Special Health and Wellbeing Board

Date	**Thursday 14 May 2015**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies for Absence
2. Substitute Members
3. Declarations of Interest
4. Minutes of the meeting held on 11 March 2015 (Pages 1 - 10)
5. Update Report on the Outcome of the Children's Centre Review - Report of Head of Children's Services, Children and Adults Services, Durham County Council (Pages 11 - 16)
6. Children's Services Update - Report of Head of Children's Services, Children and Adults Services, Durham County Council (Pages 17 - 26)
7. Guidance for the Operationalisation of the Better Care Fund in 2015-16 - Report of Integration Programme Manager - Joint Funded, Children and Adults Services, Durham County Council and Clinical Commissioning Groups (Pages 27 - 34)
8. Clinical Commissioning Group Planning Progress Update and Final Commissioning Intentions 2015-16 - Joint report of Chief Operating Officer, North Durham & Durham Dales, Easington and Sedgefield Clinical Commissioning Groups and Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 35 - 64)
9. Health Premium Incentive Scheme 2014-15 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 65 - 72)

10. Approach to Reducing Diabetes in County Durham - National Diabetes Prevention Programme Demonstrator Site and CCGs' Diabetes Service Developments - Joint report Director of Public Health County Durham, Children and Adults Services, Durham County Council and Chief Operating Officer, North Durham & Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (Pages 73 - 86)
11. County Durham Dual Needs Strategy - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 87 - 114)
12. Feedback from County Durham's Health and Wellbeing Peer Challenge - Report of Strategic Manager - Policy, Planning & Partnerships, Children and Adults Services, Durham County Council (Pages 115 - 132)
13. Healthwatch County Durham - Update - Report of Chair, Healthwatch County Durham (Pages 133 - 184)
14. Health and Wellbeing - Area Action Partnership Links - Report of Area Action Partnership Coordinator, Assistant Chief Executive's office, Durham County Council (Pages 185 - 212)
15. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration
16. 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)

17. Pharmacy Applications - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 213 - 216)
18. 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
6 May 2015

To: The Members of the Health and Wellbeing Board

Durham County Council

Councillors L Hovvels, O Johnson and M Nicholls

R Shimmin	**Corporate Director of Children and Adult Services, Durham County Council**
A Lynch	**Director of Public Health 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 **Wednesday 11 March 2015 at 9.30 am**

Present:

Councillor L Hovvels (Chairman)

Members of the Board:
Councillors O Johnson and M Nicholls, and N Bailey, J Chandy, Dr S Findlay, A Foster, S Jacques, A Lynch, J Mashiter, Dr D Smart, P Newton and P Appleton.

Also in attendance:
Councillor R Todd

1 Apologies for Absence

Apologies for absence were received from M Barkley, C Harries and R Shimmin.

The Chairman welcomed everyone to the meeting and introduced Chris Alan, Consultant in Public Health, who was shadowing her in her role.

2 Substitute Members

P Newton for M Barkley and P Appleton for R Shimmin.

3 Declarations of Interest

Dr S Findlay and J Chandy declared an interest in Item 14 Cardiovascular Disease (CVD) Prevention Strategic Framework for County Durham.

4 Minutes

The Minutes of the meeting held on 28 January 2015 were confirmed by the Board as a correct record and signed by the Chairman.

The Chair of Healthwatch County Durham referred to Item 14 and asked the Board to note that the verbal figures referred to were just one area of work they covered. She confirmed that Healthwatch County Durham had engaged with over 1200 people and had carried out signposting and advising activities during the period discussed.

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

The Board considered a report of the Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group that gave an update on the Mental Health Implementation Plan for County Durham (for copy see file of Minutes).

The Chief Operating Officer advised the Board that a new No Health without Mental Health Implementation Group had been introduced to support the delivery of the plan and would oversee the work. The priorities have been aligned to the Mental Health Partnership Board and groups under this structure. The Action Plan had been updated and the Implementation Group would monitor this area of work.

The Chairman said that this was a good news story and the Head of Planning and Service Strategy CAS DCC confirmed that this was a really important document and fully supported it. He added that it had been highlighted in the Local Government Association Peer Challenge. The Police and Crime Commissioner expressed his full support and informed the Board that this aligned with areas in the Police and Crime Plan.

Resolved:

(i) That the contents of the report, particularly the progress against the action plan be received and noted.

(ii) That the changes be noted and the proposed governance structure be agreed.

6 Mental Health Crisis Care Concordat Local Action Plan

The Board considered a report of the Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Group that presented the Mental Health Crisis Care Concordat local action plan and outlined the process of agreement for the action plan prior to publication (for copy see file of Minutes).

The Chief Operating Officer explained that a multi-agency task and finish group had been established to take forward the development of the local action plan. She went on to highlight the key priorities, the timescales for agreement and advised that North East Ambulance Service (NEAS) NHS Foundation Trust had developed a regional Mental Health Crisis Care Concordat Action Plan that sits alongside the County Durham and Darlington local plan.

The Deputy Chief Constable of Durham Constabulary welcomed the development of the Crisis Care Concordat action plan and was grateful for the support received and progress made. He questioned whether the response in the action plan from NEAS was robust enough to meet the ambitions of the Crisis Care Concordat. He said that the report highlighted areas of concern for the police, including the 30 minute response time for NEAS.

The Chief Operating Officer accepted the comments made and agreed to take the comments back to NEAS. The Director of Operations, Durham and Darlington, Tees Esk & Wear Valleys NHS Foundation Trust assured the Board that robust conversations had taken place within the group. The Chair of Healthwatch County Durham said that both Darlington and County Durham Healthwatch had been involved in the group and were happy to support the plan.

Resolved:

(i) That the County Durham and Darlington Mental Health Crisis Care Concordat action plan be agreed.

(ii) That the North East Ambulance Service (NEAS) regional Mental Health Crisis Care Concordat Action Plan, which supports the local action plan be noted.

7 Considerations and Implications of the Care Act 2014

The Committee noted a report of the Head of Adult Care, Children and Adults Services, Durham County Council regarding considerations and implications of the Care Act 2014 (for copy see file of Minutes).

The Strategic Manager, Care Act 2014 Implementation, CAS DCC gave a presentation on the overview of the Act, the wellbeing principle and focused on the key areas with relevance to the Board, including:-

- Preventing, reducing or delaying needs
- Information and advice to include choice and availability for NHS services
- Assessment, Care and Support Planning
- Personal Budgets
- Integration, Co-operation and Partnerships
- Continuity of Care
- Safeguarding Adults Board
- System risks/issues

The Strategic Manager concluded that the central theme of wellbeing will meet with the priorities set out in the Joint Health and Wellbeing Strategy, aligns with the aspirations of the Health & Wellbeing partners and will reinforce the priorities established within the strategy with a link to the Better Care Fund.

The Head of Planning and Service Strategy, CAS DCC advised that good inter-agency work would enable engagement with the public and would be a channel for other partners tying in with the Wellbeing for Life service. In terms of finance for new statutory responsibilities he stressed how important it would be for local authorities to receive the right funding as the changes had significant implications. The authority were waiting for estimates for financial models but they varied significantly at present.

Resolved:

(i) That the content of the forthcoming presentation at the HWB meeting on 11th March be noted.

(ii) That the Safeguarding Adults Board will become a statutory function in April 2015 be noted.
(iii) That to receive a further update in relation to the implementation of the Care Act at a future meeting be agreed.

8 Local Safeguarding Children Board Annual Report

The Board considered a report of the Independent Chair of the Durham Local Safeguarding Children Board (LSCB) which provided information in respect of the Annual Report of the County Durham Local Safeguarding Children Board (LCSB) setting out the work of multi-agency partners to ensure effective arrangements were in place to safeguard and protect vulnerable children and young people from abuse and neglect. The report set out achievements in 2013/14 and priorities and challenges for 2014/15 (for copy see file of Minutes).

The Strategic Manager, Safeguarding Children's Services, Children and Adults Services DCC advised of the current challenges and statistics. He referred to a key board priority of child sexual exploitation and the training given to staff to help identify these issues. A report would be brought back to the Board later in the year with progress on 2014/15.

The Head of Planning and Service Strategy, CAS DCC suggested that it would be helpful if specific areas be put to the Board to provide assurance around safeguarding activities. He suggested that the impact of parental mental health and child protection would be useful areas for the LSCB to map and then put specific questions to the Board. The Head of Planning and Service Strategy added that dialogue was very important and the two Boards should provide challenge to each other.

The Strategic Manager advised that the Chair sees the LSCB having a challenging function and would be happy to take the comments back.

Resolved:

(i) That the content of the report to ensure it remains sighted on the LSCB's effectiveness and interfaces be noted.
(ii) That the range of work that has taken place to safeguard children in county Durham, and the continued challenges, developments and achievements in this critical area of work be noted.

9 Safeguarding Adults Board Annual Report

The Board considered a report of the Safeguarding and Practice Development Manager, Children and Adults Services which provided information about the current position of the County Durham Safeguarding Adults Board (SAB) achievements on 2013/14 and plans for 2014/15 (for copy see file of Minutes).

The Safeguarding and Practice Development Manager, Children and Adults Services DCC advised of the current challenges and statistics. He highlighted the

key achievements and added that the appointment of an Independent Chair had helped to strengthen the agenda, links and opportunities for joint working.

Councillor M Nicholls commended everyone involved with the report and praised the tremendous work carried out by the board. He reported that training events for safeguarding had exceeded 5000 and awareness had increased as a result. Results of the user survey found that 75% of people felt safer following the safeguarding process.

The Head of Planning and Service Strategy, CAS DCC said that this was an interesting report and specific reference had been made to the Health & Wellbeing Board as the system leaders. He picked up on the point that information sharing was not as prominent an issue in the Safeguarding Adults Board as it was with Local Safeguarding Children Board. The Safeguarding and Practice Development Manager explained that there are information sharing arrangements in integrated health and social care teams and consent and capacity for adults was much clearer than for children.

Resolved:

(i) That the content of the report to ensure it remains sighted on the SAB's effectiveness and interfaces be noted.

(ii) That the achievements during 2013/14 and the progress of actions during 2014/15 be noted.

10 Learning Disability Joint Health and Social Care Self-Assessment Framework

The Board considered a joint report of the Head of Commissioning, Children and Adults Services, Durham County Council and Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups that gave an update on the 2013 Joint Health and Social Care Learning Disability Self-Assessment Framework (SAF) and outlined the steps being taken to complete the 2014/15 Learning Disability SAF (for copy see file of Minutes).

The Strategic Commissioning Manager, Learning Disabilities/Mental Health highlighted the priorities that were fed into the self-assessment framework and he assured the Board that activity was underway to address any shortfalls.

Councillor M Nicholls added that this was an important piece of work with real life expectations. An Improving Health Group had been set up to look at health inequalities and clinical issues. There would be more focus on improving health outcomes and improving take up on health checks. He said that the action plan would ensure that these areas are developed.

Resolved:-

(i) That the report for information be received.

(ii) That the ongoing work taking place be noted.

(iii) That further update reports regarding progress on SAF implementation be received.

11 Winterbourne View / Transforming Care Agenda Update

The Board considered a joint report of the Head of Commissioning, Children and Adults Services, Durham County Council and Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups that gave an update on progress in relation to the Winterbourne View/ Transforming Care Agenda (for copy see file of Minutes).

Councillor M Nicholls said that reviews had a clear purpose and we need to ensure a discharge plan was in place for each individual. He advised that the action plan would be followed and that the CCGs would transform the programme of care. More pressures would be faced with S117 hospital discharges and the Better Care Fund.

The Director of Operations, Durham and Darlington, TEWV assured the Board that a small number of treatment beds were available and had been reviewed by the CQC with excellent feedback received. He said that we need complex solutions to complex problems and often found that people who had been discharged return quickly to the unit. They were committed to helping people live in their own homes within the community.

The Chief Clinical Officer, DDES CCG said that there was a significant risk to the health economy as the health and social care needs were very complex. NHS England's responsibility would move to the CCG and funding for people to be transferred would be expensive.

The Chief Operating Officer, North Durham and DDES CCG agreed that some cases were complex with patients being stuck between CCGs. The issue was being explored about how to fund and how to shift care from hospital to community settings.

The Strategic Commissioning Manager, Learning Disabilities/Mental Health said that CCGs in the region would work to deliver the programme of care and agreed that a systematic approach was required with a focus on the individual.

Resolved:

(i) That the update and requirement for continuing leadership and robust partnership working be received and noted.

(ii) That the possible significant funding pressures regarding hospital discharge and the development of community based services be noted.

(iii) That further updates on the "Transforming Care: Next Steps" agenda as work progresses be received.

12 Refresh of the Joint Health and Wellbeing Strategy 2015-18

The Board considered a report of the Head of Planning and Service Strategy, Children and Adult Services which presented the refresh of the Joint Health and Wellbeing Strategy 2015-18 (for copy see file of Minutes).

The Head of Planning and Service Strategy advised that there had been extensive consultation carried out around the strategy and that a full refresh of the document was circulated with the papers.

The Chief Executive, County Durham and Darlington NHS Foundation Trust (FT) expressed her support for the document.

Resolved:
(i) That the JHWS 2015/18 be agreed.
(ii) That the JHWS Delivery Plan is presented to the July Health and Wellbeing Board meeting be agreed.

13 County Durham & Darlington NHS Foundation Trust Clinical & Quality Strategy - Right First Time, Every Time

The Board received a report and presentation from the Chief Executive and Clinical Director of Service Transformation of County Durham and Darlington NHS FT that provided an update on the Emerging Clinical Strategy (for copy of report and presentation see file of Minutes).

The Chief Executive and Clinical Director of Service Transformation, County Durham and Darlington NHS FT, gave a detailed presentation about 'Right First Time, Every Time' clinical strategy and highlighted the following areas:-

- Vision for Services – Right person, Right place, Right time, Everytime, 24/7
- Breakthrough Areas –
  - Transforming Unscheduled Care
  - Integration and Care Closer to Home
  - Centres for Excellence
- Engagement with staff and stakeholders
- Board position to deliver a range of services from two acute sites
- Strategic Priority
- Capital Plans
- Workforce – to attract and recruit clinical staff
- Next steps – completion of capital business cases, reconfiguration to achieve priorities around unscheduled care and engagement

The Chief Clinical Officer, DDES CCG said that CCGs had been discussing this for some time and although there are differences in the CCG areas based on local need, there was a common drive to do more in the community.

Following a question from Councillor M Nicholls about transforming unscheduled care, the Chief Executive, County Durham and Darlington NHS FT reported that the number of medical beds in emergency care had increased and that elective care would see people choosing where to have their surgery.

The Chief Clinical Officer, DDES CCG said that they would be concentrating on winter unscheduled care and that any changes would need to be delivered within the financial envelope available.

The Chief Executive of North Tees and Hartlepool NHS Foundation Trust referred to the three main site proposals and asked if they would be consulted on as a package or in phases. The Chief Executive, County Durham and Darlington NHS FT explained that the maternity review would be picked up by SeQIHS (Securing Quality in Health Services) and that some areas of consultation would be wrapped up this way. Overall, they hoped to deliver as a package and in as few phases as possible. Dialogue would be taking places with Overview and Scrutiny Committees on the wider consultation arrangements.

