingency plans as set out in the BCF Plan remain in place if the performance target for non-elective admissions is not achieved in the medium to longer term.

BCF EXPENDITURE TO 30 JUNE 2015

Figures in £

BCF Project	Annual Budget 2015/16	Budget to 30 June 2015	Actuals to 30 June 2015	Variance at June 2015	RAG Rating
Short Term Intervention Services					
CAMHS self harm	310,000	77,500	77,500	0	GREEN
COPE/OPAS	183,000	45,750	45,750	0	GREEN
Day hospital	550,000	137,500	137,500	0	GREEN
Falls/Osteoporosis	214,000	53,500	53,500	0	GREEN
IC community services	2,438,370	609,593	609,593	0	GREEN
Intensive Support Service	260,000	65,000	65,000	0	GREEN
Intermediate Care (plus) project	6,972,371	1,743,093	1,743,093	0	GREEN
Reablement	2,500,000	625,000	625,000	0	GREEN
Short Term Intervention Services Total	**13,427,741**	**3,356,936**	**3,356,936**	**0**	GREEN
Equipment and Adaptations for Independence					
Disability Adaptations	1,224,370	306,093	306,093	0	GREEN
Handyvan service	100,000	25,000	25,000	0	GREEN
HELS	2,458,000	614,500	614,500	0	GREEN
Telecare	500,000	125,000	125,000	0	GREEN
Wheelchairs	1,310,000	327,500	327,500	0	GREEN
Equipment and Adaptations for Independence Total	**5,592,370**	**1,398,093**	**1,398,093**	**0**	GREEN
Supporting Independent Living					
CAMHS (EP & Advisory Teachers)	236,000	59,000	59,000	0	GREEN
Community alarms and wardens	600,000	150,000	150,000	0	GREEN
Day centre and carer support	172,000	43,000	43,000	0	GREEN
Derwentside MIND	13,000	3,250	3,250	0	GREEN
Employment training and ED	71,000	17,750	17,750	0	GREEN
Floating support/supported living	2,311,206	577,802	577,802	0	GREEN
Health trainer model for MH	72,000	18,000	18,000	0	GREEN
MH Preventative Services	885,753	221,438	221,438	0	GREEN
Recovery college	370,000	92,500	92,500	0	GREEN
Specialist MH Advocacy	97,000	24,250	24,250	0	GREEN
Supported living - RF	145,000	36,250	36,250	0	GREEN
Volunteer service MH	32,000	8,000	8,000	0	GREEN
Supporting Independent Living Total	**5,004,959**	**1,251,240**	**1,251,240**	**0**	GREEN
Supporting Carers					
Aiming high for disabled children	150,000	37,500	37,500	0	GREEN
Carers breaks	381,000	95,250	95,250	0	GREEN
Carers emergency support	31,000	7,750	7,750	0	GREEN
Children's short breaks	233,000	58,250	58,250	0	GREEN
County Durham carers support	372,000	93,000	93,000	0	GREEN
Respite care at BH	54,000	13,500	13,500	0	GREEN
Young carers	140,000	35,000	35,000	0	GREEN
Supporting Carers Total	**1,361,000**	**340,250**	**340,250**	**0**	GREEN
Social Isolation					
Joint planning care bill	500,000	125,000	125,000	0	GREEN
Local coordination	621,000	155,250	155,250	0	GREEN
Social Isolation Total	**1,121,000**	**280,250**	**280,250**	**0**	GREEN
Care Home Support					
Acute & dementia liaison	244,000	61,000	61,000	0	GREEN
Care home support	1,530,000	382,500	382,500	0	GREEN
Care Home Support Total	**1,774,000**	**443,500**	**443,500**	**0**	GREEN
Transforming Care					
Maintaining current care provision	9,238,704	2,309,676	2,309,676	0	GREEN
Transformational change	1,673,226	418,307	418,307	0	GREEN
Transforming Care Total	**10,911,930**	**2,727,983**	**2,727,983**	**0**	GREEN
TOTAL BCF	**39,193,000**	**9,798,252**	**9,798,252**	**0**	GREEN

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Health and Wellbeing Board

23 July 2015

Section 256 – Year End Update 2014-15

Report of Rachael Shimmin, Corporate Director, Children and Adult Services

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

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

Purpose of the Report

1. This report provides an end of year update on the delivery of key performance indicators (KPIs) associated with the 2014-15 section 256 agreement between Durham County Council and NHS England.

Background

2. At their meeting in November 2013 the Health and Wellbeing Board (HWB) agreed options for the use of c£10.1m of NHS funding to be transferred to the local authority and ratified the associated section 256 agreement, in line with the Department of Health with regards to the use and governance of these funds.

3. The plans were developed alongside schemes linked to the Joint Health & Wellbeing Strategy priorities and both Clinical Commissioning Groups commissioning intentions which were agreed by all key partners and the Health & Wellbeing Board.

4. The funding covered by this section 256 agreement increased in 2014-15 to £12,935,888 allocated as below.

Short Term Intervention Services	3,025,000
Equipment and Adaptations for Independence	600,000
Supporting Independent Living	1,978,527
Transforming Care	7,332,361
Total Transfer	**£12,935,888**

5. The aim of the funding is to improve the health and wellbeing of the people of County Durham by innovating and transforming services with a focus on improved outcomes, prevention and integration, reducing the reliance on long term health and social care and maintaining the independence of our population.

   The schemes above link to local CCG Clear and Credible Plans 2012-17 and also form part of Better Care Fund requirements from April 2015 onwards.

Delivery of the Key Performance Indicators

6. Appendix 2 provides the detail regarding the end of year performance schemes covered by the 2014-15 section 256 agreement.

7. The overarching message from this performance report is of increased provision and positive outcomes for those individuals who have accessed the schemes covered by this agreement.

Recommendations

8. The Health and Wellbeing Board is recommended to:

   - Note the content of this report.

Contact: **Jane Robinson, Head of Commissioning, Children and Adults Services, Durham County Council**
Tel: **03000 267358**

Appendix 1: Implications

Finance
Social care funds of £12,935,888 for 2014/15 transferred over to the local authority from NHS England under a section 256 agreement

Staffing
The use of this funding had staffing implications, including recruitment and realignment

Risk
No Implications.

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

Accommodation
No Implications.

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

Human Rights
No Implications.

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

Procurement
Procurements were carried out under DCC policies and constitution.

Disability Issues
No Implications**.**

Legal Implications
No Implications.

Appendix 2 - End of Year Performance Schemes Covered by the 2014-15 Section 256 Agreement

Short Term Intervention Service (IC+)	The percentage of people completing reablement who required reduced or no ongoing care had increased from 83.8% in 13/14 to84.9% in 14/15. This has exceeded the target of 84%. The percentage of people satisfied with the reablement service was 95.7% against a target of 90%
	In 2014/15 89.6% of older people were still at home 91 days after discharge, this has exceeded the target of 85.4%, and is above the North East (87.2%) and England averages (82.5%). The rate of delayed discharges from hospital has reduced from an average of 10.76 in 2013/14, to 7.5 in 14/15, this is lower than the national rate of 10.71
Equipment and Adaptations for Independent Living	The number of people in receipt of 1 or more items of telecare has increased from 244 per 100,000 on the 31st March 2014, to 292 as at 31st March 2015
	The Home Equipment Loans Service provided an average of 776 pieces of disability equipment per month during 2014/15 compared to 714 per month in 13/14. The service achieved an average of 95.8% items delivered within 7 days against a target of 95%. (95.9% was achieved in 13/14).
Supporting Independent Living	In 2014/15 the percentage of adults with learning disabilities who live in their own home or with their family was 85.2% which is better than NE (80.6%) and England averages (74.9%).
	The percentage of Adults on CPA in contact with secondary Mental Health Service in settled accommodation is 88.04% which is significantly higher than the England average of 60.9%
Transforming Care	Eligibility Levels have remained at Substantial. The percentage of social Care contacts that have been re-directed has increased from 71.6% in 13/14 to 72.7% in 2014/15
	The number of service users that require ongoing long term care has reduced from by 2.7% from 9144 at 31st March 2014 to 8890 at 31st March 2015. Service users satisfaction in 14/15 is 94%

Health and Wellbeing Board

23rd July 2015

Joint Health & Wellbeing Strategy 4th Quarter 2014/15 Performance Report

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

Purpose of Report

1. To report 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 (BCF) and Clinical Commissioning Group (CCG) Quality Premium Indicators (QPI).

3. The Performance Scorecard, which includes all of the performance indicators within the JHWS, is attached at **Appendix 2**.

4. Due to the nature of the performance data being reported, there is significant variation in the time periods associated with each indicator. For example, several indicators have a time lag of over 12 months. This report includes the latest performance information available nationally, regionally and locally.