The Head of Planning and Service Strategy outlined that a report will be provided to a future Health and Wellbeing Board in regard to Integrated Care/Care Closer to Home from the BCF Programme Manager, which will include key milestones with an overview of vision, strategy and plan to take forward this work.

Resolved:
That the content of this report and receive further updates periodically be noted.

14 Cardiovascular Disease (CVD) Prevention Strategic Framework for County Durham

The Committee received a report from the Director of Public Health County Durham that set out the principles, supporting evidence and priorities for a cardiovascular disease (CVD) prevention strategic framework (for copy see file of Minutes).

The Director of Public Health County Durham explained that the framework was about preventing the disease including heart attacks, heart disease and strokes. Public Health were advising on how to change lifestyle and improve health overall that would help combat these factors. CVD prevalence for deprived and affluent communities were predicted to rise by 2020. This was due to a number of contributory factors including an increase in older people and an improved survival rate.

The Committee were advised that the key messages from the report were about how to build on the progress made so far and to continue to prevent early deaths from CVD whilst reducing health inequalities.

The Chief Clinical Officer, DDES CCG said however primary care had been effective with the DDES rates brought down to the England average, despite having areas of deprivation.

The Director of Primary Care, Partnerships and Engagement, DDES supported Public Health and their enthusiasm for take up of the Check4Life service. He added that DDES were actively promoting the service in all GP practices.

Resolved:-

(i) That the CVD prevention strategic framework be endorsed.
(ii) That the strategic priority to give a much greater emphasis to population and community based initiatives as part of an integrated approach to CVD prevention be endorsed.
(iii) That the action plan be noted.

(iv) That the linkage with other strategies and action plans be noted.

15 Wellbeing for Life Service Update

The Committee received a report from the Director of Public Health County Durham that provided an update on both the adult and children's elements of the Wellbeing for Life approach (for copy see file of Minutes).

Resolved:-

(i) That the report be received and that the new service is on target to be fully operational by the 1st April 2015 be noted.

(ii) That a further report on the children and young people's element will return to a future meeting, be noted.

16 Oral Health in County Durham

The Committee received a report from the Director of Public Health County Durham that gave an update on national recommendations regarding improving the oral health of local population, County Durham's current oral health status and what is currently being delivered to improve oral health and consideration of future developments (for copy see file of Minutes).

The Director of Public Health explained how poor oral health could affect someone's general wellbeing and health. She advised that the most common hospital admissions for children aged between five and nine years old was due to tooth decay. She highlighted the National Institute for Health and Care Excellence (NICE) guidance and recommendations.

The Board were informed that there was significant variation in wards within the County in relation to children's oral health.

In relation to fluoridisation, the Director of Public Health advised that Derwentside has artificially fluoridated water and a meeting will take place in April to look at the potential to roll this out.

The Chief Clinical Officer, DDES CCG said that there had been long term problems in the Dales and re-iterated the need to protect children and pay attention to their dental hygiene. He expressed how important it was to have fluoride in water.

The Head of Planning and Service Strategy, CAS DCC said that inequalities around the County need to be eliminated and targeted work focused around communities to improve the oral health needs to be carried out.

The Chief Operating Officer, North Durham and DDES CCGs said that clinicians were pushing the introduction of fluoridisation as it was evidenced based that it did work at reducing problems in oral health. The Director of Public Health County Durham said some areas overlapped and discussions would need to take place with neighbouring local authorities.

Resolved:-

(i) That the contents of the report be noted.
(ii) That the development of a County Durham oral health strategy underpinned by an up to date oral health needs assessment be noted.
(iii) That the strategy will be cross referenced to relevant frameworks / strategies, be noted.
(iv) That PHE will support partners to develop the strategy and ensuing action plan be noted.

17 Any other business

The Chairman updated the Board about the Local Government Association Peer Challenge that took place from 24 – 27 February 2015. Feedback had been given at a session on 27 February 2015 with a report to follow. She thanked all of the partners for their input and engagement throughout the process. She found the whole experience to be very positive and advised that the report would be circulated once received.

Councillor M Nicholls also thanked everyone who had taken part.

18 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.

19 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 January 2015 (for copy see file of Minutes).

Resolved:

That the Board note the Pharmacy Relocation Applications received.

Health and Wellbeing Board

14 May 2015

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

Report of Carole Payne, Head of Children's Services, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the outcome of the Council's Cabinet on 18 March 2015 relating to the Review of Children's Centre Services in County Durham.

Background

2. On 18 March 2015, Durham County Council's Cabinet agreed to recommendations on the future of Children's Centre services in County Durham which was informed by a review of the Children's Centres and a 12 week public consultation.

3. The Council's medium term financial plan requires it to make savings of £225m over the 2011 to 2018 period. Savings targets of £136.9 million for 2014/15 will have been achieved by the end of 2014/15 however these are likely to increase.

4. In accordance with the Council's commitment to review all services, a savings target of approximately £1 million is expected to be achieved as part of the Children's Centre Review.

5. Under the national framework, Early Years Foundation Stage (EYFS), the emphasis is on delivering a broad set of skills and understanding necessary to prepare very young children for their journey through school. It aims to ensure they can learn and develop, are kept safe and healthy.

6. In County Durham, EYFS results show outcomes for children in their early years are worse for those living in the most deprived circumstances when compared with their peers.

7. Historically contact with the most vulnerable and disadvantaged families has proven a challenge in the County and the Council has introduced a wide range of services to address this including Think Family, Family Pathfinder Services, Family Intervention Teams and the Stronger Families programme. This approach is already delivering results.

8. A pilot project in Chester-le-Street is already delivering real improvements for families taking part and the shift from buildings to a broader community based support network will improve many young lives.

9. A full review of the Children's Centre service delivery model was required to make sure effective use is made of the Council's resources in order to achieve maximum impact and to meet the principles contained in the Early Years Strategy, which are to:

   - Target support to those who need it most.
   - Ensure the provision of accessible services.
   - Use resources flexibly.
   - Ensure effective community engagement in early years delivery.
   - Continually develop an expert workforce.
   - Improve outcomes for the County's children.

10. The proposals that were consulted on were:

    1. **The Community Delivery Model**
       The consultation proposed the development of a Community Delivery Model which would take services closer to where children and families live and also make better use of community buildings.

    2. **The 43 Children's Centres and the 15 it is proposed to retain**
       It was proposed to retain one Children's Centre building in each of the 15 cluster areas, thereby reducing the number of designated Children's Centers from 43 to 15. These 15 centres, alongside an extensive and flexible network of community venues would deliver services across each cluster area.

Outcome of March 2015 Cabinet Decision - Key Messages

- The changes are designed to make sure outcomes for children during their early years are improved and to ensure families most in need of support receive it.
- A community delivery model will be used which means services will be delivered closer to where children and families live from community buildings families already go to. There will be no reduction in services.
- The 43 'designated' Children's Centres will reduce to 15 designated Children's Centres but **no** buildings are closing. The 28 buildings which will not be retained as designated Children's Centres will either transfer to schools or other providers who will continue to offer services for children.

The 15 Children's Centres

11. Cabinet agreed the following would be retained as designate Children's Centres:-

1	**Moorside Children's Centre**
2	**Stanley Children's Centre**
3	**Bullion Lane Children's Centre**
4	**Brandon Children's Centre**
5	**Laurel Avenue Children's Centre**
6	**Easington Children's Centre**
7	**Seaham Children's Centre**
8	**Horden Children's Centre**
9	**Seascape Children's Centre**
10	**Wheatley Hill Children's Centre**
11	**Dean Bank Children's Centre**
12	**Tudhoe Moor Children's Centre**
13	**Newton Aycliffe Children's Centre**
14	**Woodhouse Children's Centre**
15	**Willington Children's Centre**

12. Arrangements are being finalised for each of the 28 buildings that will be transferred. Transfers are expected to take place between April and October 2015.

13. It is expected that some Children's Centre services will continue to be delivered from the buildings that will be transferred, subject to negotiations.

14. Separate discussions are taking place with Daycare providers; there is no intention to reduce daycare provision.

15. Families can choose to access Children's Centre services from whichever venue they are being delivered. Families are not expected to travel to the retained Children's Centres. Services and activities will continue to be provided from a range of community venues.

16. Activity timetables will be available on a termly basis in advance. Copies of these can be accessed in hard copy from the retained Children's Centres, in libraries and other community venues or electronically via our Facebook pages (links are available at www.durham.gov.uk/onepoint) or from http://www.surestartcountydurham.org/Pages/Activities.aspx

17. During this current transition period, timetables will be produced for the half term following Easter and are available on the links above.

18. The full Cabinet Report on the Review of Children's Centre Services in County Durham at can be viewed at: http://democracy.durham.gov.uk/ieListDocuments.aspx?CId=154&MId=7388. This details the consultation process and feedback received.

Recommendations

19. The Health and Wellbeing Board is recommended to:

    - Note the contents of this report.

Contact: Carole Payne, Head of Children Services, Durham County Council
Tel: 03000 268657

Appendix 1: Implications

Finance

The agreed proposals will enable efficiency savings in line with the County Council's Medium term Financial Plan (MTFP). The Children's Centre Review will deliver approximately £1 million from a rationalisation of buildings and a restructure of the staff resource designed to maximise savings whilst minimising reduction in the number of posts. Additional costs relating to the new Community Delivery Model have been identified and existing resources identified to fund this.

Staffing

A re-configuration of the staffing resource which proposed a revised staffing structure was undertaken in 2014 in line with the County Council's Change Management Policies and Procedures. Staff and Trade Unions were fully consulted throughout. This will deliver annual savings of £244,722 from 1 April 2015. The revised structure has secured as many frontline posts as possible within the financial envelope available following the delivery of the MTFP saving. This restructure will deliver a total reduction of 11.83wte posts, however vacancies and requests for ER/VR has ensured these savings were achieved with no compulsory redundancies. The new staffing structure is required to deliver the core offer, regardless of the configuration of Children's Centres across the County.

Risk

There is a potential financial risk associated with the clawback of funding. The Project Team has maintained a 'risk log' to highlight any concerns regarding the progress of the review and this is considered on a weekly basis. The risk of financial clawback to the Council is low as alternative providers will continue to fulfil the conditions of grant.

Equality and Diversity / Public Sector Equality Duty

A full Equality Impact Assessment has been completed and can be found in the Cabinet Report.

Accommodation

The agreed proposals to reduce the number of Children's Centre buildings could result in changes to accommodation arrangements.

Crime and Disorder

N/A

Human Rights

N/A

Consultation
A 12 week public consultation was undertaken between 31 July 2014 and 23 October 2014 involving all internal and external stakeholders. The consultation plan, delivery and analysis were all approved by the Consultation Officers Group (COG). The Consultation process was also approved by Overview and Scrutiny Management Board on 18 December 2014.

Procurement
Transfers to third party providers that are not schools will take account of the Durham Ask and, where necessary, advertise lease agreements on the open market. The advert for the lease will stipulate that any conditions of grant associated with the Children's Centre building would need to be met and where required, in line with the Council's Sufficiency Duty, will stipulate that daycare provision would need to continue to be provided.

Disability Issues
A full Equality Impact Assessment has been completed following the consultation and consideration of the recommendations on all stakeholders, regardless of their ethnicity, disability, gender, age, religion or belief or sexual orientation.

Legal Implications
The agreed proposals set out in the full Cabinet Report are consistent with the Council's statutory responsibilities in relation to Children's Centres as set out in the Childcare Act 2006 and associated Sure Start Statutory Guidance 2013.

Health and Wellbeing Board

14 May 2015

Children's Services Update

Report of Carole Payne, Head of Children's Services, Children and Adults Services, Durham County Council

Purpose of the Report

1. The purpose of this report is to provide an update to the Health and Wellbeing Board on the national and local developments in relation to children's social care services.

Background

2. A report was presented to Durham County Council's Cabinet in November 2014 which provided information on the numerous national policy documents published by successive governments over the last 16 years, all pointing to a consistent strategic direction, towards early intervention and prevention alongside effective and rigorous protection of children and young people.

3. The report provided Durham County Council's Cabinet with an overview of the Children's inspection regime and an update on the transformation journey that has been undertaken in Children's Services in Durham.

4. It was agreed that further reports would be shared with the Health and Wellbeing Board.

National Context

Child Sexual Exploitation: The Report of inspection of Rotherham Metropolitan Borough Council - February 2015

5. In August 2014 Professor Alexis Jay published an Independent Inquiry into Child Sexual Exploitation in Rotherham. The report, commissioned by Rotherham Metropolitan Borough Council (RMBC) as a review of its own practices, concluded that over 1400 children had been sexually exploited in Rotherham between 1997 and 2013. The vast majority of the perpetrators were said to be 'Asian' men.

6. In response, in September 2014, the Secretary of State for Communities and Local Government appointed Louise Casey to carry out an inspection of Rotherham Metropolitan Borough Council under section 10 of the Local Government Act 1999. The inspection would assess the Council's compliance with the requirements of Part 1 of that Act, considering leadership and governance, scrutiny, services for children and young people, taxi and private hire licensing, and whether the council 'covers up' information.

7. The Casey inspection report found a council in denial about serious and on-going safeguarding failures and a failure to address past weaknesses, in particular in children's social care. It reported an archaic culture of sexism, bullying and discomfort around race and a culture of covering up uncomfortable truths, silencing whistle-blowers and paying off staff rather than dealing with difficult issues.

8. The report found ineffective leadership and management, including political leadership with no shared vision and ineffective liaisons with partners.

9. It also identified weak and ineffective arrangements for taxi licensing which leave the public at risk.

10. In March 2015 the government issued its response to the Jay report and laid out measures they would introduce to prevent the failures happening again. This includes a new whistleblowing national portal for child abuse related reports to bring child sexual exploitation to light and be able to spot patterns of failure across the country.

11. There will be a new national taskforce, and a centre of expertise, to support areas that are struggling to get it right.

12. There will be a consultation on an extension to the new 'wilful neglect' offence to children's social care, education and elected members. The criminal charge for wilful neglect is punishable by a maximum jail term of five years.

13. To help tackle offenders, child sexual abuse has been given the status of a national threat in the Strategic Policing Requirement so that this is prioritised by every police force.

14. In addition there will be an extra £7 million available in 2014/15 and 2015/16 to organisations which support those who have experienced sexual abuse.

Single Inspection Framework (SIF)

15. In late 2013, Ofsted introduced a new SIF for Children's Services, which covers children in need of help and protection, services for looked after children and care leavers, and the Local Safeguarding Children Board (LSCB).

16. The SIF operates on a three-yearly cycle and the 'overall effectiveness' is judged as either outstanding, good, requires improvement or inadequate, as will each of the following judgements this is derived from:

    - The experiences and progress of children who need help and protection.
    - The experiences and progress of children looked after and achieving permanence, including two graded judgements:
        - Adoption
        - The experiences and progress of care leavers
    - Leadership, management and governance.

17. Benchmarking and learning from other Local Authorities who have already been subject to inspection by Ofsted under this framework continues in the service. To date, 43 Local Authorities have been inspected and had reports published. Of these, 10 (23%) have received an overall effectiveness judgement of 'good'. Three-quarters are rated below Ofsted's benchmark of 'good', with 26 (61%) judged to 'require improvement' and 7 (16%) as 'inadequate'. No local authorities have been judged as 'outstanding' under the SIF.

18. With regard to reviews of the LSCBs in 42 of the local authorities inspected under SIF, 12 have been judged to be 'good' (29%), 22 (52%) as 'requires improvement' and 8 (19%) as 'inadequate'. No LSCBs have been judged to be 'outstanding' under the SIF.

19. Benchmarking analysis of the inspections to date shows a declining trend from previous inspection judgements. The overall effectiveness judgement has decreased in 44% of all Local Authorities inspected (19) and remained the same in 16 (37%). The overall judgement has improved in 8 (19%).

20. Ofsted announced on 26 February 2015, that the proposed integrated inspection framework would not be implemented from April 2015, instead 'joint' inspections of Children's Services will begin in the autumn. The inspections will have a tight focus on how well agencies work together to protect children and address specific areas of concern, such as sexual exploitation of children and young people. It is anticipated that six inspections will take place before March 2016.

21. Ofsted, the Care Quality Commission as well as Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation plan further consultation in the summer to refine the joint inspection model.

Children's Social Care Innovation Programme

22. The government has made £30m available in 2014/15 and further funding in 2015/16 to help children's professionals develop innovative ideas for reforming how children's social care is delivered.

23. The programme's key objective is to support improvements to the quality of services so that children who need help from the social care system have better chances in life.

24. The programme also seeks to help local authorities and other commissioners to get better value for public money spent to support vulnerable children and seeks to create conditions in which local systems are better able to innovate in future to drive sustained improvements in outcomes for vulnerable children.

Troubled Families

25. In June 2013, the Government announced plans to expand the Troubled Families Programme (known in County Durham as Stronger Families) for a further five years from 2015/16 and to reach up to an additional 400,000 families across England. This increased investment was aimed to support the Government's commitment to improve the lives of troubled families and as this work is taken to a significantly greater scale, to transform local public services and reduce costs for the long-term.

26. The Government announced in the Budget 2014 that it would offer the highest performing areas including Durham the opportunity to start delivery of the expanded Troubled Families Programme early, during 2014/15. These areas began delivery in September 2014 and worked intensively with the Troubled Families Team to implement and refine the operating model for the national roll out of the expanded Troubled Families Programme in April 2015.

Regional Context

27. There is a regional commitment to develop regional protocols for child sexual exploitation, including inter-agency information sharing.

28. Durham is represented on a regional workforce development group which was set up after the joint Association of Directors of Adult Social Services (ADASS)/ Association of Directors of Children's Services (ADCS) group agreed that they could better co-ordinate their efforts on workforce development.

29. The group is working towards a number of objectives including Step Up to Social Work (SUSW) which is an 18 month employment based pathway to social work qualification and work with children and families for high quality graduates. The region was successful in two bids for funding from the Department for Education, with the programme expected to commence in January 2016.

30. It is difficult to recruit high quality managers into social worker management posts. The workforce development group is planning a management development programme for potential managers/existing social work managers.

Local Context

Child Sexual Exploitation (CSE)

31. The Durham Local Safeguarding Children Board (LSCB) has prioritised work on child sexual exploitation since 2011.

32. Durham Constabulary, working to the direction of the Local Safeguarding Children's Board (LSCB) Missing and Exploited sub group carried out an analysis of Child Sexual Exploitation covering the period April 2013 to March 2014. Across the North East, only Durham and Darlington have attempted analysis of this nature.

33. The analysis found that CSE generally involves the exploitation of children and young people by lone perpetrators, mostly white males under 30 years of age.

34. There were 124 young people referred under child protection procedures having displayed common risk factors associated with sexual exploitation. The majority of these referrals were for children considered at risk of exploitation, rather than known to have been the victim of actual abuse. Each of these young people has been referred to the First Contact Service, where an initial risk assessment has been undertaken, using a CSE risk matrix, to ascertain whether the child was at low, medium or high risk.

35. For those assessed at low risk, the referral has been passed to the One Point service for early help. Medium and high risk cases were allocated to the locality team manager of the Children's Services Assessment and Intervention teams to coordinate multi-agency support for each young person.

36. In the year April 2013 to March 2014, 21 young people received therapeutic support for CSE through a contract with Barnado's specialist CSE service, as a result of their being assessed as high risk or due to their known status as victims of CSE.

37. Taking a snapshot at the end of February 2015, there were 66 young people assessed as being at medium or high risk of CSE and of these, 19 were known to be victims. Of these, 13 young people are currently accessing Barnados therapeutic support for CSE.

38. The majority of referrals related to females (88%) and the most common age for a referral was 13 years.

39. The most significant threat to young people originates from the use of social media (25% of referrals) particularly involving the growth of various sites and apps which facilitate communication and the sharing of images.

40. Alcohol consumption by young people continues to be a common theme.

41. The LSCB has agreed a new Child Sexual Exploitation Strategy for 2014-2017 together with an Action Plan which outlines the key actions to be progressed to achieve the strategic aims within the Strategy of:

    - Prevent – making it more difficult to exploit children.
    - Protect – identifying and safeguarding children who are at risk.
    - Pursue – the offenders, disrupt and where possible prosecute their activity.

42. The Action Plan provides clarity in relation to strengthening leadership and improving the governance of the work to tackle CSE. It will ensure that training of professionals will be effective, co-ordinated and targeted and single and multi-agency processes and procedures are effective.

43. A multi-agency marketing strategy, called ERASE, has been developed to ensure that consistent and accurate messages are communicated to key stakeholders and there will be coordinated protection, support and guidance for CSE victims, and their families, as well as those at risk of CSE.

44. Progress of the strategy is monitored through the Action Plan, underpinned by a performance management framework. The Action Plan is used to provide periodic updates on progress to both the LSCB Missing and Exploited sub-group and the Local Safeguarding Children Board.

45. Following the Casey report, Durham County Council has agreed to conduct a corporate review, to provide assurance on the activity and governance in place in the Council. This will be chaired by the Assistant Chief Executive.

Children's Social Care Innovation Programme

46. Durham was successful in two bids to the Children's Social Care Innovation Fund. The first was for £496,000 for a therapeutic support programme at Aycliffe secure centre for children that have been sexually exploited. This will offer targeted support in helping young people deal with trauma and in making the transition from the secure setting into more independent living.

47. The second successful bid was for £3.26 million to deliver on a large scale a new approach to social work and to work with families, building on the learning from past initiatives in Durham and elsewhere.

48. The current social care model can result in too many cases being worked at statutory levels and insufficient activity at lower levels, particularly where multi-agency family support is required.

49. Social work remains largely reactive and episodic, due to the volume of work and social workers do not always have the capacity to offer the intensive family support that is needed over a longer period of time.

50. The intention is to identify and meet the needs of children sooner, address the root causes of the problems and so reduce the numbers of families who are re-referred for support.

51. Durham will implement an approach to working with families that has been demonstrated to be effective and which is valued by families themselves.

52. The programme is underpinned by a significant programme of workforce development designed to create a new culture by developing new skills and attitudes, through training, mentoring, clinical consultation and challenge.

53. The main innovative elements of Durham's programme are:

    - Creation of ten integrated early help and social work teams to create Innovation teams across the County, significantly increasing the range, access, quality and effectiveness of services for the whole family across the continuum of need.
    - Creation and development of third sector alliances in all areas of County Durham to build community capacity and sustainable change for families.
    - An intensive workforce development programme to support the new teams and the whole workforce.
    - Significantly enhanced service user engagement to change the relationship between professional and service user.

54. New team structures, roles and relationships will be implemented, building on the existing strengths of the workforce in County Durham. Extensive staff engagement will drive the change programme, as will the voice of service users.

55. Innovation Funding of £3.26 million will be used to enable rapid roll out of the programme, whilst minimising risk to existing statutory service delivery. Work to date has delivered a reduction in Looked After Children of 8% and a cost reduction of £2.5 million, against national and regional trends. This further investment is required in order to take the next step and to accelerate Durham's progress.

56. It is anticipated that the programme will deliver improved services and outcomes for the whole population of County Durham by the end of 2016 including a further 12% reduction in Looked After Children, a reduction in re-referrals to children's social care services and a reduction in child protection plans as a result of neglect.

57. Durham will realign the whole children's service workforce into five co-terminus areas of the county. Each area will have two Innovation Teams. This will include the current Assessment and Intervention social work service; the integrated One Point Service, which delivers universal and targeted services and the current Family Pathfinder Service, which delivers intensive whole family support.

58. The ten newly created Innovations teams, led by social workers, will work from the One Point hubs to ensure a seamless and fully integrated service for children and families regardless of their level of need.

59. Underpinning these arrangements is an aligned model of universal services, such as schools, community health services and voluntary and community sector organisations. It is their role to ensure that need is identified at the earliest point, so that early help can be provided. These services are already engaged through five early Help Forums.

60. Three child protection teams will continue working with children subject to child protection plans and children in care proceedings and a Looked After Children's Service will work with children with permanence plans.

61. The Innovation teams will support families who have complex needs and require intensive family support, but who do not need a child protection plan or to be Looked After.

62. In addition to the £2.5million already saved, as a result of reducing the number of Looked After Children by 8%, this model has the potential to reduce spending on Looked After Children (LAC) by a further 12% (£3.5million) in Durham, resulting in a total saving of £6 million. The approach has potential to establish a national precedent in good practice and were this to be replicated nationwide, a saving to the public purse of £688million could be delivered (based on March 2014 LAC rates).

63. Workforce support and development has been a key strength of our work to date and this will continue. The Stronger Families workforce development programme won the Children and Young People Now Staff Development award in 2014.

64. Building on this award winning approach, a workforce development programme has been developed to support implementation of this programme, and a mentoring programme is already in place.

Stronger Families

65. Durham is meeting its full target of 'turning around' 1,320 families by March 2015.

66. In August 2014, due to the successful implementation and delivery of Phase 1, Durham was invited to be one of the Early Starters for Phase 2 of the Troubled Families Programme. This new phase includes much broader criteria with locally derived outcome measures. Families must hit two of the six eligibility criteria below to be included on the programme:

- Parents and children involved in crime or antisocial behaviour.
- Children who have not been attending school regularly.
- Children who need help.
- Adults who are out of work or are at risk of financial exclusion and young people at risk of worklessness.
- Families affected by domestic violence and abuse.
- Parents and children with a range of health problems.

67. This broader set of criteria will enable the majority of families worked with by social care services to be part of the programme and to achieve results payments.

68. There is a very clear need to shift our focus to ensuring families are worked with in such a way that supports significant and sustained change. Phase 2 will be delivered over a 5 year time period and Durham will work with 4,330 families to within this period.

69. As part of being an early starter Durham was asked to deliver work to an additional 650 families by March 2015. Durham was also invited to be take part in the design and development of Phase 2 ready for national implementation in April 2015.

Next Steps

70. The delivery of the Child Sexual Exploitation Strategy 2014-17 and Action Plan will continue with regular updates provided to the Local Safeguarding Children Board.

71. The first stage of the Children's Social Care Innovation Programme will start in one area of the county in June 2015. The second stage will follow in February 2016 with the final third stage starting in June 2016. All phases will be concluded by November 2016.

72. Durham will work with an additional 4,330 families as part of Phase 2 of the Stronger Families Programme.

Recommendations

73. The Health and Wellbeing Board is recommended to:

- Note the contents of this report.
- Agree to receive further updates in relation to the transformation of Children's Services on a six monthly basis.

Contact: Carole Payne, Head of Children Services, Durham County Council
Tel: 03000 268657

Appendix 1: Implications

Finance
Substantial efficiencies have already been delivered through this approach as part of the Medium Term Financial Plan. Further efficiencies are planned. The successful bid to the Children's Innovation Fund will result in funding of £3.26m coming in to the authority to be used to develop new approaches to children's social care. As part of the Children's Innovation Fund an additional £496,000 bid was successful for a therapeutic support programme at Aycliffe secure centre for children that have been sexually exploited.

Staffing
Workforce development will benefit staff and will help to challenge thinking and introduce new ways of working into practice. Roles and responsibilities are being amended in line with revised requirements. Embedding culture change is dependent on staff working effectively and understanding service aims, supported by managers.

Risk
Changes need to be carefully managed to ensure the protection of children remains robust and the system is not de-stabilised during transition.
Risk to the safety of children and young people of failure to prevent CSE.
Major reputational risk to the Council of failure to prevent and address CSE.

Equality and Diversity / Public Sector Equality Duty
The needs of vulnerable children and families will be better met through implementation of these changes

Accommodation
The innovation programme will require relocation and co-location of staff teams across the county, which will be managed within existing resources.

Crime and Disorder
Effective partnership working through the Safe Durham Partnership.

Human Rights
None

Consultation
Any changes to workforce will be subject to consultation with affected staff.

Procurement
None at this stage

Disability Issues
None at this stage

Legal Implications
There are a number of key policy developments/initiatives that have led the way and contributed to the Children's Services Transformation agenda in County Durham. All changes must be compliant with legal requirements

Health and Wellbeing Board

14 May 2015

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

Report of Phil Emberson, Integration Programme Manager – Joint Funded, Children and Adults Services, Durham County Council and Clinical Commissioning Groups

Purpose of Report

1. The purpose of this report is to update the Health and Wellbeing Board on the requirements and recommendations set out in the Better Care Fund (BCF) Operationalisation Guidance released on the 20th March 2015.

Background

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

3. The BCF plan for County Durham was submitted in line with the national requirements and fully signed off in December 2014. The BCF plan is supported locally by a financial Risk Sharing Agreement developed by the partner agencies and was agreed at the Health and Wellbeing Board in January 2015.

4. The five priorities for transformation underpinned by the BCF plan are

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

5. The seven work programmes and levels of investment within the BCF plan are as follows:

   - **IC+ Short term intervention services** which includes intermediate care Community services, reablement, falls and occupational therapy Services (£13,428,000).
   - **Equipment and adaptations for independence** which includes Telecare, Disability adaptations and the Home Equipment Loans Service (£8,562,000).

- **Supporting independent living** which includes mental health prevention services, floating support, supported living and community alarms and wardens (£5,005,000).
- **Supporting Carers** which includes carers breaks, carer's emergency support and support for young carers (£1,361,000).
- **Social inclusion** which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services (£1,121,000).
- **Care home support** which includes care home and acute and dementia liaison services (1,774,000).
- **Transforming care** which includes maintaining the current level of eligibility criteria, the development of IT systems to support joint working and Implementing the Care Act (12,484,000).

6. Reports relating to the Better Care Fund have previously been received at Health and Wellbeing Board meetings on 21st January 2014, 5th March 2014, 23rd September 2014, 5th November 2014 and 28th January 2015.

7. On the 20th March 2015 NHS England released the final guidance for the operationalisation of the BCF. The guidance sets out the reporting and monitoring requirements of the fund, how progress against conditions of the fund will be managed, the future role of the BCF Support Team and advice about the alignment of the BCF targets for reducing non-elective admissions with the planning assumptions included in final Clinical Commissioning Group (CCG) operational plans.