5. 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

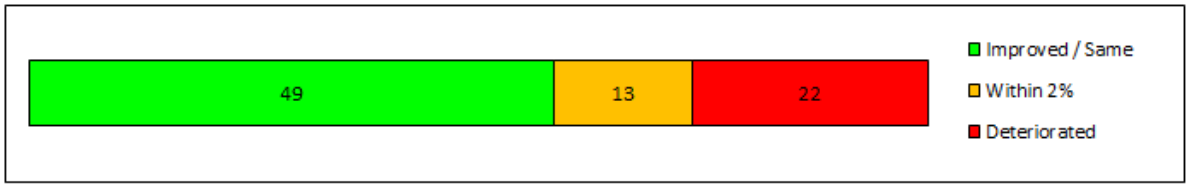
6. There are 209 actions within the JHWS 2014-17 Delivery Plan. Of these, 1 action is to be deleted and is included in this report under the relevant objective. Progress against the remaining 208 actions is as follows:

7. There are 13 actions where revised target dates have been set for the completion of the work. These actions are identified in this report under the relevant objectives.

8. There are 107 Indicators on the JHWS Performance Scorecard. Since the last report, updated data is available for 88 indicators.

9. There are 47 indicators with targets where updated data is available and included in the report. **Performance against target** is as follows:

10. There are 84 indicators where updated data is available and it is possible to track **Direction of Travel.** Performance is as follows:



11. The following sections of the report are structured by JHWS Objective and provide updates about the following:

- Delivery Plan actions behind target/deleted
- Performance indicators more than 2% behind target
- Other areas for improvement i.e. where performance has a significantly deteriorating trend and/or is significantly behind the national average.
- Performance highlights

Objective 1: Children and young people make healthy choices and have the best start in life

12. There are 56 actions under objective 1. Progress is as follows:

13. Revised targets dates have been set for the following actions:

- Implement recommendations from the review of universal, targeted and specialist Child and Adolescent Mental Health Services (CAMHS). The target completion date has been revised by the CCGs and Durham County Council (DCC) Public Health from April 2015 to July 2015.

- Work together to reduce incidents of self-harm by young people by clarifying 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 Durham County Council (DCC) Public Health from April 2015 to July 2015.

- Adopt a better use of technology by the CAMHS services, for example Skype. The target date has been revised by Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) from March 2015 to March 2016 to align to the award of funding for the setup of the Virtual Recovery College, which will improve the use of technologies across all services, including CAMHS.

- Develop the knowledge and skills of school based staff to identify and support vulnerable young people engaging in self-harm behaviours. Target revised by DCC Public Health from March 2015 to October 2015 to reflect the implementation of self-harm training within schools from October 2015.

- Develop relevant clinical protocols across agencies to ensure quality of care for Children and Young People involved in accidental injury. The target has been revised by DCC Public Health from May 2015 to October 2015 to enable further work to be undertaken with staff to develop awareness and support effective implementation.

14. There are 3 indicators with targets under Objective 1 for which new data is reported. Performance against target is as follows:

Performance indicators more than 2% below target (2 indicators):

The number of young people in Tier 3 treatment with former 4Real Service

15. Numbers in treatment have shown a slight increase since 2013-14 but are still significantly below target.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
220 (2013-14)	Number of young people in Tier 3 treatment for drugs and alcohol with 4Real	227 (2014-15)	295 (2014-15)	Not available	Not available	⇧

The percentage of exits from young person's treatment that are planned discharges

16. Performance is behind target and less than the national average.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
74% (2013-14)	Percentage of exits from young person's treatment that are planned discharges	69% (2014-15)	79% (2014-15)	79% (2014-15)	n/a	⇩

17. Performance in relation to exits from young person's treatment was consistently achieving target between April - December 2014 (83% for the period). However, the final quarter of the year (Jan - Mar 2015) had the highest number of young people discharged (95) with only 49% of these being planned discharges. The impact of the final quarter was to reduce performance to 69% for the full 2014/15 year.

18. A new contract for Drug and Alcohol Treatment Services (including young person's treatment) commenced with Lifeline on 1st April 2015 offering individuals and their families' integrated drug and alcohol treatment journeys, and to benefit from the positive influences of people attending who are in recovery.

Other Areas for Improvement

Under 18 and under 16 conception rates

19. Although rates have fallen, they are both above the North East and national averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
33.8 (2013)	Under 18 conception rate	30.9 {Prov} (2014)	Tracker	23.9 {Prov} (2014)	29.7 {Prov} (2014)	⇩
8.9 (2012)	Under 16 conception rate	7.9 (2013)	Tracker	4.8 (2013)	7.4 (2013)	⇩

20. Actions being taken to continue this improvement include:
    - The Teenage Pregnancy and Sexual Health Steering Group is undertaking a Health Needs Assessment to review under 18 and under 16 conceptions. This is due to be completed by September 2015 and will:
        - Map all commissioned and mainstream services with a remit to deliver to young people to prevent pregnancy, young people who are pregnant, and teenage parents;
        - Identify barriers and enablers to current delivery;
        - Produce a final report with recommendations to inform future service delivery.

21. Consultation and engagement events are being undertaken by Investing in Children to ensure key stakeholders provide input into the Health Needs Assessment and shape future service delivery.

The number of emergency admissions for children with lower respiratory tract infections

22. The rate of emergency admissions has increased in both North Durham & DDES CCGs and is above national and regional averages (2014-15 QPI)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
431.5 (2013-14)	Emergency admissions for children with lower respiratory tract infections - Durham Dales Easington & Sedgefield (DDES) CCG (0-18 per 100,000 registered patients)	532.3 (Apr 14-Mar 15)	Tracker	372.9 (2013-14)	449.6* {Prov} (Oct 13-Sep 14)	⇧
467.6 (2013-14)	Emergency admissions for children with lower respiratory tract infections - ND CCG (0-18 per 100,000 registered patients)	560.5 (Apr 14-Mar 15)	Tracker	372.9 (2013-14)	449.6* {Prov} (Oct 13-Sep 14)	⇧

*Durham, Darlington & Tees area team

23. North Durham and DDES CCGs worked with County Durham and Darlington NHS Foundation Trust to pilot a front of house assessment programme where children go directly to see a senior paediatrician/nurse practitioner on the children's ward to be assessed without admission. The pilot demonstrated a reduction in paediatric admissions. The pilots were operated at both University Hospital of North Durham and Darlington Memorial Hospital. However both pilots have ended due to a lack of suitably trained staff to run the scheme for the hours required.

24. For 2015/16, the CCGs have included a Commissioning for Quality and Innovation scheme to expand the children's community nursing service to include referrals from GPs to prevent admissions. Part of the scheme is the development of a local tariff to cover these visits as they would not attract a Payment By Results (PBR) tariff under the current arrangements.

Performance Highlights

25. Progress since the previous performance report includes:

- The Strategy for the Prevention of Unintentional Injuries in Children and Young People in County Durham has been agreed. This aims to reduce unintentional injuries in children and young people aged 0-19.

- Durham's percentage of mothers smoking at time of delivery decreased to 18.3% for the period October to December 2014. This is a 0.4 percentage points decrease from the same period of 2013. Durham has a lower percentage of mothers smoking than the latest North East average of 20.0% (Apr-Sept 2014), but is still behind the national average of 11.5%. For the period April to December 2014, 108 pregnant women accessed stop smoking support and quit smoking. This is an improvement on the 2013 figures when 81 women quit.

Objective 2: Reduce health inequalities and early deaths

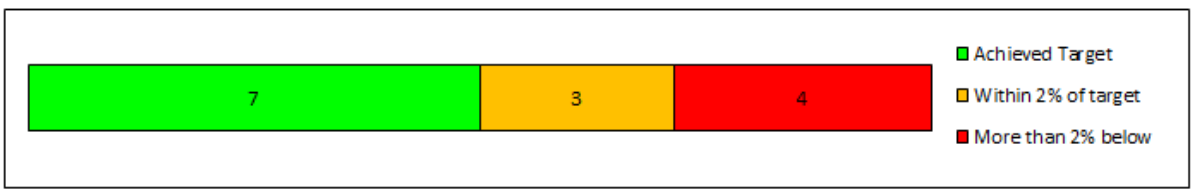
26. There are 53 actions under this objective. Progress is as follows:

27. Revised targets dates have been set for the following actions:

- Review of current cancer pathway to identify gaps in service provision e.g. diagnostics, which will result in improvements in cancer treatment time targets. The review is underway, and the target completion date has been revised by the CCGS from March 2015 to August 2015.

- Develop pathways to ensure that individuals with learning disabilities and behavioural problems have access to appropriate services to improve their physical health and wellbeing. The target date has been revised by the CCGs from April 2015 to March 2016 to reflect a 2 year *CQUIN (Commissioning for Quality and Innovation)* target relating to the physical health of patients with Learning Disabilities or a Mental Health problem.