Legal Powers of the Care Act

8. The guidance sets out the powers from the Care Act (2014) that underpin the arrangements within which the BCF allocation can be released to CCG's and the conditions which will need to be satisfied. A number of conditions have to be met to facilitate the release of funding from NHS England to the CCGs including that a Section 75 agreement is in place and that clear, agreed and approved plans are in place to reduce non elective admissions.

9. At a local level, as legal recipients of the funding, the CCGs and the local authority are the accountable bodies for their respective elements of the BCF allocated to them. This means that they retain responsibility for ensuring the appropriate use of the funds, spending decisions and monitoring the expenditure of the fund in accordance with the plan. At present these tasks cannot be delegated to Health and Wellbeing Boards, however, new regulations are being consulted upon which may broaden the role of the Health and Wellbeing Boards to include the functions set out.

10. In terms of the operational oversight of the BCF the regulations governing the Section 75 Agreement require it to set out:

    - The arrangements for monitoring the delivery of the services that it covers.

- Who the host organisation is that will be responsible accounting and audit.

- Who the ‘pool manager’ is that will be responsible for submitting to the partners quarterly reports, and an annual return about income and expenditure from the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements.

11. The guidance advises that the governance of the Section 75 should be through the Partnership Board made up of those authorised to act upon the behalf of their employing organisation. In County Durham the Governance of the Section 75 agreement will be managed by the Officer Health and Wellbeing Group and the Integration Board which is the new name for the Better Care Fund Chief Officer Group and is now part of the Health and Wellbeing Board governance arrangements to monitor the Better Care Fund and other integration elements.

12. At the time of writing this report, a draft Section 75 agreement is being considered by the partners which should cover all of the requirements set out in the guidance. In the meantime both CCG’s have made arrangements with their executive to allow the funding arrangements to proceed in anticipation of the Section 75 being agreed.

13. The Section 75 agreement identifies that the local authority will be the pooled fund holder and a nominated pooled fund manager has been identified who will ensure that the required information is available for monitoring the plan.

Reporting and Monitoring 2015/16

14. The BCF will be embedded into business as usual processes in NHS England for planning and performance management as far as possible and on the most part this will be at CCG level.

15. The conditions as set in the assurance outcome letters will stand relating to the use of the fund and those conditions are broadly that:

    - The fund is to be used in accordance with the final approved plan and through a Section 75 pooled fund agreement. The full values of the element of the fund linked to non-elective admissions reduction targets will be paid over to CCG’s at the start of the financial year, however, the CCG’s can only release this part of the funding in line with achieving the non-elective admissions performance targets.

16. The guidance requires that the area submits reports using the BCF quarterly and annual reporting templates provided with the guidance at five points in the year. The guidance suggests that the Health and Wellbeing Board signs off the performance report before it is submitted.

17. The date for the submission of these reports are:

    - 29th May 2015 for period January to March 2015.
    - 28th August 2015 for periods April to June 2015.
    - 27th November 2015 for periods July to September.
    - 26th February 2016 for periods October to December 2015.
    - 27th May 2016 for periods January to March 2016. (TBC)

18. There is a timing difficulty in matching the running of the reports with the Health and Wellbeing Board in relation to 'signing off' the reports to be returned to the BCF Task Force, as the performance data will either not be complete or possibly not processed in time.

19. It is recommended that the Health and Wellbeing Board should consider delegating the authority to sign off the performance reports due to the timeframes involved in gathering, formulating and reporting the data.

20. The performance reports could be considered as soon as practical post submission to the BCF Support Team in the Health and Wellbeing Board.

Payment for Performance

21. The Guidance document raises the issue of the Health and Wellbeing Board wishing to review the BCF targets with planning assumptions included in final CCG operational plans. In some cases differences may have occurred when a broad range of planning factors are taken into account, including:

    - Actual performance in the year to date, particularly through the winter.
    - The actual outturn for 2014/15.
    - Progress with contract negotiations.

22. The guidance stresses that BCF targets should remain ambitious in terms of reducing admissions and they may be higher than the operational plans and a difference between the two does not mean the target should be lowered. However, if large differences are beginning to effect the credibility of BCF ambitions they may wish to amend the BCF targets to more closely align with the operational plan. If this is the case the guidance expects that:

    - *There will be no change to targets included in BCF plans where these are within 2 percentage points of assumptions in operational plans.*
    - *Where the target is greater than 2 percentage points than the operational plan the Health and Wellbeing Board may at its discretion amend the BCF target where it believes the change is required to ensure it remains credible and realistic.*
    - *Any changes will need to be agreed by the Health and Wellbeing Board and will be subject to approval by NHS England in consultation with Ministers.*

23. The BCF target for non –elective admissions for County Durham was set at 3.5% following negotiations with NHS England, however, narrative was added to the BCF Plan to stress that local data suggested that the target was ambitious and a more realistic operating range would be between 1% and 3.5%. Both CCG's have set their operational plans, investment strategies and contractual plans with a clear focus on the achievement of a 3.5% reduction in non-elective admissions. The target set for a 3.5% reduction is still very ambitious and recent data has demonstrated that there has been an increase in unscheduled admissions of 1.6 % in comparison to 2013/14. At this point any proposed reduction in the target would have significant impact on the CCGs plans and strategies and would also fall out with the 2 percentage points reduction in target parameters that can be re- negotiated.

24. The guidance states that the payment of performance element of the Fund will be linked to the performance of local areas in reducing non-elective admissions in line with the trajectory agreed in their BCF plan. This performance element should be paid by CCG's into the pooled fund in four quarterly instalments and payment will be proportionate to actual performance. The first payment should be made in May 2015 based upon the performance in the final quarter of 2014/15 and following the payments should be based upon the trajectory for improvement set out in the BCF plan.

25. The partners in County Durham have agreed the process for the payment of the funds into the pooled budget, including the performance element, as appropriate, and have a Risk Sharing Agreement in place to assist with any financial pressures that may arise.

Better Care Fund Support Team

26. A joint BCF Support team with representation across NHS England, the Local Government Association (LGA), the Department of Health (DH) and the Department for Communities and Local Government (DCLG) will continue into 2015/16 and working through NHS England and Local Government regions will focus on:

    - Supporting Local Areas with the implementation of their plans.
    - Monitoring progress with the delivery of plans through the reporting set out in this report.
    - Supporting the performance management and escalation processes for the BCF, including the enactment of Care Act Powers where relevant.
    - Reporting progress to the national BCF Programme Board and Cross Ministerial Board.

27. The BCF Support Team will be responsible for monitoring performance of the areas against plans and will check to ensure that the standard conditions of the fund are being met in line with the assurance letters.

28. Failure to meet the standard conditions may result in the BCF Support Team initiating an escalation process which will aim to get the plan back in line with the agreement, failure to do so may lead to further interventions.

Recommendations

29. The Health and Wellbeing Board is recommended to:

- Note the content of the report.
- Delegate 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 in consultation with the Chair of the Health and Wellbeing Board.

Contact: Phil Emberson, Integration Programme Manager – Joint Funded, Children and Adults Services, Durham County Council and Clinical Commissioning Groups
Tel: 03000 268245

Background Paper - Guidance for the Operationalisation of the BCF in 2015-16

Appendix 1: Implications

Finance
The BCF for County Durham is £43.735m for 2015/16 and the arrangements and requirements for the use of the fund are set out in the report and appendices.

Staffing
A number of posts are included within BCF projects.

Risk
Non-achievement of performance-related targets may lead to financial pressures on the BCF

Equality and Diversity / Public Sector Equality Duty
None

Accommodation
None

Crime and disorder
None

Human Rights

Consultation
None

Procurement
None

Equality Act
None

Legal Implications
The BCF Operationalisation Guidance is set out in this report and needs to be followed

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Health and Wellbeing Board

14 May 2015

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

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

Background

2. Durham Unit of Planning developed a five year strategic plan which was aligned to the Joint Health and Wellbeing Strategy (JHWS). The CCGs already contribute to the performance measures within the JHWS and this feeds into the process for planning and identifying any gaps.

3. The Durham Clinical Commissioning Groups (CCG's) were required to develop two year priorities based on this overall strategy in March 2014.

4. The national Five Year Forward View was published in October 2014; there is a requirement to refresh commissioning plans for 2015/16 in light of this most recent guidance.

National Planning Guidance

5. The final planning guidance was published in late December 2014. This included details relating to:

    - Any new 2015/16 requirements (mental health access is expected to be the only major new requirement).
    - Requirements for NHS Constitution standards.
    - The immediate implications of the Forward View.
    - Emerging system changes.
    - Revised financial planning assumptions, allocations and drawdown envelopes.
    - Revised activity planning assumptions.

- Strategic enablers, including workforce, estates and IT.

6. The minimal planning requirements are designed to enable CCGs and providers to focus on improving quality, meeting NHS constitution requirements and financial sustainability.

7. Commissioning intentions for 2015/16 are focussed on current priorities as set out within the two year operational plan. DDES CCG Final Commissioning Intentions 2015-2016 are attached at Appendix 2 and North Durham CCG Final Commissioning Intentions 2015-2016 are attached at Appendix 3.

8. Commissioning priorities will continue to be based on the strategic aims reflecting the JHWS to ensure that there is a close link between the planning refresh and the refresh of the JHWS.

Quality Premium Indicators

9. Both CCG's will need to refresh their outcome trajectories and select quality premium indicators in line with guidance published by NHS England. Durham County Council is represented on the planning group where these issues are discussed.

10. The Quality Premium Indicators (QPI's) are intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

11. The national guidance on the QPI's has recently been published and sets out the measures for 2015/16 and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards, NHS England and local NHS England teams, required to agree the local measures and levels of improvement in preparation for 2015/16.

12. Two national Quality Premium indicators are mandated to CCGs for inclusion and these correspond to supporting delivery of the NHS Constitution Standards. These national mandated indicators are as follows:

    - **Reducing potential years of lives lost through causes considered amenable to healthcare - 10% of total funding available.**
    - **Improving antibiotic prescribing in primary and secondary care - 10% of total funding available.**

13. There are several indicators that CCGs need to choose in conjunction with the Health and Wellbeing Board. These are from pick lists in the areas of Urgent and Emergency Care and Mental Health. In addition, local indicators also need to be selected, which align to the Joint Health and Wellbeing Strategy. Further detail in relation to the range of QPI's

available is included in Appendix 4, with the proposed indicators outlined below.

14. It is proposed that the CCG selects one indicator from the Urgent and Emergency Care list as below with the full value of 30% of the funding available attributed to this indicator:

    - **‘Reduction in delayed transfers from care.’**

    This indicator links to a number of key projects such as the Intermediate Care Plus pilot, vulnerable adult wrap around services (VAWAS) schemes and frail elderly. There has also been a real focus between commissioners, providers, the local authority and other partners to improve performance for this indicator.

15. It is proposed that the CCG selects the following indicators from the Mental Health list, with 12.5% of the funding available attributed to the first two of these indicators and 5% funding allocated to the final indicator:
    - **Reduction in the number of people with severe mental illness who are currently smokers.**
    - **Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.**
    - **Improvement in the health related quality of life for people with a long term mental health condition.**

    All of the indicators are challenging. Work has been carried out in 2014/15 with the local mental health provider to reduce smoking for service users. In addition to this the CCG has commissioned a number of pilot services such as the ‘recovery college’ which may help to achieve the necessary improvement around paid employment.

16. It is proposed that the CCG selects the following local indicators, with each indicator worth 10% of the funding available.

    - **% of patients on a palliative care register.**
    - **% 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. (Composite indicator)

System Changes

17. The overarching direction of travel for the local health economy is outlined within the Five Year Forward View. This describes new models of care which focus on integration between settings and across health and social care.

18. A number of system changes have already begun to take shape, this includes:

    - Primary care co-commissioning.
    - Specialised service co-commissioning.
    - The introduction of integrated personal commissioning. (IPC)

Primary care co-commissioning

19. New guidance has emerged detailing the next steps. There are to be three levels of responsibility for CCGs to decide upon:

    1) Greater involvement in primary care decision-making.
    2) Joint commissioning arrangements.
    3) Delegated commissioning arrangements.

20. Both Durham CCGs are now delivering delegated arrangements for primary care co-commissioning as of the 1st April 2015. This addition to CCG remit has been added to both sets of commissioning plans.

Specialised Service Co-commissioning

21. NHS England has established a task force for specialised commissioning to analyse the current commissioning arrangements; to address a number of challenges causing significant pressures across the system; and to identify options for future commissioning models.

22. Following the outcome of this any planning guidance will identify the specific services to be included under the CCG's commissioning remit.

23. There will be guidance on whether funding will be based on populations or place.

Integrated Personal Commissioning

24. In July 2014, NHS England announced plans to pool funding across local authorities, CCGs and specialised commissioning for certain population groups.

25. The aims of this approach, to be known as Integrated Personal Commissioning (IPC), will be to test new commissioning and funding models including joined-up capitated funding approaches, and to explore how individuals can have more control over how the funding is used through personalised care and support planning.

26. Durham CCG's and Durham County Council submitted a bid to be a pilot site for IPC implementation which was unsuccessful. All partners are working together to understand how this work can be taken forward.

Alignment of Plans

27. Better Care Fund plans were submitted in September 2014 which included a target reduction in emergency admissions. A refresh of CCG operational plans will require this ambition to be reflected in activity plans.

28. Work will also be needed to ensure consistency between commissioner and provider plans.

Durham Unit of Planning CCG Priorities

29. Durham Unit of Planning priorities are:

- Mental Health.
- Learning Disabilities.
- Urgent Care.
- Diabetes.
- Frail and Elderly.
- Primary Care Transformation.
- End of Life Care.

Recommendations

30. The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Note the final CCG commissioning intentions 2015/16 (Appendices 2 and 3).
- Agree the CCG Quality Premium Indicators (paragraphs 9-16 and Appendix 4).

Contact: Rachel Rooney, Strategy and Development Manager
North Durham Clinical Commissioning Group
Tel: 0191 605 3172

Appendix 1: Implications

Finance
All priorities will require clear financial plans on potential disinvestment and investment required. All plans have to support the achievement of financial balance.

Staffing
Individual commissioning priorities may have an impact on staffing. Individual impact assessments will be undertaken.

Risk
Individual commissioning priorities will be impact assessed in terms of the risks and mitigating against these.

Equality and Diversity / Public Sector Equality Duty
There is a commitment to ensure that equality and human rights are integral to the planning process.

Accommodation
No implications at this stage.

Crime and Disorder
No implications at this stage.

Human Rights
No implications at this stage.

Consultation
Both CCGs have utilised their own engagement models as part of this process.

Procurement
No implications at this stage.

Disability Issues
No implications at this stage.

Legal Implications
The CCGs must comply with statutory obligations as laid out in *'The Functions of a CCG'* (NHS England, 2013) that includes the duty to prepare, consult on and publish a commissioning plan. The approach and arrangements outlined in this report are intended to fulfil these duties.