28. There are 14 indicators with targets under Objective 2 for which new data is reported. Performance against target is as follows:



Performance indicators more than 2% below target (4 indicators):

The percentage of the eligible (those with high prevalence of CVD risk factors) population who have received a health check

29. Performance between April and December 2014 is below target and is behind the North East and National averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
10.3% (2013-14)	Percentage of the eligible population aged 40-74 who received an NHS Health Check	7.4% (2014-15)	8% (2014-15)	9.6% (2014-15)	8.25% (2014-15)	⇩

30. 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 risk factors. The contract for 2015/16 was issued to providers at the end of May 2015 and performance will be monitored by Public Health. The target for 2015/16 will remain at 8%.

Four week smoking quitters

31. During April to December 2014 performance was below target and less than the same period in 2013.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
675 per 100,000 (2,875 quitters) (Apr-Dec 13)	Four week smoking quitters per 100,000 population	527.7 per 100,000 (2248) (Apr-Dec 14)	788 per 100,000 (3,369 quitters)	359 per 100,000 (Apr-Dec 2014)	436 per 100,000 (Apr-Dec 2014)	⇩

32. The number of people accessing the Stop Smoking Service (SSS) across all services nationally, regionally and in county Durham continued to fall between April and December 2014 compared to the previous year. County Durham had the second lowest reduction in the north east region (-27%).

33. In County Durham 4303 people accessed SSS and set a quit date during Quarters 1 to 3. Of these, 52.2% did go on to quit, the highest quit rate across all North East services during this period and higher than 48.8% in the same period of the previous year.

34. Colleagues in Public Health suggest the impact of e-cigarettes may be one factor in the declining numbers accessing SSS, with smokers choosing to self-manage quit attempts rather than accessing support via the SSS.

35. Actions taken to tackle the declining numbers accessing the SSS include:

- A review of the SSS is currently underway. A soft market testing exercise took place in May 2015 and a Market Engagement Day was held in June 2015 to develop ideas for the service in future.
- In February 2015 PHE re-ran the Smokefree Homes and Cars campaign. Smoking in cars when someone under the age of 18 is present will be banned from 1 October 2015. the campaign featured on TV, radio, online and social media to encourage voluntary adoption before legislation comes into effect.

Successful completions of people in drug treatment for opiate use

36. Between October 2013 and September 2014 performance was below target and below national performance.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
6.8% (2013)	Successful completions as a percentage of total number in drug treatment - Opiates	7.1% (Oct 13-Sep 14)	7.9%	7.6% (Jul 13-Jun 14)	6% (2013)	⇧

37. Following the completion of the review of Drug and Alcohol Treatment services a new contract with Lifeline Project Ltd commenced on 1st April 2015. New and challenging targets have been agreed for 2015/16 including:

- 9.4% for successful completions of those in treatment for opiates.
- 41.7% for successful completions of those in treatment for non-opiates and
- 39.5% for successful completions of those in treatment for alcohol

The percentage of women eligible for cervical screening who were screened adequately

38. Performance is behind target but better than national and North East averages, and has increased from the previous year.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
77.7% (2013)	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	78% (2014)	80%	74.2 (2014)	76.1 (2014)	⇧

39. The screening programme is the responsibility of NHS England. The Director of Public Health has a local responsibility to monitor performance and has received assurance from the NHS England Area Team that take-up rates for County Durham are some of the best in the North East.

Other Areas for Improvement

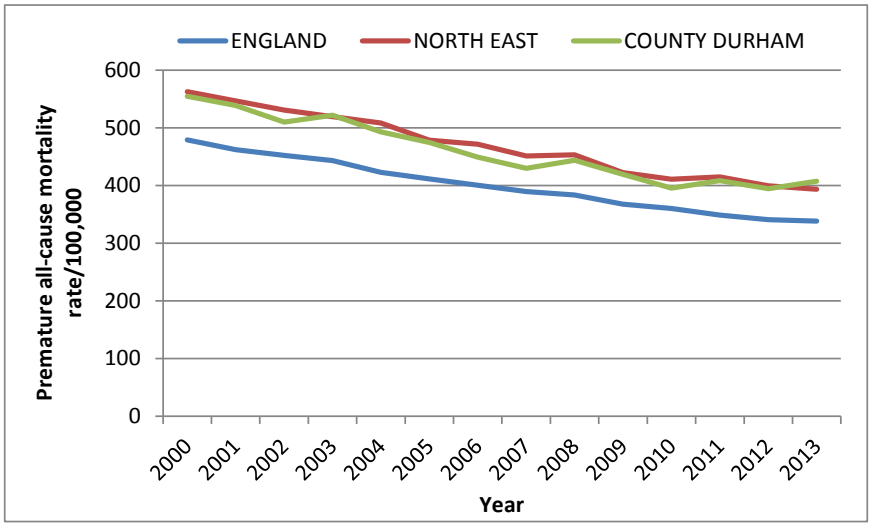
Under 75 all-cause mortality rate

40. In 2013 the under 75 all-cause mortality rate has increased from 2012 rate and is higher than national and North East averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
394.18 (2012)	All cause mortality for persons aged under 75 years per 100,000 population	407.1 (2013)	Tracker	337.97 (2013)	393.44 (2013)	⇧
91.3 (2010-12)	Mortality from all CvD (including heart disease and stroke) for persons aged under 75 per 100,000 population	88.8 (2011-13)	Tracker	78.2 (2011-13)	88.9 (2011-13)	⇩
164.2 (2010-12)	Mortality from cancer for persons aged under 75 per 100,000 population	166.6 (2011-13)	Tracker	144.4 (2011-13)	169.5 (2011-13)	⇧
21.7 (2010-12)	Mortality from liver disease for persons aged under 75 per 100,000 population	21.9 (2011-13)	Tracker	17.9 (2011-13)	22.3 (2011-13)	⇧
40.1 (2010-12)	Mortality from respiratory disease for persons aged under 75 per 100,000 population	43.4 (2011-13)	Tracker	33.2 (2011-13)	42.6 (2011-13)	⇧

41. The increase of 12.9 persons per 100,000 between 2012 and 2013 equates to an additional 72 deaths over one year. Public Health colleagues have confirmed that mortality rates can fluctuate between years, and that it is important to also consider the long term trend which shows that since 2000 the rate in County Durham has fallen by 26.6%. Regional and National averages have also seen significant reductions.

42. The graph below highlights the longer term trend for this indicator:



43. The long term trends for Under 75 mortality from cancers, circulatory disease and respiratory disease have reduced from 2001-3 to 2011-13.

44. However, the under 75 mortality rate from liver disease has risen slightly in the period 2011-13 and is above national averages. Additionally, the long term trend is an increase of 3.9 deaths per 100,000 from 2001-03 to 2011-13. Public Health is leading work with partners to develop the Alcohol Harm Reduction Strategy 2015/17 for County Durham, which is currently out for consultation. The strategy is scheduled for approval at the Safe Durham Partnership Board on the 29th September 2015.

Excess Winter Deaths

45. During 2010-13 there were more winter deaths than during 2009-12. Durham's rate is higher than the national and North East rates, both of which also increased over the same period.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
16.8% (2009-12)	Excess Winter Deaths	19% (2010-13)	Tracker	17.4% (2010-13)	16% (2010-13)	⇧

46. The longer term trend from 2006-09 to 2010-13 shows excess winter deaths reduced by 2.8 percentage points (134 fewer deaths) in County Durham. This is greater than the national decrease of 0.7 percentage points and the North East reduction of 2.5 percentage points over the same period.

47. Actions being taken include:
- The Warm and Healthy Homes programme is being funded by Public Health until March 2017 to help tackle excess winter deaths and cold related illness. It is one of many interventions addressing fuel poverty across the county as outlined in the County Durham Affordable Warmth Strategy 2015-20.
- The following have been achieved up to the end of Quarter 4 2014/15:
  - 169 health and social care staff briefed about the programme. This has led to 130 referrals from staff.
  - 55 people received help such as insulation, replacement boilers and central heating.
  - 23 received a benefits check and 18 received a fire safety check.

48. A Winter Plan and System Resilience update is on the agenda for the July 2015 Health and Wellbeing Board which reviews the previous winter plan and makes recommendations for 2015/16. A further follow-up report is scheduled for January 2016.

Performance Highlights

49. Progress since the previous performance report includes:

- The percentage of patients receiving their first definitive treatment for cancer within 31 days of diagnosis between January and March 2015 has exceeded

target (96.0%) and is higher than the national average (97.4%) in both CCG areas (DDES 97.7% and North Durham 98.8%).

- The first County Durham Drug Strategy was agreed, which aims 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.

- From April 2015 Lifeline Project Ltd will deliver community based alcohol and drug misuse services from recovery centres across the county.

- Male life expectancy at birth (years) continues to rise in Durham, and is now at 78.0 for the period 2011-13. This is the same as the North East average. The national average is 79.4 years.

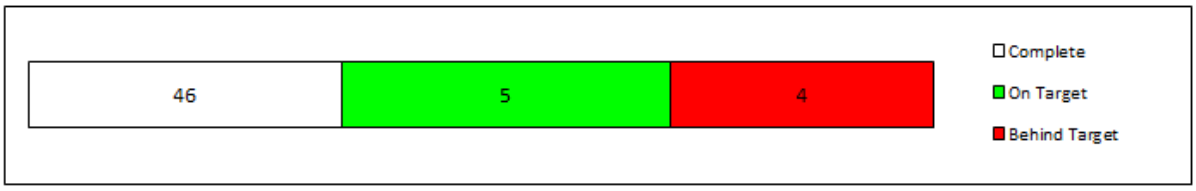
- Successful completions of people in alcohol treatment is 38% for 2014-15. This is above target (36.6%) and an improvement from 34.8% for 2013-14. The national average for 2014-15 of 39.2%.

Objective 3: Improve the quality of life, independence and care and support for people with long term conditions

50. There are 56 actions under this objective. 1 action has been deleted as follows:

51. Implement the Telehealth service. The pilot within the Intermediate Care Plus Service has not evaluated successfully and further work is required to decide if this model progresses.

52. Progress against the remaining 55 actions is as follows:



53. Revised targets dates have been set for the following actions:

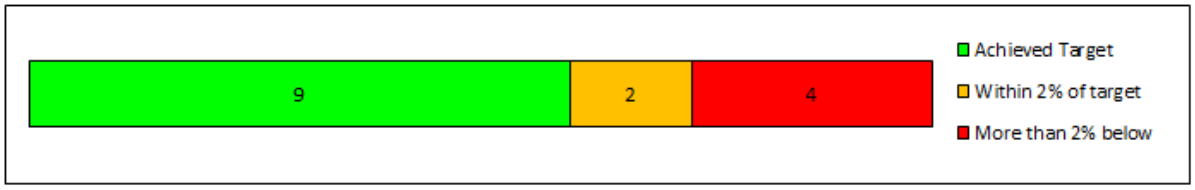
- Complete the review of specialist residential care provision in relation to long term and complex mental health and learning disability clients to ensure that there is capacity to deal with complex needs. The Target date has been revised by Durham County Council from March 2015 to March 2016 to enable a wider strategic review of Mental Health accommodation needs to be carried out jointly with CCGs as part of the 'No Health Without Mental Health' implementation.

- Develop a community service for diabetes moving services out of hospital into the community through the development of a lead provider model. The target date has been revised by the CCGs from March 2015 to April 2016 to align with the CCGs Commissioning Intentions Delivery Plan.

- Help people to manage their own long term conditions through self-management programmes. This action relates to the Diabetes Service re-design and a Chronic Obstructive Pulmonary Disease (COPD) project. The target date has been revised by Community Services / Care Closer to Home Group from March 2015 to April 2016 to align with the CCGs Commissioning Intentions Delivery Plan.

- Develop preventative services in conjunction with key partners to meet gaps in provision. The target date has been revised by Durham County Council from March 2015 to March 2016 to reflect agreed changes to the scope of the action.

54. There are 15 indicators with targets under Objective 3 for which new data is reported. Performance against target is as follows:



Performance indicators more than 2% below target (4 indicators):

Carer reported quality of life

55. Carer reported quality of life is behind target but is better than national and regional averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
8.7 (2012-13)	Carer reported quality of life	8.7 (2014-15)	9.0 (2014-15)	7.9 {Prov} (2014/15)	8.4 {Prov} (2014/15)	⇔

56. This is a complex indicator from the Adult Social Care Outcomes Framework which combines and weights the individual responses to six questions from the Carers' Survey into a single score. The 6 questions relate to different aspects of quality of life include occupation, safety, inclusion, control etc. Although Durham is below the agreed local target, performance has been maintained from 2012-13 and is above the provisional national and North East average.

Adults aged 18-64 admitted on a permanent basis to residential or nursing care

57. The number of adults aged 18-64 admitted on a permanent basis to residential or nursing care has increased since 2013-14, and is behind target and the North East and National averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
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	16.8 per 100,000 (2014-15)	14 per 100,000 (2014-15)	14.4 per 100,000 (2013-14)	14.4 per 100,000 (2013-14)	⇧

58. Robust panels operate to ensure that only those in most need and who can no longer be cared for within their own home are admitted to permanent care. The numbers for this indicator are small (53 admissions in 2014-15) and performance can therefore fluctuate.

Adults aged 65 and over admitted on a permanent basis to residential or nursing care

59. During 2014/15 the number of adults aged 65 and over permanently admitted to residential or nursing care has increased to a rate of 820.9 per 100,000 population. This has failed to achieve target and is higher than the 2013/14 national and North East outturn. (BCF Indicator)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
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	820.9 Per 100,000 (2014/15)	727 per 100,000 (2014/15)	650.6 (2013/14)	803.4 (2013/14)	⇧

60. The actual numbers of people aged 65 and over who are admitted to permanent care have increased from 755 in 2013/14 to 836 in 2014/15.

61. Despite this increase, the longer term trend in the number of residential and nursing care bed days purchased by Durham County Council shows a 7% reduction since 2011-12, as demonstrated in the table below:

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
973,147 (2011-12)	The number of residential/nursing care bed days purchased by Durham County Council	904,437 (12/05/14-10/05/15)	N/A	N/A	N/A	⇩

62. Factors which have contributed to increased permanent admissions in 2014/15 include:

- Increased pressures on the wider health community in County Durham, with older people a particularly vulnerable group. There has been a 5.4% increase in presentations to Accident and Emergency and a 2.4% increase in hospital discharge referrals.

- Increasing complexity of cases with an additional 21 people admitted to nursing care and 38 additional people admitted to specialist dementia care when compared to 2013/14.

63. Robust panels operate to ensure that only those in most need, who can no longer be cared for within their own home, are admitted to permanent care.

Non-elective admissions into hospital

64. Non-elective admissions into hospital have increased and are behind target.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
2,929 (Jan-Mar 14)	Total non-elective admissions into hospital (general & acute), all age, per 100,000 population	3009 (Jan-Mar 15)	2,868 (Jan-Mar 15)	n/a	n/a	⇧

65. This is a Better Care Fund indicator for 2015/16. It has a linked financial incentive for achievement of the target, which is a reduction of 3.5% in the actual number of non-elective admissions compared to the same period in the previous year. For the period January to March 2015 the target is 14,914 non elective admissions which gives a rate of 2,868 per 100,000 population.

66. The performance incentive funding will be based on the final quarter of 2014/15 and the first three quarters of 2015/16. In line with NHS England requirements, the data will be reported on a quarterly basis and used to compare performance to the same quarter of the previous year.

67. A number of initiatives are ongoing to review and improve admission avoidance services across the CCGs, including:

- The ongoing refinement of the Frail Elderly / Vulnerable Elderly Wrap Around Services.
- DDES CCG's GP weekend working, including expansion to focus on care home patients, and ND CCG' s planned care scheme in primary care working with patients at risk of admissions over the weekend.
- The Urgent Care review
- North Durham CCG has set up a demand and activity management programme to focus on resolving the top 10 high admission areas.
- A review of paediatric admission avoidance services and the piloting of a paediatric admissions Commissioning for Quality and Innovation (CQUIN) in both CCG's.

Other Areas for Improvement

Falls and injuries, and hip fractures

68. Rate of falls and injuries, and hip fractures in the over 65s have both increased since 2012-13 and are above regional and national averages.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
2,085 (2012-13)	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 per 100,000 population)	2159 (2013-14)	Tracker	2,064 (2013-14)	2,051 (2013-14)	⇧
636.0 (2012-13)	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)	674 (2013-14)	Tracker	580 (2013-14)	651 (2013-14)	⇧

69. To support delivery on the local and national strategy for frail elderly DDES CCG are commissioning services described as vulnerable adults wrap around services. These services will compliment other commissioned services to ensure the best possible care and care planning for this cohort of patients. As part of this, a falls prevention assessment takes place. Monitoring will take place through the Clinical Quality Review Group with providers.

70. North Durham CCG are identifying the most frail elderly patients living in their own homes and carrying out a multi-faceted patient assessment using the Edmonton Frail Scale, which has a 'timed-up and go' test, lying/sitting and standing blood pressure test, a falls assessment, and medicine reviews for those on multiple medicines. As part of the pathway, a nurse from the patient's practice will work with other primary care clinicians to devise a care plan to treat any issues identified, including the risk of falling. The nurse will be responsible for ensuring any primary, community and secondary care services needed by the patient are delivered. The patient is reviewed and reassessed using the same assessment tools at least every year.

71. In care homes, residents will receive the same assessment as described above, but this will be undertaken by community matrons.

72. In secondary care, North Durham CCG are integrating existing acute and community elderly care clinics so the most frail patients have access to a comprehensive geriatric assessment and care planning.

Performance Highlights

73. Progress since the previous performance report includes:

- The proportion of older people who were still at home 91 days after discharge into reablement/rehabilitation services is 89.9% for the period October to December 2014 (national monitoring period). This exceeds the target (85.4%)

and is better than national (82.5%) and regional (87.2%) averages in 2013/14. This is a Better Care Fund indicator.