APPENDIX 2

Durham Dales, Easington and Sedgefield CCG
Commissioning Intentions List
2015/16

Priority Area	What	Why	Rationale
Cancer	Improvements required in cancer 52 day performance, improved diagnosis rates and mortality	National must do and links to a number of key targets	National must do and links to a number of key targets
Primary care Macmillan nurses	Recruitment of 3 Primary care nurses to work funded by Macmillan for 3 years	Funding required for costs of employment	Pre-commitment
Tier 3 Weight Management - children	Enhancement to DCC commissioned tier 2 service to provide tier 3 equivalent with psychology input	To be compliant with NICE guidelines following DCC de-commissioning of paediatric obesity service	NICE requirement
Intermediate Care	Continuation of the Intermediate Care Plus service pilot	Need to reduce emergency admissions to hospital or facilitate early discharge where appropriate	Legacy commitment
Frail elderly	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	Pilots should become self-funding through non elective activity	Existing project
Personal health budgets	Ensure that those who are eligible for PHB are supported to use them, giving control over decisions	Improve the health and take ownership of their own health provision	National must do to implement personal health budgets, but the amount of investment required for this is uncertain
Better Care Fund	Funding for the Better Care Fund	National requirement	National must do

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Priority Area	What	Why	Rationale
HELS re-procurement	Re-procurement of the HELS service	Procurement is underway	Existing project
Wheelchair service re-procurement	Re-procurement wheelchairs service	Different models of service are in place across DDES. There are unacceptably long waits in some services.	Existing project
OPAT	Alternative pathway for community IV therapy for cellulitis grade 2	Avoiding unnecessary admissions and provide care closer to home	Existing project
Learning Disabilities inc Winterbourne	Need to ensure the requirements of the Winterbourne Review are fully implemented	Gaps in current pathway identified. Different models of care need to be implemented.	National must do
Recovery college	Assists patients to return to a full and fulfilled life following an episode of mental illness.	To aid recovery following an episode of mental illness	Need to await outcome of the review to identify if service should be continued
CAMHS crisis (self-harm) service	A pilot service was developed by TEWV to support children who self-harm	DDES have very high levels of childhood self-harm.	Need to await outcome of the review to identify if service should be continued
Mental health intensive support service	Pilot specialist intensive support service. for individuals who have been identified as needing a level of support above that which can be offered by community mental health teams and more long term than the intensive home treatment offered by crisis teams.	Agreed pilot continues into 2015/16. A decision on further continuation would be taken based on the evaluation of the service	Need to await outcome of the review to identify if service should be continued

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Priority Area	What	Why	Rationale
Crisis care concordat	Need to ensure that any improvements required following development of the concordat and action plan are understood and implemented	Need to be compliant with national standards	National must do
Place of safety for adults and children (S136)	We need to ensure that we have commissioned a place of safety for patients in mental distress under S136 of the mental health	Need to be compliant with national standards	National must do
Implementation of national mental health strategy via County Durham Mental Health implementation plan	Implementation of the County Durham mental health implementation plan	Improve access to MH services and achievement of national Mental health targets and reduce reliance on hospital treatment	National must do
Tier 3 Weight Management - adults	Procurement of a Tier 3 Weight Management service	To be compliant with NICE guidelines	NICE requirement
Diabetes - interim service	Development of pilot community diabetes services across three DDES Federations	Ensuring no gaps in services for patients, and provide close to home, sustainable service	Existing project – pre commitment
Diabetes - longer term service re-design	Re-design of diabetes service to develop an outcome based model delivered out of hospital	Ensuring no gaps in services for patients, and provide close to home, sustainable service	Existing project
COPD/Respiratory	DDES are piloting a COPD nurse co-ordinator	To improve standards of care for COPD	Existing project
Demand management	Fund a team of staff to focus on demand management	To manage pressures on acute budgets	Existing project

APPENDIX 2

Priority Area	What	Why	Rationale
Ophthalmology - managing demand and improving quality	MECATS and IOP pilots	Pilot services to provide care in the community and reduce demand on secondary care services	Existing project
AQP – re-procured	Re-procurement of AQP services where contracts are due to expire(Podiatry - June 15, Adult hearing - June 15, INR - January 15)	Must do as contracts due to end	Contracts expired - must do
Tele -dermatology	Service that enables remote access to a clinician opinion using digital images	To reduce referrals to secondary care outpatient services	Existing project
Paediatric SALT/OT – TUPE risk	Provision of funding to mitigate TUPE risk following re-procurement of services	To ensure there were no barriers to new providers entering the market	Completion of staff transition following procurement process
Prescribing - waste management programme	Continuing to focus on medicines waste	Opportunities for QIPP	Existing project
Workforce (focus on primary care)	Ensure that there is a sustainable primary care workforce for DDES.	Large number of GPs coming up to retirement age and difficulties recruiting to DDES practices	Links to Primary Care strategy
Primary Care - 7 day working	Extension of the DDES weekend opening scheme	Need to consider extension of the current scheme depending on whether we are successful through PMCF	Impact on urgent care and A&E demand
LES	Locally agreed primary care provision over and above core contract responsibilities	Avoiding unnecessary admissions and provide care closer to home	Pre-commitment

APPENDIX 2

Priority Area	What	Why	Rationale
LIS	Primary Care Local Incentive Scheme	Support integration provide services in primary care and QIPP	Pre-commitment
Primary Care Co-Commissioning	Commissioning of primary care services	To improve commissioning of integrated pathways across healthcare services. To improve quality of primary care. To ensure primary are services are sustainable	
Urgent care review	Review of urgent care services across DDES	National Urgent Care Review expected to mandate standard service levels for urgent care. Demand for services is growing. There is inequity of services across DDES.	Existing project
GP out of hours procurement	Out of hours GP Services must be reproduced under an APMS Contact (currently wrapped up in Urgent Care Standard NHS Contract)	Contract has expired	Contract has expired
Readmissions	Need to establish new process in relation to monitoring & reinvestment of 30 day readmissions monies under PBR Contract	To ensure that the money is re channelled back to support patient care	Contractual requirement
Ambulance performance issues including Teesdale/Weardale	Clinical senate are carrying out an audit of cases and the need for two paramedics on ambulances in Teesdale and Weardale	Improve ambulance response times and reduction in delayed transfers of care	Performance improvement is a national must do

APPENDIX 2

Priority Area	What	Why	Rationale
Intrahealth unregistered list	Funding for the walk in service for unregistered patients at Healthworks	Continuation of existing service	Continuation of existing service
System Resilience	Review of 14/15 pilots to identify if any should be continued	Some may have demonstrated effectiveness	To reduce pressures on urgent and emergency care system
Securing Quality in Health Care Services (SeQIHS)	Review of clinical standards at NHS acute hospitals across Durham and Darlington	To ensure that services area sustainable	Regionally agreed project
Pulmonary Rehab	Commissioning of pulmonary rehabilitation service	To improve patient outcomes and ensure equity of provision across DDES. To be moved into contracts as a recurrent service line.	Evidence based programme. To provide equity of provision across DDES
Prescribing Incentive Scheme	A local primary care initiative	Ensure prescribing of the most beneficial and cost effective medicines and help patients stay well	Reduce precribing costs
7 day working - acute	County Durham and Darlington are a national pilot site for seven day working	Possible funding requirements, but amount not known at this point	National must do
Macmillan- Peterlee Talking Cancer Service	Need to support the review of current Macmillan services	No funding required for 15/16, but may be a call for 16/17. Need to participate in review of service	Need to be involved in review and development of potential future service options

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Priority Area	What	Why	Rationale
Children's self-harm acute pathway	Pathway review for paediatric admissions for self- harm	County Durham has one of the highest rates of admission for children who self-harm. It was part of the CDDFT SDIP to review the pathway, but this was not carried out in 14/15 so it is proposed this rolls over into 15/16	Meets organisational priorities
Paediatric continence Review	Review of pathway for paediatric continence services	Review required in light of new NICE guidance and changes to Local Authority commissioning.	New national guidance has been published.
Lymphedema	Further develop and invest in lymphedema services.	To address current service delivery pressures and secure delivery access	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Palliative and EoL - consultant staffing	To employ palliative care consultants	To support 24/7 access to advise and 7 face to face assessments	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Palliative and EoL Single point of access	Re procure rapid response service	To support 24/7 crisis patient care and family support	Work is ongoing to review existing spend and outcomes. Paper coming to a future exec on this.
Delayed Transfers of Care	Review of systems and processes to reduce delayed transfer of care	Reduce unnecessary delays for patients	National must do
District nursing re-design	A review of the current service and explore opportunities to re-design services	Long standing service need to understand the service provision and potential gaps	Links to development of multispecialty community providers

APPENDIX 2

Priority Area	What	Why	Rationale
Specialist nursing re-design	A review of the current service and explore opportunities	Long standing service need to understand the service provision and potential gaps	Links to development of multispecialty community providers
Maternal mental Health	Review of maternal mental health pathway in light of new guidance	New NICE guidance has been published. It may be that funding is required at some point, but until the review is concluded this is not known.	Need to review pathway in light of new guidance
Review of EIP (Early Intervention Psychosis) service	To review the EIP service to ensure that new national targets can be met	Need to meet the EIP targets	Need to ensure we meet new EIP targets
IAPT services	Review and potential re-procurement of IAPT services	Contract for services expired and re-procurement is required	Contract has expired and we need to take a decision on procurement options.
Counselling services	Review of counselling services	Waiting times are below the new national target (6 weeks). Data reporting requirements need to be embedded in contracts	Need to meet national targets for IAPT and waiting times
Dementia prevalence and implementing the dementia strategy	Improve diagnostics and review patient pathways	Improve diagnostics of people in early stages, improve dementia treatment patient experience and health outcomes	National must do

APPENDIX 2

Priority Area	What	Why	Rationale
CAMHS Review	Review if Child and Adolescent Mental Health Services (CAMHS)	There is currently a review of CCG commissioned services underway and due for completion 31.3.15. Changes to the service may be made as a result of the review (the TEWV SDIP for 15/16 will note this and prepare the trust to receive feedback and propose changes in year)	Existing project
Crisis review - Adults	Consider the recent review of the crisis service and consider gaps in current services	Crisis Telephone Triage Service which was a recommendation of the Crisis Review. Joint funding with ND	Need to do further work to identify if any additional funding or enhancement to services is required.
Primary care CPN	Implementation of primary care based Mental Health Nurses	To better integrate primary and secondary care mental health services and reduce demand on secondary mental health services	Propose we look at this as part of the wider primary care mental health re-design model
Primary care Suicide Model	Review and potential expansion of the current pilot in Sedgefield	Reduce suicides in DDES following a recent cluster	Need to link his with the primary care CPN proposal to identify if we need to invest in both
Outpatient Review	A review of outpatient services to support primary and secondary care working together	To improve integration, transfer care closer to home and improve outcomes for patients	Existing project
Choose and Book	Implementation of E-referral system delayed until April 15 at the earliest.	Respond to changes in national guidance	National must do

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Priority Area	What	Why	Rationale
Clinical Systems Improvement (CSI)	Continued development of referral guidelines for GPs	To supportive effective clinical decision making	Existing project
Prostate pathway	Out of hospital cancer follow up in Primary care	Fully implement prostrate shared care arrangements	This has been an on-going project which requires completion
111 DOS and 111 Review and capacity	Improve range of dispositions available. Reduce referral to A&E & Urgent Care	To reduce referral to A&E and Urgent Care and work more closely with primary care	Part of the urgent care strategy action plan
GP support to paramedics	Rapid access to a GP for advice for paramedics	Reduce unnecessary conveyances to A&E	Existing project
DUCT and other transport	Service provided since February 2009. Originally 3 year contract with added 2 year extension until March 2014. Agreed to extend for further 12 months however contract needs to be formalised to prevent using non-recurrent funds year on year.	Potential efficiencies to be achieved by contract review. Needs to link into out of hours re-procurement	Existing project
Haematology - 2B services	Review of level 2 haematology services and re-design following closure of services at North Tees hospital	A medium-long term solution needs to be developed following the closure of services at North Tees	Commitment to providers develop a long term solution
Child exploitation	Funding to support multi agency work to tackle child sex exploitation	To omplement local action plns to tackle child sex exploitation	Multi agency commitment
Adult's safeguarding	Contribution to costs of adult safeguarding board	CCGs will be formally part of the membership of the Board in future	Multi agency commitment

APPENDIX 2

Priority Area	What	Why	Rationale
Lead Provider Framework	Procurement of commissioning support services - financial support for projet management	National requirement to do so before April 2016	National must do
Clinician involvement in projects	Funding for clinical input into commissioning projects e.g. CSI	Clinical input into commissioning development is crucial	To support effective commissioning processes
Enhanced activity management	Fundig for additional support for activity management processes	Secondary care activity continues to grow whereas GP referrals are decreasing	To mitigate financial over performance
Palliative and EoL Hardwycke Ward	Re-development of Hardwycke Ward	DDES has no palliative care beds within it's boundaries	EoL is a priority area. The project is ongoing
Community stroke	Review of post discharge stroke services	Commitment given following re-design of stroke services in County Durham	Commitment made to review services following redesign of stroke services in County Durham
Boilers on prescription	Pilot scheme where boilers are prescribed for patients with diseases that are exacerbated by living on cold damp conditions	To reduce demand for healthcare services	Pilot is ongoing and evaluation will be presented once it is complete
Radiology/Diagnostics	Procurement of additional diagnostics capacity.	Not consistent access to diagnostics across DDES. Waiting times have been long in some areas.	Existing project
Physiotherapy review	Review of community physiotherapy	Potential efficiencies to be achieved.	Range in provision and cost. Potential to provide in the community at a reduced cost.
Back pain pathway	Nice Guidance - implementation and roll out of lower back pain and radicular pain pathway	Northern Forum agreed this project	Agreed by Northern Forum

APPENDIX 2

Priority Area	What	Why	Rationale
Trauma Rehabilitation	Gaps in rehabilitation following major trauma	Gaps in current pathway identified. Business case has been produced by NuTH	It was previously agreed that trauma rehabilitation services would be reviewed following establishment of Major Trauma Centres
Ambulatory care pathways	Review potential to expand ambulatory care County Durham and Darlington NHS Foundation Trust have implemented RAT & Ambulatory Pathways in ED at DMH & UHND from April 2014	To enable ambulance crews to arrange direct admissions	Existing project, links to urgent care review, potential QIPP
	Funding for 3 Locality Health Networks		Continuation of existing service
Learning Disabilities inc Winterbourne	Eye care in the community. Specifically for patients with learning disabilities from the age of 14.	Pilot scheduled for review in August 2015. Decision then required about the future of the service.	

APPENDIX 3

North Durham CCG Commissioning Intentions List 2015/16

PRIORITY AREAS		AIMS TO BE ACHIEVED BY MARCH 2016
1. UNPLANNED / EMERGENCY CARE		**CLINICAL LEAD - Dr JAN PANKE**
1a	Resilience Planning - Winter Pressures	Resilience plans agreed through the County Durham and Darlington System Resilience Group
2	QE Gateshead	Agree divert policy and commission additional bed capacity within GHFT Urgent and Emergency Care Centre
3a	Urgent Care model	Continue to support the minor injuries service (in Hours) at Shotley Bridge
3b		Renegotiate urgent care tariff (in hours activity)
3c		Update of the 111 Directory of Services
3d		Re-procurement of out of hours service
3e		Complete review of Durham urgent Care Transport (DUCT). Agree and implement in year changes to contract
3f		Further roll out 111 remote booking of practice appointments
3h		Review unplanned discharge transport service through decommissioning policy

2. FRAIL ELDERLY		**CLINICAL LEAD - Dr Neil O'Brien**
1a	Frail Elderly – Primary care	Design and implementation of the primary care services pathway to focus on care planning for high risk/vulnerable patients
1b	Frail Elderly – Secondary care	Redesign/integration of the secondary care services pathway to provide a front of house rapid assessment service
1c	Frail Elderly – Nursing homes	Design and implementation of one GP – one community matron – one care home, community matrons aligned to GP practices
2	Intermediate Care +	Implementation of phase 1-3 (double running services, de-commissioning previous services, bringing online new service).
3	Home Equipment Loans Service	Procurement and implementation of service
4	Wheelchair Services	Procurement and implementation of service to reduce waiting times and quality of service
5	Post Diagnosis Support	Improve Dementia Services to provide support to patients diagnosed with dementia

3. END OF LIFE CARE		CLINICAL LEAD - Dr PHILIP LE DUNE
1a	Keeping People at home (Palliative Care Consultant and Middle Grade Doctors)	Recruit to additional wte palliative care consultant and current vacant post; Recruit additional middle grades doctors to support palliative care services
1b	Specialist Lymphedema service	To have service in place for North Durham
2	Palliative/End of Life Strategy	Continued Implementation of the Palliative / End of Life Care Strategy
3	Palliative Care in Primary Care	To confirm whether Local Quality Premium for palliative care registers can be continued into 2015/16 to support continued momentum and service improvement.
4	Rapid response teams CDD (palliative care)	Full service review to commence February 2015 to provide CCG with overall picture of what the service would look like this will then form the basis for procurement

4. PRIMARY CARE		CLINICAL LEAD - Dr NEIL O'BRIEN (Dr David Graham)
1a	Primary Care Co Commissioning	GP Weekend Opening (Summer 2014 and winter Federated practice Model) – Review and consider continuation of scheme and focus of the scheme
1b		Enhanced Services (Phase 1 and 2 reviews) - Decommission Insulin Initiation, Continue Near Patient Testing, Reduce Minor Injuries spec
1c		Enhanced Services - Shared Care: Prostate Cancer Follow up - Review current numbers on Shared Care Prostate Cancer Follow up Scheme
1d	Primary care outcomes scheme	Review and agree plans for year 2 Evaluate the impact of the Scheme
2	Clinical Support Information	Expecting any clinical areas outstanding from 14/15 to be completed, plus 6 new areas, plus 3 month reviews of existing guidelines
3	Primary Care Strategy Implementation	Develop and implement Primary Care Strategy

5. MENTAL HEALTH		CLINICAL LEAD - Dr RICHARD LILLY
1	Continence (MH Patients)	
2a	No Health without Mental Health - Implementation of the National Strategy priorities for 2015/16	Re-commission IAPT services
2b		Counselling Service Improvements - new spec
2c		Mental Health Navigator Model
2d		Improved ambulance response times for Mental Health Patients
2e		Parity of Esteem - develop and implement CQUIN re physical health checks for people with Mental Health issues
2g		Care Crisis Concordat - Implement national and local requirements defined by the Crisis Care Concordat
2h		Place of Safety (Adults and Children) – NFR in place to provide crisis resource in terms of places of safety – need to evaluate – further funding likely to be required.
2i		service review of respite and recovery services
3a	Continuous improvement of Mental Health Services	Review of EIP services and requirement for additional resource following end of resilience funding
3b		Psychoanalytical Therapy service review
4	Child & Adolescent Mental Health Services (CAMHS)	Review of service and production of new interim strategy and final strategy

6. LEARNING DISABILITY		CLINICAL LEAD - Dr CHANDRA ANAND
1a	Transforming Care	Enhancement of Community Based Adult Learning Disability Service (TEWV 2 yr pilot)
1b		Increase Provision of Integrated Community Based Housing Support for Complex Cases
1c		Commissioning plan developed to support recommendations from Care and Treatment Reviews.
1d		Commissioning plan developed to support discharges from offender health (early mapping)
2	Improve Health Services for People with Learning Disabilities	Additional Support to Primary Care to improve uptake of AHC/HAPs - including awareness training around reasonable adjustments

7. DIABETES		CLINICAL LEAD - Dr PATRICK OJECHI
1a	Develop a Community Based Model of Care for Diabetes	Design and implement community based model of care for diabetes
1b		Continue to develop and roll out education programme for primary care
1c		Improve uptake and delivery of structured education for high risk and newly diagnosed diabetics
1d		Improve care planning and self-management
2a	Review of Podiatry Specification (all elements)	Review of Podiatry Specification
2b		Decommission / extension of AQP Podiatry contracts

8. 'OTHER PROJECTS'		
1	Increase roll out of personal health budgets	Commission additional CHC capacity to maintain delivery of personal budgets throughout 15/16
1b		Develop a service model to provide ongoing support the delivery of personal health budgets - including expansion to childrens / SEND
2a	Demand Management	O/P Review Programme - Reducing outpatient appointments to gain efficiencies and productivity
2b		Demand and Activity Management
2c		Black Box Medical pilot
3a	Cardiology Diagnostics	Re-evaluation of ECG interpretation service
3b		Develop clear pathways for cardio diagnostics - including ECG interpretation, Echo and Holter monitoring
4	Obesity - Community Tier 3 Weight Management Service (Adults)	Continue current interim service. Implement revised service following agreement of regional specification for tier 3 and 4 services.
5	Breast service review	Recommendation following provider review to reduce breast services from 4 to 2 sites. Continue to work with provider to minimise impact on patients and maximise quality and outcomes.
6a	Childrens services	CAMHS Review
6b		SEND Reforms
6c		Post diagnostic support - autistic children

APPENDIX 4

DRAFT QUALITY PREMIUM 2015/16

1.0 Background

The Quality Premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. The value is equivalent to £5 per head of a CCG's population. This is approximately £1.2m for North Durham CCG and £1.4m for Durham Dales, Easington and Sedgefield (DDES) CCG.

Each CCG is required to publish an explanation of how it has spent a quality premium payment.

The CCG achieves funding for achievement of improved performance for key areas. There is a corresponding deduction for non-achievement of the following four constitutional standards:

- maximum 18-week waits from referral to treatment,
- maximum four-hour waits in A&E departments,
- maximum 14-day wait from a urgent GP referral for suspected cancer, and
- maximum 8-minute responses for Category A red 1 ambulance calls (overall provider performance)

This effectively means there is a 25% deduction of quality premium funding for each constitutional target failed.

The quality premium guidance is updated annually. This guidance sets out the measures for 2015/16 and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It includes the actions to be taken by CCGs with Health and Wellbeing Boards and NHS England local NHS England teams to agree measures to be selected from menus, local measures and levels of improvement in preparation for 2015/16.

CCGs are able to set their own quality premium indicators although work has been done to align the selection across DDES CCG and North Durham CCG (ND CCG) as both CCGs form the County Durham Unit of Planning.

2.0 2015/16 Guidance

2.1 Nationally mandated indicators

There are two nationally mandated indicators which are:
Reducing potential years of lives lost through causes considered amenable to healthcare - 10% of total funding available
The target improvement is (TO BE ADDED)
Improving antibiotic prescribing in primary and secondary care - 10% of total funding available
The target improvement is (TO BE ADDED)

2.2 Urgent and emergency care pick list

This indicator(s) is worth 30% of the total funding available.

There is a menu of measures for CCGs to choose from which must be agreed by the Health and Wellbeing Board. The CCG can select one, several, or all measures from the menu (below) and also the proportions of the 30 per cent that is attributed to each measure.

1. Reduction in emergency admissions (composite measure)
2. Reduction in delayed transfers from care
3. Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.

It is proposed that the CCG selects one indicator as below with the full value attributed to this indicator:

'Reduction in delayed transfers from care'

This indicator links to a number of key projects such as the intermediate care plus pilot, vulnerable adult wrap around services (VAWAS) schemes and frail elderly. There has also been a real focus between commissioners, providers, the local authority and other partners to improve performance for this indicator.

2.3 Mental health pick list

This indicator(s) is worth 30% of the total funding available

There is a menu of measures for CCGs to choose from which must be agreed by the Health and Wellbeing Board. The CCG can select one, several, or all measures from the menu (below) and also the proportions of the 30 per cent that is attributed to each measure.

1. Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.
2. Reduction in the number of people with severe mental illness who are currently smokers
3. Increase in the proportion of adults in contact with secondary mental health services who are in paid employment.
4. Improvement in the health related quality of life for people with a long term mental health condition

It is proposed that the CCG selects indicators 2, 3 and 4 with 12.5% weighting for 2 and 3 and 5% for indicators 4.

All of the indicators are challenging. Work has been done in 14/15 with the local mental health provider to reduce smoking for service users. In addition

to this the CCG has commissioned a number of pilot services such as the 'recovery college' which may help to achieve the necessary improvement around paid employment.

The target improvement is (TO BE ADDED)

2.4 Local indicators

The CCG is required to select two local measures that are worth 20% of the quality premium (10% each).

The indicators must be based on local priorities, should align to Joint Health and Wellbeing Strategy and must be agreed by both the Health and Wellbeing Board and NHS England. They should also use national data sources wherever possible.

It is proposed that the following indicators are selected:
% of patients on a palliative care register

% 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

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Health and Wellbeing Board

14 May 2015

Health Premium Incentive Scheme 2014-15

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

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Purpose of the Report

1. The purpose of this report is to provide an update on the Health Premium Incentive Scheme for public health 2014-15.

Background

2. The White Paper “Equity and Excellence: liberating the NHS” published in July 2010 set out the policy direction that resulted in the Health & Social Care Act 2012 being implemented. Equity and Excellence stated that a new health premium designed to promote action to improve population wide health and reduce health inequalities would be introduced.

3. The public health finance update, *Healthy Lives, Healthy People: Update on Public Health Funding,* published in June 2012, included a high level design summary of the health premium incentive. In summary the premium would be:

    - Innovative.
    - Based on Public Health Outcomes Framework (PHOF) indicators.
    - Have national indicators set by the Government, supplemented by locally chosen indicator.
    - Be weighted to areas facing the greatest challenges.
    - Be formula driven to minimise bureaucracy and maximise transparency and
    - Be introduced from 2014-15 with the first payments being made in 2015-16, reflecting improvements made in 2014-15.

4. The Advisory Committee on Resource Allocation (ACRA) was commissioned to make detailed recommendations about how the scheme should operate and established a technical sub group with the appropriate expertise – the Health Premium Independent Advisory Group (HPIAG).

5. In summary, HPIAG recommended that:

    - Fifty one PHOF indicators or sub-indicators were deemed suitable for use as part of the incentive scheme, based on a set of criteria.

- Notwithstanding technical difficulties with measuring progress on smoking, alcohol and substance misuse, any credible scheme should have the potential to include indicators in relation to these areas.
- Alongside nationally set indicators, local authorities should have the flexibility to select a small number of indicators from those meeting the criteria, different to that selected nationally.
- Local authorities should have further local flexibility to select locally relevant indicators, provided they could demonstrate they were suitably robust.
- The health premium incentive was not the right mechanism for promoting innovation.
- Progress should be considered to have been made if a threshold is met. Ideally this would be set at a statistically significant level, but this might not always be possible.
- Local authorities should seek to incentivise the reduction in health inequalities.
- Indicators chosen should cover the four PHOF domains; and
- Benefits criteria and an evaluation methodology to be developed in conjunction with key stakeholders.

6. Following the consultation Department of Health and Public Health England informed Local Authorities and Directors of Public Health that the scheme would be piloted for 2014-15 and of the following regarding the indicators:

   - “Successful completion of drugs treatment” with combined data for opiate and non-opiate users is confirmed as the national indicator. Though this measure is not straight forward to use, the majority of responders were supportive of its inclusion as the national indicator, recognising that it provides a litmus test of local authorities capacity to improve the change of recovery of some of the most vulnerable in our society and success in working with a wide range of partners. The measure reinforces and supports the new grant condition which requires LAs to have regard to the need to improve the take up of, and outcomes from, their drug and alcohol misuse treatment services.
   - The majority of respondents did not support smoking prevalence as the default local indicator. Various issues were raised in terms of its use in an incentive scheme. As a result of the feedback received it was decided to use “Cumulative % of the eligible population aged 40 – 74 who received an NHS Health Check” as the default local indicator, in line with the refined indicator for NHS Health Checks in the Public Health Outcomes Framework.

7. Local Authorities (LAs) were requested through Directors of Public Health (DsPH) to choose which local indicator from a basket of 33 from the Public Health Outcomes Framework they want to be measured against as part of the pilot scheme (attached as Appendix 2).

8. The local indicator selected and submitted was:

   - 1.03: pupil absence – percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence).

9. This indicator was selected as performance against the PHOF baseline in 13-14 is good and shows an improving trend.

10. For those local authorities that did not submit a return the Department of Health (DoH) / Public Health England (PHE) will use the NHS Health checks indicator as the default indicator.

Financial implications

11. The financial implications to the council of achieving the health premium incentive is unclear. It is unlikely that the confirmed national indicator, successful completion of drugs treatment with combined data for opiate and non-opiate users will demonstrate improvement in County Durham. It is expected that the local indicator identified in Paragraph 9 will demonstrate the required improvement although the threshold methodology is unclear.

12. The incentive payment is from a fixed pot of £5m and is dependent on the number of local authorities showing improvement against one or both of the indicators. It is therefore not possible to estimate the likely payment in any meaningful way.

13. The timing of the payment (if any) is also unclear due to the time lags for the receipts and analysis of 2014-15 data.

14. PHE will analyse the data from each Local Authority on the improvement made in 2014-15 against the 2013-14 baseline position. There will not be any need for local authorities to submit any additional data. All data is collected via the normal Public Health Outcomes Framework data collection route and any additional statistical analysis will be done centrally within PHE with support from the technical sub group of the Advisory Committee on Resource Allocation. The data used to assess payment will be that presented in the Public Health Outcomes Framework.

15. The level of payment will depend on the total number of authorities that achieve the necessary level of improvement based on the threshold methodology. Payments will be made in quarter 4 of 2015-16 and will be proportional to target allocations.

16. In order to understand further detail in relation to the methodology of the Health Premium Incentive Scheme 2014-15, the Director of Public Health, County Durham will contact Public Health England to seek clarification.

Recommendations

17. The Health and Wellbeing Board is recommended to:

- Note the progress and pilot phase of the Health Premium Incentive Scheme.
- Note the submitted local indicator as per paragraph 9.
- Note the uncertainty regarding incentive payment value.
- Note the delayed timescale for payment.
- Note that the Director of Public Health, County Durham will contact Public Health England to seek clarity on the methodology of the Health Premium Incentive Scheme 2014-15.