- 65.3% of people had no ongoing care needs following completion of a reablement package in 2014-15. This is an improvement on 62.3% in 2013-14, and exceeds target (55.0%). The regional average is 60.2%.

- The number of carers receiving a specific carers' service, as a percentage of service users receiving community based services, has improved from 33.8% in 2013-14 to 39.4% in 2014-15. This is above the North East (31.9%) and national (33.5%) averages.

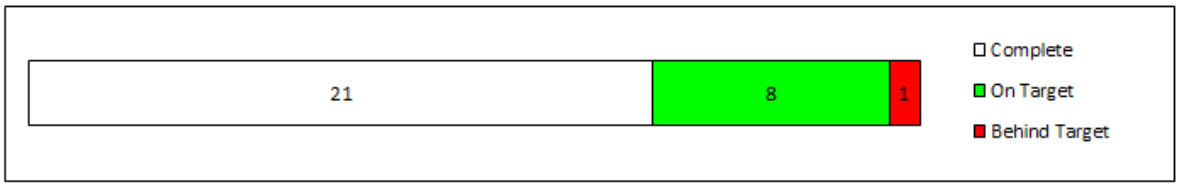
- The estimated diagnosis rate for people with dementia has risen in both CCGs and is well above the 2013/14 national average (52.5%). Performance in North Durham has risen from 57.4% in 2013-14 to 67.3% 2014-15 and in DDES from 66.0% 2013-14 to 75.6% 2014-15.

- The Dementia Strategy for County Durham and Darlington 2014-17 has been agreed.

- The rate of delayed transfers of care from hospital is 7.5 per 100,000 population (2014-15). This has decreased from 10.5 in 2013-14, and is better than the national average of 11.2 (2014/15).

Objective 4: Improve Mental Health and Wellbeing of the Population

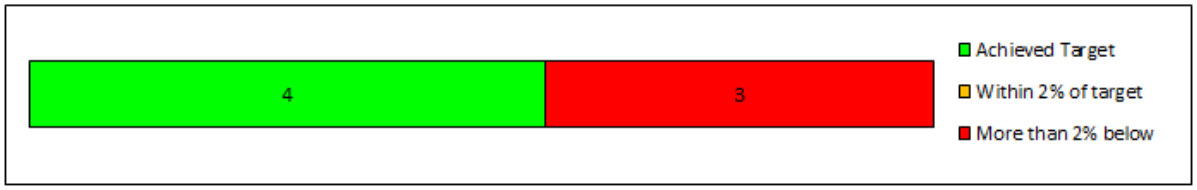
74. There are 30 actions under objective 4. Progress is as follows:



75. Revised targets dates have been set for the following actions:

- Develop integrated care pathways to address physical and mental health needs where appropriate. The Target date has been revised by the CCGs from December 2015 to March 2016 to reflect their commissioning intentions delivery plan.

76. There are 7 indicators with targets under Objective 4 for which new data is reported. Performance against target is as follows:



Performance indicators more than 2% below target (3 indicators):

Recovery rate for IAPT treatment

77. The recovery rate of those completing IAPT treatment in Durham Dales, Easington and Sedgefield (DDES) CCG is behind target. (2014-15 QPI). The North Durham CCG recovery rate for 2014-15 was above target at 51.2%.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
45.4% (2013-14)	Improving Access to Psychological Therapies (IAPT): Recovery rate of those completing treatment - DDES	46.4% (2014-15)	50%	45.5% (Jan-Mar 14)	46.8% [Durham, D'ton & Tees Area Team] (Jan-Mar 14)	⇧

78. The recovery rate measures the percentage of people that were above the clinical threshold before treatment but below the threshold following treatment. It considers factors such as anxiety and depression. Recovery occurs if that person subsequently scores below the clinical threshold on depression *and* anxiety.

79. Due to the existence of separate counselling service in DDES, the generic IAPT service deal with a higher proportion of more complex, severe need individuals who are less likely to move to a full recovery. The counselling service sees a higher proportion of individuals who are more likely to make a full recovery through therapy.

80. Discussions are ongoing with individual Clinical Commissioning Groups on transforming Counselling Services during 2015/16. The primary aim is to move the services into a position where they individually contribute towards the national targets shown.

81. The CCGs are to produce an update paper on talking therapies for discussion at the Health and WellBeing Board in September 2015.

Access to IAPT

82. Access to IAPT is behind target in both CCGs, however access has improved since 2013-14 and is above the National average. (2014-15 QPI)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
8.2% (2013-14)	Access to IAPT - DDES	11.6% (2014-15)	12.8%	9.5% (Dec 2013)	n/a	⇧

9.1% (2013-14)	Access to IAPT - ND	11.8% (2014-15)	12.8%	9.5% (Dec 2013)	n/a	⇧

83. The completion of an improvement action plan agreed with the provider has resulted in a substantial improvement in month on month performance for both CCGs. However, achievement of key performance targets has been affected by staff vacancies.

84. Actions being taken to continue recent improvements include:
- Performance will be monitored closely to ensure the measures instigated through the improvement action plan continue to be applied.
- Recruitment to vacant posts is in progress and issues around vacancies, staff retention and recruitment will continue to be monitored.
- Achievement of minimum staffing levels is pivotal to sustaining performance and this will be reflected in the 2015/16 contract arrangements.

Other Areas for Improvement

Suicide rate

85. The suicide rate in County Durham has increased, and is higher than the national and regional rates.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
11.3 per 100,000 (2010-12) [172]	Suicide rate	13.4 per 100,000 (2011-13) [204]	Tracker	8.8 per 100,000 (2011-13)	10.6 per 100,000 (2011-13)	⇧

86. The long term trend shows that since 2001-03 the County Durham rate has increased by 29% compared to regional and national reductions of 6% and 16% respectively.

87. Actions being taken to tackle this 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 new early alert process was implemented in September 2014 which identifies people at risk of suicide within a maximum of 48 hours from an attempt.
- The 'Suicide Safer Communities' programme was agreed at the Mental Health Partnership Board in February 2015. This is an internationally accredited programme which supports community resilience and suicide prevention. The implementation plan is currently under development.

Performance Highlights

88. Progress since the previous performance report includes:

- The proportion of adults in contact with secondary mental health services who are in paid employment is 10.9% for 2014-15. This exceeds the target of 8% and is above the national average of 7.1%. This is a 2015-16 QPI.

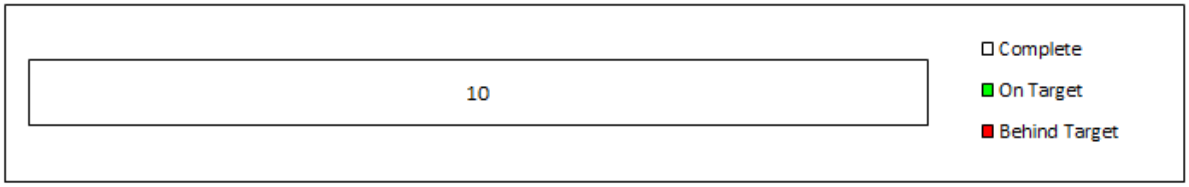
- The Wellbeing for Life Service has been developed to help people to live well, and build on their capacity to be independent, resilient and maintain good health for themselves and those around them.

- In 2014-15, 84.1% of service users reported they have as much or adequate social contact with people as they like. This is an increase from 83.4% in 2013-14.

- In the 2014/15 national Carers Survey, 52.4% of Carers in Durham reported that they had as much social contact as they would like. The national average was 38% and regional average is 45.7%.

Objective 5: Protect vulnerable people from harm

89. There are 10 actions for objective 5. Progress against them is as follows:



90. There are 6 indicators with targets under Objective 5 for which new data is reported. Performance against target is as follows:

Performance indicators more than 2% below target (3 indicators):

Children becoming the subject of a Child Protection plan for a second or subsequent time

91. The percentage of children becoming the subject of a Child Protection plan for a second or subsequent time within 2 years of the previous plan ending has not achieved target and is higher than last year's outturn.

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
8.0% (Apr-Sep 13)	%age of children becoming the subject of a Child Protection Plan for a second or subsequent time (within 2 years of a previous plan)	12.6% (Apr-Sep 14)	10.0%	n/a	n/a	⇧

92. This indicator is from the DfE's national safeguarding framework (which became effective in 2013/14) and is also reported to the Children and Families Partnership.

93. The County Council is undertaking an analysis of identified child protection cases to understand the underlying factors behind performance. This will be completed by the end of July 2015.