Contact: **Anna Lynch, Director of Public Health County Durham, Durham County Council**
Tel: **03000 268146**

Appendix 1: Implications

Finance
To be confirmed

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
No implications

Disability Issues
No implications

Legal Implications
No implications

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Annex A: Health Premium Incentive Scheme nominated local indicator

Local Authority:	Durham County Council
Lead Contact (name)	Anna Lynch
Lead Contact (position)	Director of Public Health, County Durham
Lead Contact (e-mail)	anna.lynch@durham.gov.uk
Lead Contact (phone)	03000 268146
Local Indicator chosen	1.03 Pupil absence

PHOF ref	**Indicator Description**
0.1 ii	Life Expectancy at Birth
1.01	Children in poverty - Percentage of children in relative poverty (living in households where income is less than 60 per cent of median household income before housing costs)
1.03	Pupil absence - Percentage of half days missed by pupils due to overall absence (including authorised and unauthorised absence)
1.05	Percentage of 16-18 year olds not in education, employment or training (NEET)
1.06 i	Percentage of all adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family
1.12 i	Age-standardised rate of emergency hospital admissions for violence per 100,000 population
1.12 ii	Rate of violence against the person offences based on police recorded crime data, per 1,000 population
1.15 ii	Statutory homelessness / Household in temporary accommodation
2.01	Percentage of all live births at term with low birth weight
2.04	Under 18 conception rate per 1,000 population
2.06	Excess weight in 4-5 and 10-11 year olds
2.07i	Hospital admissions for unintentional and deliberate injuries in children age 0-14

2.07ii	Hospital admissions for unintentional and deliberate injuries in young people age 15-24
2.13i	Physically active adults
2.13ii	Physically inactive adults
2.14	*Smoking prevalence –Adults aged 18 and over (Default local indicator)*
2.15	*Successful completion of drug treatment (National indicator)*
2.20 ii	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
2.22v	Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check
2.24 i	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over per 100,000 population
3.03 i	Hepatitis B vaccination coverage (1 and 2 year olds)
3.03 iii	DTaP/IPV/Hib vaccination coverage (1, 2 and 5 year olds)
3.03 iv	MenC vaccination coverage (1 year olds)
3.03 v	PCV vaccination coverage (1 year olds)
3.03 vi	Hib/MenC booster vaccination coverage (2 and 5 year olds)
3.03 vii	PCV booster vaccination coverage (2 year olds)
3.03 viii	MMR vaccination coverage for one dose (2 year olds)
3.03 ix	MMR vaccination coverage for one dose (5 year olds)
3.03 x	MMR vaccination coverage for two doses (5 year olds)
3.03 xii	HPV vaccination coverage (females 12-13 year olds)
3.03 xiii	PPV vaccination coverage (aged 65 and over)
3.03 xiv	Flu vaccination coverage (aged 65 and over)
3.03 xv	Flu vaccination coverage (at risk individuals from age six months to under 65 years, excluding pregnant women)

Health and Wellbeing Board

14 May 2015

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

Report of Anna Lynch, Director of Public Health, County Durham 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 highlight 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 highlights the impact and costs of diabetes to the Clinical Commissioning Groups (CCGs) and the development being progressed to establish a new diabetes service model.

Background

2. The rationale for the National Diabetes Prevention Programme was set out by Simon Stevens, NHS Chief Executive, in his speech to the Diabetes UK professional conference March 12th 2015. The main points are:

   - About 20,000 people with diabetes die prematurely. Diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack, and stroke. As well as the human cost, diabetes accounts for around 10 per cent of the annual NHS budget. This is nearly £10 billion a year. Diabetes is also the cause of more than 100 amputations per week.
   - The NHS currently spends more on bariatric surgery than lifestyle interventions to prevent diabetes. The costs associated with the treatment of diabetes combined with the cost of managing the complications caused by diabetes currently totals £23.7 billion and is predicted to rise to £39.8 billion by 2035/36.

3. Diabetes is a priority for CCGs in County Durham. A strategy group working on the development of a new diabetes service model has been established. The rationale for the changes needed for the management of diabetes is still work in progress. The main points in the 'case for change' presented to the clinical leaders on April 21st 2015 include:

- The cost of managing diabetes in the local health economy is rising. The County Durham and Darlington CCGs spent more than £24million managing diabetes in 2013/14.
- There has been progress in reducing the numbers of undiagnosed people with diabetes, but more than 6% of patients remain undiagnosed and require care (approximately 2000 individuals in County Durham and Darlington).
- Diabetes prevalence increased by 24.3% in the five years from 2008-9 to 2012-13 in County Durham, a larger increase than 18.4% for the rest of the UK. The prevalence of diabetes is forecast to continue rising, with more than 26% increase forecast by 2030 leading to an additional 10,000 more patients with diabetes across County Durham. If the model of care does not change then the cost of managing patients with diabetes will increase at least in line with increasing prevalence implying that additional funding of £5m per annum will need to be found by 2025.
- With expensive new Diabetes drugs and devices coming into the market in the next few years there is a risk that this cost will increase even faster if the model of care remains unchanged. Spend on drugs used to treat patients with diabetes is rising faster in County Durham (5.74% in North Durham, 4.88% in Durham Dales, Easington and Sedgefield) than spend in other North East CCGs (3.64%). Prescribing spend varies considerably across County Durham GP practices with no correlation to clinical outcomes or markers of the quality of care e.g. HbA1c control.

4. About 90 per cent of people with diabetes have Type 2, which is largely preventable. The World Health Organization estimates that up to 80% of Type 2 diabetes could be prevented by reducing weight, reducing waist size achieved through eating less/healthier eating and being more physically active.

5. The rationale for the National Diabetes Prevention Programme is that by investing in prevention, and stopping or delaying people getting Type 2 diabetes, there will be a reduction in costs further down the pathway of care. The risk factors for Type 2 diabetes are also risk factors for other serious conditions like cardiovascular disease, so helping people reduce their risk of Type 2 diabetes will also reduce their risk of other serious illness.

6. In May 2011 the National Institute for Health and Care Excellence (NICE) published guidance on the prevention of type 2 diabetes through population and community level interventions (NICE PHG 35, 2011). The recommendations for local action include:

- Local joint strategic needs assessments and local strategy (Diabetes is identified in both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy).
- Interventions for communities at high risk.
- Conveying messages to the local population.
- Promoting a healthy diet.
- Promoting physical activity.
- Training.

7. In July 2012 NICE published guidance on the prevention of Type 2 Diabetes including identification and interventions for those at high risk (NICE PHG 38, 2012). The recommendations focus on two major activities:

   - Identifying people at risk of developing type 2 diabetes using a staged (or stepped) approach.
   - Providing those at high risk with a quality-assured, evidence-based, intensive lifestyle programme to prevent or delay the onset of Type 2 diabetes.

Check4Life and Just Beat It

8. The background paper attached to this report ‘Expression of Interest template’ sets out the reasons why County Durham has been chosen to be a demonstrator site for the National Diabetes Prevention Programme. The developments to the NHS Health Check programme commissioned by Durham County Council public health service include the two main recommendations in the NICE guidance on the prevention of Type 2 diabetes that the National Diabetes Prevention Programme aims to replicate.

9. Check4Life is the County Durham version of NHS Health Checks. The programme is based on health checks carried out in GP practices, community pharmacies, by staff in local authority and independent leisure centres, businesses and at community events. As well as the standard check for the risk of developing cardiovascular disease, Check4Life also includes a diabetes risk assessment using the Diabetes UK Risk Score. Those people identified as having a high risk of developing Type 2 diabetes are referred to an evidence-based, intensive lifestyle programme to reduce that risk called Just Beat It.

10. Just Beat It is a programme developed by the Health Improvement Service of County Durham and Darlington NHS Foundation Trust and commissioned by Durham County Council public health service. It aims to replicate the outcomes of the randomised controlled trials of intensive lifestyle programmes to prevent diabetes. The key indicators of the programme are:

    - Weight loss of 5 – 10kg or 5% of baseline weight at 6 months.
    - Increased physical activity at 12 weeks and 6 months.
    - Improved diet at 6 months.

National Diabetes Programme

11. The aim of the National Diabetes Prevention Programme is to build on the experience of the seven demonstrator sites during 2015/16 before developing a plan for the national roll out during 2016/17. The national programme includes a review of the international evidence on diabetes prevention looking at what works in different contexts and evaluating how this evidence can be implemented in the demonstrator sites. A briefing note describing how interested sites can register their interest in becoming a demonstrator site for the National Diabetes Prevention Programme is attached at Appendix 2.

12. The evaluation of the demonstrator sites will inform the specification for the diabetes prevention programme and a national procurement exercise. The evaluation will include the:

- Effectiveness of models for identification and referral.
- Feasibility of different lifestyle interventions.
- Barriers and facilitators for providers and participants.
- Impact of scaling up the programme nationally.
- Extent of local variation.
- Data necessary for monitoring the effectiveness of the programme.

13. The evaluation of the demonstrator sites will enable the national programme to assess the likely impact of the programme at a national scale. The expected outcomes and benefits that should be achieved as a result of the implementation of the programme are that:

- More people at high risk of developing diabetes will receive lifestyle interventions to support them to lower their risk.
- The incidence of Type 2 diabetes will reduce over the longer term; and
- The incidence of heart, stroke, kidney, eye and foot problems (and associated mortality) related to diabetes will reduce over the longer term.

Preliminary findings from the Check4Life and Just Beat It programmes

14. The planning assumptions behind the Check4Life and Just Beat It programmes are as follows:

- The eligible population for a health check is 111,633.
- The target number of health checks in 2015/16 is 20% of this figure – 22,326.
- The likely number of health checks carried out is 50% - 11,163.

15. Based on 6 months data from the 26 practices taking part in check4Life between August 2014 and February 2015, out of 1,852 health checks:

- 396 (28%) had a diabetes UK risk Score > 15 (High and Very High Risk).

- In the next year over 3,000 people with a Diabetes UK Risk Score > 15 are expected to be identified.
- Of these, it is anticipated that one third will take up the offer of participating in a just Beat It programme – 1000 people.

16. Those identified with a diabetes UK risk score <15 (Low and Increased Risk) still have a risk of developing diabetes but at a lower level of risk compared with those with the score >15. As there are more people in this population group, over the next 10 years about 55% of all new cases of diabetes in County Durham will occur among people who will not be offered a place on the Just Beat It programme.

17. The implication of these findings is that the National Diabetes Programme aimed at people with a high risk of developing diabetes will not have the expected impact on the prevalence of diabetes over the next 10 years. More action therefore needs to be taken to promote healthier lifestyles at a population and community level in line with NICE Public Health Guidance 35 if diabetes prevalence is to be reduced.

Recommendations

18. The Health and Wellbeing Board is recommended to:

    - Note 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.
    - Note the future intention is to procure a diabetes prevention programme across England.
    - Note that local delivery forms part of the Check4Life programme in County Durham.
    - Note the preliminary findings from the check4Life and Just Beat it programmes and their implications.
    - Note the strategy group established by the CCGs to develop a diabetes service model.

Contact: Dr Mike Lavender, Consultant in Public Health Medicine, Durham County Council
Tel: 03000 267681

Appendix 1: Implications

Finance:
None – the programme costs are included in the Public Health baseline budget

Staffing
None – the staff are employed by provider organisations

Risk
None

Equality and Diversity / Public Sector Equality Duty
None

Accommodation
None

Crime and Disorder
None

Human Rights
None

Consultation
None

Procurement
The Check4Life and Just Beat It programmes are commissioned as part of the Health Check programme and are still in development

Disability Issues
None

Legal Implications
None

APPENDIX 2

Registering interest to join the National Diabetes Prevention Programme

This note describes how interested sites can register their interest in becoming a demonstrator site for the National Diabetes Prevention Programme and outlines at a high level, what we are looking for from demonstrator sites and how we will go about selecting them.

We are looking to collaborate with demonstrator sites on:

- Co-designing type 2 diabetes prevention programme;
- Ensuring that the international, national and local evidence of "what works" is factored into the design of these programmes
- Implementing these programmes and learning lessons on implementation for national roll-out; and
- Evaluation and sharing of learning.

Demonstrator sites will have:

- An ambitious vision of what change local areas want to achieve in relation to diabetes prevention, that meets the needs and preferences of their local population;
- A track-record of successful implementation of public health prevention programmes;
- A desire and commitment to move at pace with us, delivering change in 2015/6;
- A commitment to support programme implementation with co-investment of time and resources;
- Effective managerial and clinical leadership, with the capacity and capability to succeed;
- Active and synergistic local relationships, for example the support of local commissioners, providers, health professionals and communities;

They will also need to show:

- A commitment to be prepared to modify and change existing local programmes to reflect emerging evidence and to test different approaches as part of the collaboration to define a nationally implementable programme;
- An appetite to engage intensively with other sites across the country, and with national bodies, in a co-designed and structured programme of support aimed at (a) developing and implementing an effective and scalable diabetes prevention programme; (b) developing common rather than unique local solutions that can be replicated by subsequent sites; and (c) evaluating progress and making improvements, through a staged development process;
- A commitment to the collection and analysis of standardised data to enable real-time monitoring and evaluation, the cost-effectiveness of implementation approach and service design, and the benefits that accrue as the programme develops

To assist this first group of demonstrator sites, a national and local offer of support from PHE, NHS England and Diabetes UK will include:

- A named account manager, dedicated to coordinating national help and support, including

removing barriers to change

- Input of expert clinical advice on most suitable approaches
- Shared findings from comprehensive international evidence reviews of what works in practice,
- Support with planning, commissioning and implementation
- Support with engagement of service users
- Support with marketing and communications, data flows and evaluation
- Celebration of local demonstrator sites as exemplars of diabetes prevention

This will be expended on as we start to work jointly with our demonstrator sites and understand the unique requirements.

To help us identify the most appropriate local partners, we need to learn a bit more about their existing diabetes prevention programmes, the progress they have made to date and their ambitions for the future. Interested sites are asked to complete a two page form, which is attached at the end of this email, and send it to the National Diabetes Prevention Programme team at **george.connor@phe.gov.uk** by **2nd March 2015**.

We will use the registrations of interest, combined with other available information about local populations, to select demonstrator sites. This will involve discussing plans with a shortlist of applicants on the 5th and 6th March.

From April onwards, we will collaborate with identified partner sites to develop dedicated support and joint working relationships. Our aim is to implement diabetes prevention approaches in ways that can be replicated elsewhere. We will have a wider national engagement and regular communications throughout the year.

Q1. Who is making the application?

What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.

The applicant is Dr Mike Lavender, Consultant in Public Health Medicine, Durham County Council.

Dr Mike Lavender MBBS MSc FFPH
GMC Number 2417589
Consultant in Public Health Medicine
Public Health Department
Durham County Council
County Hall
Durham
DH1 5UJ

Mobile: 07775019639
Telephone: 03000 267681
Email: mike.lavender@durham.gov.uk

Dr Lavender commissions the NHS Health Check programme – locally branded as Check4Life. Health Checks are carried out in GP practices, community pharmacies, by staff in local authority and independent leisure centres, businesses and community events. Check4Life includes a diabetes risk assessment using the Diabetes UK Risk Score. Linked to this is a referral pathway to a newly developed diabetes prevention programme called Just Beat It.