Medication-related safety incidents

94. TEWV and County Durham & Darlington Foundation Trust (CDDFT) have not achieved targets in relation to reporting medication-related safety incidents. (2014-15 QPI)

Previous Data	Indicator	Latest Data	Target	National Average	North East Average	Direction of Travel
12.7% (Apr 13 – Sep 13)	Reported number of medication-related safety incidents - CDDFT	8.8% (Apr 14 – Sep 14)	10.0%	11% (Oct 13 - Sep14)	n/a	⇩
17.0% (Apr 13 – Sep 13)	Reported number of medication-related safety incidents - TEWV	17.2% (Apr 14 – Sep 14)	26.0%	9.0% (Oct 13- Sep 14)	n/a	⇧

95. CDDFT have designated medication safety officers and have implemented all the actions in the patient safety alert *(Improving medication error incident reporting and learning NHS/PSA/D/2014/005)* to improve reporting rates. They also produce a separate medication incident /safety report to the Clinical Quality Review Group (CQRG) with the CCG on a 6 monthly basis for scrutiny. The Trust has undertaken a number of campaigns across all their care groups to raise awareness with staff and to try and increase their incident reporting rates.

96. TEWV has implemented improvements to facilitate increased incident reporting, which should be fully implemented by September 2015.

97. Medication incidents are recorded via the Trust's incident reporting system. Incidents are assigned to the team looking after the patient at the time for investigation and resolution. The Patient Safety Pharmacist also scrutinises the data for themes and trends and uses them as a focus for targeting lessons learned which are discussed at the Safe Medication Practice Group. Learning

from incidents is also incorporated into the Medicines Management training for nursing staff, and junior doctor e-learning and face to face training.

98. The minutes from the Safe Medication Practice Group are also discussed at the Drugs and Therapeutics Committee. The Patient Safety Pharmacist also attends the Patient Safety Meeting to raise key points and to action plan on areas of particular concern. The patient safety pharmacist has also been involved in the Trust's larger project which is addressing incident reporting as a whole.

Performance Highlights

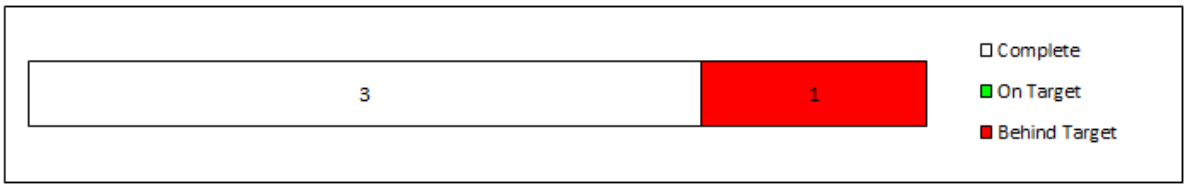
99. Progress since the previous performance report includes:

- The number of children with a child protection plan has decreased from 45.1 per 10,000 population in March 2014 to 37.6 in March 2015. The Durham rate is now below the 2014 North East (59.3 March 2014) and national (42.1 March 2014) rates.

- The percentage of Children in Need referrals occurring within 12 months of a previous referral in 2014-15 was 22.8%. This is a decrease from 27.4% in 2013-14. The North East average is 22.9% (2013-14) and National is 23.4%.

Objective 6: Support people to die in the place of their choice with the care and support that they need

100. There are 4 actions under objective 6. Progress is as follows:



101. Revised targets dates have been set for the following action:

- Incorporate requirements for quality monitoring of end of life care in residential and nursing home contracts. The target date of April 2015 has not been achieved. The timeline will be reviewed by Durham County Council and CCGs at a Joint Commissioning meeting in July 2015.

102. There are 2 indicators with targets under Objective 6 for which new data is reported. Performance against target is as follows:

103. There are no performance indicators under objective 6 which are more than 2% below target.

Performance Highlights

104. Progress since the previous performance report includes:

- The number of patients in need of palliative care/support as recorded on practice disease registers is now 1,726 (2014-15). This is above target for both CCG areas. (2014-15 and 2015-16 QPI)

- Deaths in usual place of residence have increased to 45.4% for DDES CCG and 47.4% for North Durham CCG for the year October 2013 to September 2014, from 44.5% in DDES and 45.5% in North Durham. Both CCGS are above the North East (44.5%) and National (45.1%) averages.

Recommendations

105. 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 action planning.

Contact:	**Keith Forster, Strategic Manager – Performance & Information Management, Children & Adults Services; Tel: 03000 26739**

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: 4th 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	55.89% (Jan-Mar 15)	Tracker	⇩	Qtr 2 (2014/15)	73.9% (Oct-Dec 14)	54.8% (Oct-Dec 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	28.76% (Jan-Mar 15)	Tracker	⇧	Qtr 2 (2014/15)	47.2% (2012/13)	26.7% (Oct-Dec 14) [Durham, D'ton & Tees Area Team]	Not available
23.6% (2011/12)	21.9% (2012/13)	Percentage of children aged 4-5 classified as overweight or obese	23.8% (2013/14)	Tracker	⇧	Qtr 3 (2014/15)	22.5% (2013/14)	24.4% (2013/14)	24.6% (2013/14)
38.4% (2011/12)	35.9% (2012/13)	Percentage of children aged 10-11 classified as overweight or obese	36.1% (2013/14)	Tracker	⇧	Qtr 3 (2014/15)	33.5% (2013/14)	36.1% (2013/14)	35.2% (2013/14)
2150 (2012/13)	2667 (2013/14)	Number of new referrals to Child and Adolescent Mental Health Services (CAMHS)	2797 (2014/15)	Tracker	⇧	Qtr 2 (Apr- Jun 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	227 (2014/15)	295 (2014/15)	⇧	Q2 2015/16 (Apr - Jun 15)	Not applicable	Not applicable	Not applicable
102.6 (2009/10-2011/12)	81.5 (2010/11-2012/13)	Alcohol specific hospital admissions for under 18's (rate per 100,000)	69.9 (2011/12 - 2013/14)	Tracker	⇩	Qtr 1 2016/17 (2012/13-2014/15)	40.1 (2011/12-2013/14)	65.8 (2011/12-2013/14)	Not available
88% (2012/13)	74% (2013/14)	Percentage of exits from young person's treatment that are planned discharges	69% (Apr 14 -Mar 15)	79%	⇩	Data release date TBC	79% (Apr 14-Mar 15)	Not available	Not available
7.7 (2011)	8.9 (2012)	Under 16 conception rate	7.9 (2013)	Tracker	⇩	Qtr 4 (2014)	4.8 (2013)	7.4 (2013)	7.2 (2013)
33.7 (2012)	33.8 (2013)	Under 18 conception rate	30.9 {Prov} (2014)	Tracker	⇩	Qtr 1 (Jan-Mar 15)	23.9 {Prov} (2014)	29.7 {Prov} (2014)	Not available
19.9% (2012/13)	19.9% (2013/14)	Percentage of mothers smoking at time of delivery	18.3% (Oct-Dec 14)	20.5%	⇩	Qtr 1 (Jan-Mar 15)	11.5% (Apr-Sept 14)	20% (Apr - Sept 14) [Durham, D'ton & Tees Area Team]	Not available
4.0 (2009-11)	3.9 (2010-12)	Infant mortality rate, per 1,000 live births and stillbirths	3.3 (2011-13)	Tracker	⇩	Qtr 3 2015/16 (2012-14)	4.1 (2011-13)	3.5 (2011-13)	3.8 (2011-13)

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
9.0 (2011)	5.9 (2012)	Stillbirth and neonatal mortality rate, per 1,000 live births and stillbirths	6.5 (2013)	Tracker	⇧	May-16	7.3 (2013)	7.1 (2013)	Not available
16.3 (2012/13)	15.1 (2013/14)	Emotional and behavioural health of Looked After Children [lower score is better]	15.2 (Prov) (2014/15)	Tracker	⇧	Qtr 4 (2015/16)	13.9 (2013/14)	13.9 (2013/14)	14.6 (2013/14)
493.7 (2012/13)	431.5 (2013/14)	Emergency admissions for children with lower respiratory tract infections - DDES CCG (0-18 per 100,000 registered patients)	532.3 (Apr 14 - Mar 15)	Tracker	⇧	Qtr 2 2015/16 (Apr Jul 15)	372.9 (2013/14)	449.6 Prov] (Oct 13-Sep 14) [Durham, D'ton & Tees Area Team]	Not available
510.0 (2012/13)	467.6 (2013/14)	Emergency admissions for children with lower respiratory tract infections - North Durham CCG (0-18 per 100,000 registered patients)	560.5 (Apr 14-Mar 15)	Tracker	⇧	Qtr 2 2015/16 (Apr Jul 15)	372.9 (2013/14)	449.6 Prov] (Oct 13-Sep 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	208 (108 quit) (Apr-Dec 14)	Tracker	⇧	Qtr 1 2015/16 (2014-15)	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 1 2015/16 (2013/14)	346.3 (2012/13)	479.6 (2012/13)	Not available
Strategic Objective 2: Reduce health inequalities and early deaths									
408.14 (2011)	394.18 (2012)	All cause mortality for persons aged under 75 years per 100,000 population	407.1 (2013)	Tracker	⇧	Qtr 3 2015/16 (2014)	337.97 (2013)	393.44 (2013)	Not available
96.6 (2009-11)	91.3 (2010-12)	Mortality from all cardiovascular diseases (including heart disease and stroke) for persons aged under 75 years per 100,000 population	88.8 (2011-13)	Tracker	⇩	Qtr 3 2015/16 (2012-14)	78.2 (2011-13)	88.9 (2011-13)	Not available
163.5 (2009-11)	164.2 (2010-12)	Mortality from cancer for persons aged under 75 years per 100,000 population	166.6 (2011-13)	Tracker	⇧	Qtr 3 2015/16 (2012-14)	144.4 (2011-13)	169.5 (2011-13)	Not available
8.6 (2009-11)	7.0 (2010-12)	Slope Index of Inequality (Males)	7.0 (2011-13)	Tracker	⇔	Q1 2016/17 (2012-14)	Not available	Not available	Not available
7.2 (2009-11)	7.2 (2010-12)	Slope Index of Inequality (Females)	7.5 (2011-13)	Tracker	⇧	Q1 2016/17 (2012-14)	Not available	Not available	Not available
14.2% (2012/13)	10.3% (2013/14)	Percentage of the eligible population aged 40-74 who received an NHS Health Check	7.4% (2014/15)	8%	⇩	Q2 (2015/16) (Apr -Jul 15)	9.6% (2014/15)	8.25% (2014/15)	Not available
22.1 (2009-11)	21.7 (2010-12)	Mortality from liver disease for persons aged under 75 years per 100,000 population	21.9 (2011-13)	Tracker	⇧	Qtr 4 2015/16 (2012-14)	17.9 (2011-13)	22.3 (2011-13)	Not available
42.1 (2009-11)	40.1 (2010-12)	Mortality from respiratory disease for persons aged under 75 years per 100,000 population	43.4 (2011-13)	Tracker	⇧	Qtr 4 2015/16 (2012-14)	33.2 (2011-13)	42.6 (2011-13)	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
98.3% (Jul - Sep 2014)	98.3% (Oct -Dec 2014)	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date) DDES CCG	97.7% (Jan - Mar 15)	96%	⇩	Qtr 2 (July-Sept 15)	97.4% (Jan - Mar 2015)	98.7% [Durham, D'ton & Tees Area Team] (Jan -Mar 2015)	Not available
98.6% (Jul - Sep 2014)	99.1% (Oct -Dec 2014)	Percentage of patients receiving first definitive treatment for cancer within 31 days from diagnosis (decision to treat date) North Durham CCG	98.8% (Jan-Mar 15)	96%	⇧	Qtr 2 (July-Sept 15)	97.4% (Jan - Mar 2015)	98.7% [Durham, D'ton & Tees Area Team] (Jan -Mar 2015)	Not available
81.7% (Jul - Sep 2014)	81,1% (Oct -Dec 2014)	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer DDES CCG	83.5% (Jan-Mar 15)	85%	⇧	Qtr 3 (July-Sept 14)	82% (Jan - Mar 2015)	86.1% [Durham, D'ton & Tees Area Team] (Jan - Mar 2015)	Not available
85.2% (Jul - Sep 2014)	86,2% (Oct -Dec 2014)	Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer North Durham CCG	90% (Jan-Mar 15)	85%	⇧	Qtr 3 (July-Sept 14)	82% (Jan - Mar 2015)	86.1% [Durham, D'ton & Tees Area Team] (Jan - Mar 2015)	Not available
77.5 (2009-11)	77.9 (2010-12)	Male life expectancy at birth (years)	78 (2011-13)	Tracker	⇧	Qtr 3 2015/16 (2012-14)	79.4 (2011-13)	78 (2011-13)	Not available
81.4 (2009-11)	81.5 (2010-12)	Female life expectancy at birth (years)	81.3 (2011-13)	Tracker	⇩	Qtr 3 2015/16 (2012-14)	83.1 (2011-13)	81.7 (2011-13)	Not available
7.3% (2012)	6.8% (2013)	Successful completions as a percentage of total number in drug treatment - Opiates	7.1% (Oct 13 - Sep 14)	7.9%	⇧	Qtr 2 2015/16 (2014)	7.6% (Oct 13 - Sep 14)	6% (2013)	
36.1% (2012)	39.9% (2013)	Successful completions as a percentage of total number in drug treatment - Non Opiates	40.1% (Oct 13-Sep 14)	40.4%	⇧	Qtr 2 2015/16 (2014)	39% (Oct 13- Sep 14)	31.2% (2012)	Not available
792.8 (2012/13)	784.4 (2013/14)	Alcohol related admissions to hospital per 100,000	382.73 [Prov] (Apr-Sep 14)	Tracker	⇩	Qtr 1 2015/16 (Apr-Dec 14)	320.05 [Prov] (Apr-Sep 14)	423.55 [Prov] (Apr-Sep 14)	Not available
43.7% (2012/13)	34.8% (2013/14)	Successful completions as a percentage of total number in treatment – Alcohol	38.0% (Apr 14-Mar 15)	36.6%	⇧	Qtr 2 2015/16 (Jul 14-Jun 15)	39.2% (Apr 14 - Mar 15)	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
1,165 per 100,000 (4,949 quitters) (2012/13)	675 per 100,000 (2,875 quitters) (Apr-Dec 14)	Four week smoking quitters per 100,000 population	527.7 per 100,000 (2248) (Apr-Dec 14)	788 per 100,000 (3,369 quitters)	⇩	Qtr 1 2015/16 (2014-15)	359 per 100,000 (Apr-Dec 2014)	436 per 100,000 (Apr-Dec 2014)	Not available
21.2 (2011)	22.2 (2012)	Estimated smoking prevalence of persons aged 18 and over	22.7 (2013)	Tracker	⇧	Qtr 3 2015/16 (2014)	18.4 (2013)	22.3 (2013)	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
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)
79.3% (2012)	78.6% (2013)	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	77.9% (2014)	70%	⇩	Data release date unknown	75.9 (2014)	77.1 (2014)	75.8 (2013)
78.8% (2012)	77.7% (2013)	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	78% (2014)	80%	⇧	Data release date unknown	74.2 (2014)	76.1 (2014)	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		
18.1% (2008/11)	16.8% (2009/12)	Reduce excess winter deaths	19% (2010/13)	Tracker	⇧	Qtr 4 2015/16 (2011/14)	17.4% (2010/13)	16% (2010/13)	Not available
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% (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	84% (Mar 15)	81.2% by March 15	⇧	Qtr 1 (Apr-Jun)	87% (Mar 15)	87% [Durham, D'ton & Tees Area Team] (Mar 15)	Not available
Not available	75% (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	85% (Mar 15)	85.2% by March 15	⇧	Qtr 3 2015/16 (Apr-Oct 14)	87% (Mar 15)	87% [Durham, D'ton & Tees Area Team] (Mar 15)	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
Not available	68 (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	85% (Mar 15)	78.2% by March 15	⇧	Qtr 3 2015/16 (Apr-Oct 14)	87% (Mar 15)	87% [Durham, D'ton & Tees Area Team] (Mar 15)	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	39.4% (2014/15)	35%	⇧	Qtr 1 2015/16 (Apr- Jun 15)	33.5% (2013/14)	31.9% (2013/14)	Not available
8.7 (2012/13)	Not reported 2013/14	Carer reported quality of life	8.7 {Prov} (2014-15)	9.0	⇔	Qtr 4 (2015/16)	7.9 {Prov} (2014/15)	8.4 {Prov} (2014/15)	Not reported
84% (2012/13) [National Survey]	74.2% (2013/14) [Local Survey]	Overall satisfaction of carers with support and services they receive (Extremely/Very/Quite Satisfied)	84.9% {Prov} (2014-15)	78.0%	⇧	Qtr 4 (2015/16)	Not available	Not available	Not available
79.2% (2012/13) [National Survey]	73% (2013/14) [Local 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 (Always/Usually)	85.9% {Prov} (2014-15) [National Survey]	75%	⇧	Qtr 4 (2014/15)	72.9% (2012/13)	79.4% (2012/13)	76.4% (2012/13)
55.2 (2012/13)	66 (2013/14)	Estimated diagnosis rate for people with dementia DDES CCG	75.6 (2014/15)	Tracker	⇧	Data release date TBC	52.5 (2013/14)	Not reported	Not reported
52.6 (2012/13)	57.4 (2013/14)	Estimated diagnosis rate for people with dementia North Durham CCG	67.3 (2014/15)	Tracker	⇧	Data release date TBC	52.5 (2013/14)	Not reported	Not reported
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	92.6% (2014/15)	93%	⇩	Qtr 3 2015/16 (Apr-Aug 15)	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	93.3% (2014/15)	80.0%	⇩	Qtr 3 (Apr-Sept 15)	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	61.3% (2014/15)	56.5%	⇧	Qtr 3 (Apr-Sept 15)	61.9% (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	16.8 (2014/15)	14 per 100,000 (2014/15)	⇧	Qtr 3 (Apr-Sept 14)	14.4 (2013/14)	14.4 (2013/14)	13.5 (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	820.9 Per 100,000 (2014/15)	727 per 100,000 (2014/15)	⇧	Qtr 3 (Apr-Sept 15)	650.6 (2013/14)	803.4 (2013/14)	724.9 (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	89.9% (Oct-Dec 2014)	85.4%	⇧	Qtr 3 (Jan-Jun 15)	82.5% (2013/14)	87.2% (2013/14)	85.3% (2013/14)

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
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	65.3% (2014/15)	55%	⇧	Qtr 3 (Apr-Sept 15)	Not available	60.2% (Q2 2012-13)	Not available
11.2 (2009/10)	12.1 (2010/11)	Emergency readmissions within 30 days of discharge from hospital	12.4 (2011/12)	Tracker	⇧	Data release date TBC	11.8 (2011/12)	Not available	Not available
10.7 per 100,000 (2012/13)	10.5 per 100,000 (2013/14)	Delayed transfers of care from hospital per 100,000 population	7.5 per 100,000 (2014/15)	Tracker	⇩	Qtr 3 (Apr-Sept 15)	11.2 (2014/15)	8.1 (2013/14)	7.9 (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	1.3 per 100,000 (2014/15)	Tracker	⇧	Qtr 3 (Apr-Sept 14)	3.7 (2014/15)	2.0 (2013/14)	2.0 (2013/14)
2,062 (2011/12)	2,085 (2012/13)	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 per 100,000 population)	2159 (2013/14)	Tracker	⇧	Data release date TBC	2,064 (2013/14)	2,051 (2013/14)	Not reported
601.5 (2011/12)	636.0 (2012/13)	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)	674 (2013/14)	Tracker	⇧	Qtr 1 2016/17 (2014/15)	580 (2013/14)	651 (2013/14)	Not reported
85.9% (2012/13)	86.1% (2013/14)	Proportion of adults with learning disabilities who live in their own home or with their family	85.2% (2014/15)	85%	⇩	Qtr 3 (Apr-Sept 15)	74.9% (2013/14)	80.6% (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	88.0% (2014/15)	88.5%	⇩	Qtr 3 (Oct 14-Sept 15)	60.8% (2013/14)	Not available	59.2% (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
Not available	2929 (Jan-Mar 14)	Total non-elective admissions into hospital (general & acute), all age, per 100,000 population	3009 (Jan-Mar 15)	2868 (Jan-Mar 15)	⇧	Qtr 2 2015/16 (2014/15)	Not available	Not available	Not available
197.0 (2012/13)	225.7 (2013/14)	The number of people in receipt of Telecare per 100,000	292 (2014/15)	215	⇧	Qtr 2 201516 (2014/15)	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

Previous Data		Indicator	Latest Data	2014/15 Target	Direction of Travel against same period previous year	Next Data Refresh	National	North East	Similar Councils
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
18.3% (Oct-Dec '13)	16.5% (Jan-Mar '14)	Gap between the employment rate for those with a long term health conditions and the overall employment rate	13.2% (2013/14)	Tracker	⇩	Qtr 3 2015/16 (Apr-Jun 15)	8.7% (2013/14)	11% (2013/14)	Not available
11% (2012/13)	10.9% (2013/14)	Proportion of adults in contact with secondary mental health services in paid employment	10.9% (2014/15)	8%	⇔	Qtr 2 2015/16 (Apr-Jun 15)	7.1% (2013/14)	Not available	Not available
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
12.0 per 100,000 (2009-11) [181]	11.3 per 100,000 (2010-12) [172]	Suicide rate	13.4 per 100,000 (2011-13) [204]	Tracker	⇧	Qtr 4 2015/16 (2012-14)	8.8 per 100,000 (2011-13)	10.6 per 100,000 (2011-13)	Not reported
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
66.3% (2012/13)	49.2% (2013-14)	Percentage of service users reporting that care and support services help in having social contact with people	74.0% {Prov} (2014/15)	Not set for 2014/15	⇧	Qtr 4 (2015/16)	59.0% [2013/14]	56.3% [2013/14]	Not available
85.7% (2012/13)	Survey not carried out in 2013/14	Percentage of service users who have as much/adequate social contact with people as they like - carers	91.6% [Prov] (2014/15)	86%	⇧	Q4 2016/17	Not available	Not available	Not available
79.5% (2012/13)	83.4% (2013/14)	Percentage of service users who have as much/adequate social contact with people as they like - social care users	84.1% (2014-15)	80%	⇧	Q3 (Apr-Sept 15)	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
365.4 (2010/11)	427.8 (2011/12)	Excess under 75 mortality rate in adults with serious mental illness per 100,000 population	413.2 (2012/13)	Tracker	⇩	Qtr 3 2015/16 (2013/14)	347.2 (2012/13)	Not reported	Not reported
45.4% (2012/13)	45.4% (2013/14)	Improving Access to Psychological Therapies (IAPT): Recovery rate of those completing treatment - DDES	46.4% (2014/15)	50% [1410]	⇧	Qtr2 2015/16 (Apr-Aug 15)	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	51.2% (2014/15)	50% [1238]	⇩	Qtr2 2015/16 (Apr-Aug 15)	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	11.6% (2014/15)	12.8%	⇧	Qtr2 2015/16 (Apr-Aug 15)	9.5% (Dec 2013)	Not available	Not available
Not available	9.1% (2013/14)	Access to IAPT - ND	11.75% (2014/15)	12.8%	⇧	Qtr2 2015/16 (Apr-Aug 15)	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)	14.8% (2014/15)	Less than 25%	⇧	Qtr 3 (Apr-Sep 15)	24% (2014)	28% (2014)	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	94% (2014/15) [Local Survey]	85%	⇧	Qtr 3 (Apr-Sept 15)	Not available	Not available	Not available
Not available	8.5% (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)	12.6% (Apr-Sept 14)	10.0%	⇧	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
40.9 (March 13)	45.1 (March 14)	Number of children with a Child Protection Plan per 10,000 population	37.6 (Mar 15)	Tracker	⇩	Qtr 3 (Sept 15)	42.1 (March 2014)	59.3 (March 2014)	54.8 (March 2014)
51.1% (2012/13)	49.3% (2013/14)	Percentage of adult safeguarding referrals substantiated or partially substantiated	50% (2014/15)	Tracker	⇧	Qtr 3 (Apr-Sep 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
63.4 (March 13)	60 (March 14)	Rate of Looked After Children per 10,000 population	62.1 (Mar 2015)	Tracker	⇧	Qtr 3 (Sept 15)	60 (March 2014)	81 (March 2014)	81 (March 2014)
16.8% (2012/13)	27.4% (2013/14)	Percentage of Children in Need (CIN) referrals occurring within 12 months of previous referral	22.8% (2014/15)	28%	⇩	Qtr 2 (Apr-Jun 15)	23.4% (2013/14)	22.9% (2013/14)	25.9% (2013/14)
12.7% (Apr 13 - Sep 13)	7.4% (Oct 13 - Mar-14)	Reported number of medication-related safety incidents - CDDFT	8.8% (Apr 14 - Sep 14)	10%	⇩	Qtr 2 2015/16 (Oct -Dec 14)	11% (Oct 13 - Sep14)	Not available	Not available
17% (Apr 13 - Sep 13)	16.1% (Oct 13 - Mar-14)	Reported number of medication-related safety incidents - TEWV	17.2% (Apr 14 - Sep 14)	26%	⇧	Qtr 2 2015/16 (Oct -Dec 14)	9.0% (Oct 13-Sep 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									
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
44.1% (2012/13)	45.4% (2013/14)	Proportion of deaths in usual place of residence (DDES CCG)	45.4% (Oct '13 - Sep '14)	Tracker	⇧	Qtr 3 2015/16 (2014)	45.1% (Oct '13 - Sep '14)	44.5% (Oct '13 - Sep '14)	Not available
45.6% (2012/13)	46.6% (2013/14)	Proportion of deaths in usual place of residence (North Durham CCG)	47.4% (Oct '13 - Sep '14)	Tracker	⇧	Qtr 3 2015/16 (2014)	45.1% (Oct '13 - Sep '14)	44.5% (Oct '13 - Sep '14)	Not available
1098 (0.4%) (2012/13)	1406 (0.5%) (2013/14)	Number and percentage of patients in need of palliative care/support, as recorded on practice disease registers - DDES	1726 [Prov] (0.6%) (2014/15)	1435 (0.5%) (2014/15)	N/A	Qtr 2 2015/16 (Apr-Aug 15)	0.3% (2013/14)	0.4% [Durham, D'ton & Tees Area Team] (2013/14)	Not available
425 (0.2%) (2012/13)	762 (0.3%) (2013/14)	Number and percentage of patients in need of palliative care/support, as recorded on practice disease registers - ND	1190 [Prov] (0.5%) (2014/15)	729 (0.3%) (2014/15)	N/A	Qtr 2 2015/16 (Apr-Aug 15)	0.3% (2013/14)	0.4% [Durham, D'ton & Tees Area Team] (2013/14)	Not available

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