Just Beat It is provided by a collaboration of organisations including:
County Durham & Darlington Foundation Trust Health Improvement Service
Durham County Council Leisure Services
Leisureworks – an independent sector leisure services company
Pioneering Care Partnership – a voluntary sector health development organisation

Q2. What are you trying to achieve?

Please outline your objectives in relation to prevention of type two diabetes, and the principal changes you are planning. What will it look like for your local community and for your staff?

The overall objective is to implement and evaluate the recommendations in NICE Public Health Guidance 38: Preventing type 2 diabetes. This includes:

1. Introducing a validated diabetes risk assessment tool across the all providers (GP practices and community settings) in the Check4Life programme
2. Training all staff conducting a health check in diabetes risk identification, risk communication, brief interventions and appropriate referral and signposting to lifestyle interventions
3. Implementing a quality assured, evidence based intensive lifestyle programme for those people identified at high risk of Type 2 diabetes
4. Evaluating the outcomes of the intensive lifestyle programme as part of the diabetes pathway re-design

When this programme of work is completed and the programme is embedded into the Health Check programme and diabetes care pathway the key features include:

For the local community

- Just Beat It is a locally branded diabetes prevention programme that includes a core offer of different lifestyle programmes matched to the level of diabetes risk. It is provided in a wide range of settings by different providers appropriate for the community. The communities in County Durham range from relatively affluent rural areas to relatively deprived urban areas. The Check4Life and Just Beat It provider network includes organisations and services that have developed according to the needs of these different communities.
- The Just Beat It branding and quality assured programme content will enable better and more consistent marketing for the programme, a single point of contact for referrals, an evidence-based programme to reduce risk and high quality risk communication materials for clients.

For staff:

- For all Check4Life staff they will receive training, supervision to increase their understanding of diabetes risk, and to improve their competence around risk communication and risk reduction
- For the Just Beat It provider network, the opportunity to build on their existing programmes with the offer of an intensive lifestyle programme appropriate to the needs of their community.

Q3. Which evidence based type two diabetes prevention interventions are you currently pursuing?

Which interventions are you currently using within your area?
How are they working?
What do you think you are doing particularly well?
Do you have any evaluation mechanisms in place?
Please summarise the main concrete steps or achievements you have already made on prevention of type two diabetes, e.g. progress made in 2014/15
(*If there is strong will to work with us, even if your current T2D prevention activity is limited we still welcome approaches.)*

The overall objective of the Just Beat It programme is to implement and evaluate the recommendations in NICE Public Health Guidance 38: Preventing type 2 diabetes

Diabetes Risk Assessment tool

In the absence of any national guidance on the most appropriate tool to use, we have included the Diabetes UK Risk Score into the Check4Life software. We have collaborated with the Public Health England national team in the review of NHS Health Checks on behalf of the Expert Scientific and Clinical Advisory Panel (ESCAP) on risk assessment scores for the diabetes filter. We are aware of the scientific debate around the most appropriate tool to use and will adapt the programme in the light of published evidence and guidance. Specifically we will look at the QDiabetes tool through the Chck4Life programme in GP practices. In the meantime, the Check4Life quality assurance programme is training and supervising staff in the information and measurements needed for the Diabetes UK Risk Score.

Diabetes Risk Assessment

Embedded in the Check4Life software is a range of prompts and guidance on communicating the

diabetes risk score and appropriate lifestyle advice based on the score. Date from community health checks are automatically transferred to GP practices. The evaluation of the programme is to follow up those individuals identified at high risk to see what proportion had the confirmation of the diabetes risk by HbA1c or blood glucose levels.

Intensive lifestyle programme – Just Beat It

Just Beat It aims to replicate the intervention arms of the diabetes prevention programmes in Finland and the USA. We ran a 'proof of concept' pilot programme with people included in the Exercise on Referral programme. We have begun the next phase of the project by taking referrals from the Check4Life programme and concentrating the lifestyle programme in the more deprived area of the county. The next phase of the project is to bring on board a range of different providers to extend the coverage 'to scale' across all of County Durham. This builds on existing collaborations around Exercise on Referral and Adult Wellbeing for Life service with the Check4Life team providing the overall quality assurance of the programme. The final phase of implementing Just Beat It is to link the intensive lifestyle programme with the DESMOND patient education programme for people newly diagnosed with Type 2 diabetes. The key indicators of the programme are:

- Proportion of participants completing the 6 month programme
- The average contact time of participants
- Diabetes risk score at 6 months
- Hba1c result at 6 months
- Weight loss of 5 – 10kg or 5% of baseline weight at 6 months
- Increased physical activity at 12 weeks and 6 months
- Improved diet at 6 months
- Improved Self-Efficacy / Confidence at 6 months
- Participant satisfaction (85%) at 6 months

Evaluation of Just Beat It

The Just Beat It programme is an integral part of the re-design of the diabetes care pathway that has a greater emphasis on prevention and self-management. Just Beat it is a 3 year programme commissioned by County Durham Public Health. Public Health will evaluate the programme in collaboration with Newcastle University. We have developed a Return on Investment economic model based on the assumptions in NICE PHG 38 as part of the business case for the programme.

Key features of the County Durham Check4Life and Just Beat It programme are:

- JBI is integrated with the NHS Health Checks through the local Check4Life programme
- JBI is integral to the re-design of the diabetes care pathway including links to the DESMOND patient education programme
- Check4Life has an established quality assurance component including a competency framework, staff training and supervision. This will extend to the JBI programme.
- Check4Life has an integrated information system based on a common software package that ensures a consistent diabetes risk assessment and risk communication across GP practices and community providers
- The Check4Life information system ensures that all diabetes risk assessments carried out in GP practices and community settings are accurately recorded, correctly coded and automatically transferred to the patient's record on the GP practice system.
- We are running a pilot in a number of practices with different IT systems, to identify patients

at risk of diabetes based on information already recorded in the patient record. This will then enable the invitations and marketing of the programme to be targeted at those with an estimated higher risk.

- We have extended the NHS Health Check to adults outside of the 40 to 74 age range. The modified health check includes a diabetes risk assessment including blood pressure, BMI and waist measurement. These are opportunistic checks in a range of settings including gym inductions, workplace events and community roadshows featuring the Check4Life bus.
- We are developing the protocol for using the Check4Life software in GP practices to carry out a diabetes risk assessment in patients diagnosed with high blood pressure at their annual review.

Q5. If chosen as a demonstrator site to work with us on developing and implementing a diabetes prevention programme what do you perceive as realistic deliverables in 12 months?

Please describe the changes, realistically, that could be achieved by then, if we were to start working together in April with a view to delivery from the Summer 2015

The Check4Life and Just Beat It programmes are already in place therefore the deliverables in the 12 months will build on progress already made.

By April 2015 we will have the following:

- Check4Life software and about 300 staff trained to conduct a diabetes risk assessment in 50 GP practices, 12 community pharmacies, 8 leisure centres and a range of business and community venues
- The results from the cohort of patients completing the first 6 month of the Just Beat It pilot programme

By Summer 2015 we will have the following:

- Data from up to 6 months of Check4Life health checks that will include a diabetes risk assessment (about 5500 data sets)
- The results from the second 6 month cohort of Just Beat It participants

We would like to collaborate with the national team to assess the content of the programme in the light of the early finding and to make any changes based on evidence, best practice and the interim evaluation of the programme so far. This will enable us to make the necessary changes with a view to implementing a local programme consistent with the expectations of the national programme by summer 2015.

Q6. What do you want from a structured national programme?

What national support would be helpful to accelerate progress in your area?

We have learnt a great deal from our collaboration with Public Health England on the evidence behind the different diabetes risk scores. Collaboration with NHS England working with colleagues in other parts of the country will give us the opportunity to share ideas and learn from their experience. The coming 6 months will throw up a range of questions and challenges from the implementation of the Diabetes UK risk score in the Check4Life programme, the implementation of the Just Beat It programme, the interpretation of the results from the early cohorts of participants and a critical review of the extent to which the programme replicates the findings of randomised

controlled trials and the evaluation of other programmes. We would like to participate in the shared learning and critical feedback of our programme by working with other partners.

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Health and Wellbeing Board

14 May 2015

County Durham Dual Needs Strategy

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

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Purpose of the Report

1. The purpose of this report is 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.

Background

2 The aim of this strategy is to identify people with dual needs and ensure they have access to coordinated and responsive services to meet their complex and changing needs and that their families and carers are supported. It is important that that joint commissioning opportunities and pathway design is undertaken collaboratively.

3. People with dual needs have concurrent learning disabilities and/or mental behavioural diagnosis and/or dementia as well as a substance misuse issue. Nationally and locally they have reported difficulty in accessing services able to address their complex needs. Although guidance refers to ‘diagnosis’ it is vital that our focus is on the **needs** of people with dual problems and their families. People with dual needs experience problems in many diverse ways with varying degrees of severity and may require different services to help them.

4. Previously those with dual needs received services delivered in a ‘serial’ or ‘parallel’ way. ‘Serial’ refers to the person having to resolve their substance use problem before mental health services become involved. ‘Parallel’ refers to both services providing care at the same time, yet not collaborating effectively. The ‘Collaborative’ model refers to services working together, each bringing their specialised skills to implementing a single plan of care and providing mutual staff support. Services across County Durham are committed to working in a collaborative model.

5. This strategy sets out ways to help individuals, families, carers, providers and commissioners work together to respond to the complex and changing needs of individuals and families living with dual needs. The scope of this strategy covers all ages.

6. This strategy has been developed in partnership with organisations working with people with dual needs, individuals with dual needs and their families. Strategy consultation included a public event, open workshops and public consultation through Durham County Council website.

Dual Needs Strategy Vision and Objectives

7. The Vision:

   'Improve the mental and physical health of people with dual needs through improved care and support to individuals, their families and carers'.

8. Key Objectives

<u>Prevention</u>

Objective 1: Reduce stigma and discrimination towards people who experience dual needs by raising awareness with the general public, workplaces and other settings.

Objective 2: Develop a multiagency workforce able to support people with dual needs, their carers and families.

Objective 3: Define and collate data on people with dual needs and use to identify gaps ensuring a seamless pathway of support.

Objective 4: Improve access to support services including housing, employment, financial and relationship support.

<u>Early identification and intervention</u>

Objective 5: Develop capacity in the voluntary and community sector increasing opportunities for early intervention.

Objective 6: Improve access to family support and interventions for children at the earliest opportunity.

Objective 7: Increase early identification through screening and improved response to dual needs.

Objective 8: Improve the physical health of people with dual needs.

<u>Improve the care of people with dual needs</u>

Objective 9: Ensure ease of access to services through referral pathways and clear joint working arrangements including agreement of the Lead Professional role.

Objective 10**:** Adopt a 'whole family approach' when offering interventions including support for carers and pathways for parental dual needs.

Recovery

Objective 11: Promote long term recovery and empowerment of the individual by developing community projects including mentoring and a visible recovery community.

Objective 12: Develop a person centred recovery approach when agreeing care/interventions which includes involvement of individuals, families and carers to ensure services are coordinated and responsive to their needs (including children within the family).

Next Steps

9. The Dual Needs Implementation group will drive forward the strategy as well as acting as the forum for arbitration. An action plan for the first year will be agreed by October 2015.

10. It is recommended that the Dual Needs Implementation Group reports to the Mental Health Partnership Board.

Recommendations

11. The Health and Wellbeing Board is recommended to:

    - Endorse the Refreshed Dual Needs Strategy.
    - Agree to receive the first year action plan and update reports on delivery of the strategy at future meetings.
    - Note the joint commissioning opportunities to ensure the needs of those with dual needs are met.

Contact: Catherine Richardson, Public Health Portfolio Lead, Durham County Council
Tel: 03000 267667

Appendix 1: Implications

Finance:
Funding of services for people with dual needs is the responsibility of the following commissioners.

- *Clinical Commissioning Groups*- Primary and Secondary Mental Health Services, healthcare services for people with Learning Disabilities.

- *Public Health in Local Authorities*- Drug and Alcohol Treatment in the community and custody settings.

- *NHS England (Health and Justice Team*) – commission all healthcare within prisons including mental health, drug and alcohol services

- Integrated Learning Disability Services are delivered in *Local Authorities*.

- *Police and Crime Commissioners* - Drug Intervention Projects

Staffing
No additional staffing required however training for staff core to the success of the strategy.

Risk
Ensuring joint commissioning opportunities are fully explored.

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
The *Prison Reform Trust Bromley Briefing* (2010) reports that 75% of all prisoners have a dual diagnosis.

Human Rights
No implications

Consultation
A consultation event was held in October 2014 with further events held in January and February 2015

Procurement
None

Disability Issues
People with dual needs have concurrent learning disabilities and/or mental behavioural diagnosis and/or dementia as well as a substance misuse issue.

Legal Implications
None

APPENDIX 2

Dual Needs in County Durham
- A Strategy for Action

2015-2017

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1. Introduction

People who experience problems associated with learning disability and/or mental illness (including dementia) and a concurrent problematic substance misuse issue (drugs and/or alcohol) are at increased risk of serious poor physical health outcomes. Use of drugs and alcohol also increases the chance of unstable housing or homelessness, social isolation and stigma, disrupted family relationships, unemployment and imprisonment. People with dual needs often have very complex needs, and the provision of effective treatment and support may require input from a range of health and social care providers. Although guidance refers to diagnosis it is vital that our focus is on the needs of people with dual issues and the needs of their families and carers.

Dual needs refers to an individual with needs arising out of one or more of the following as well experiencing a substance misuse issue (drugs and/or alcohol):

- Mental and behavioural disorders;
- Dementia;
- Learning disability.

This strategy aims to raise awareness, challenge stigma and promote good practice by supporting individuals and families through integrated care pathways, ensuring they have access to coordinated and responsive services to meet their complex and changing needs.

Assessing which is a primary and secondary need may be possible but, all too often this approach can be a barrier to accessing treatment. It is important that the needs of the individual are placed first, and treating concurrent issues together should be the treatment of choice. The emerging evidence suggests components of 'An Integrated Treatment Approach' have better outcomes for individuals and families.

This Dual Needs Strategy will set out the vision and values for local service provision and be the focal point for collaboration between all key stakeholders who will work to address the varying needs of individuals and families using a comprehensive and flexible approach. This strategy will reflect recommendations from national policy guidance and best practice to ensure prevention, early intervention, care and recovery of those with co-existing needs.

The scope of this strategy is all age and mirrors that of 'No Health Without Mental Health' (UK Government, 2012) and sets out ways to help individuals, families, providers and commissioner's to work together to respond to complex and changing needs of individuals living with dual needs.

2. Dual Needs Strategy Vision and Objectives

The Vision:
'Improve the mental and physical health of people with dual needs through improved care and support to individuals, their families and carers'.

Key Objectives
<u>Prevention</u>

Objective 1: Reduce stigma and discrimination towards people who experience dual needs by raising awareness amongst the general public, workplaces and other settings.

Objective 2: Develop a multiagency workforce able to support people with dual needs, their carers and families.

Objective 3: Define and collate data on people with dual needs and use to identify gaps ensuring a seamless pathway of support.

Objective 4: Improve access to support services including housing, employment, financial and relationship support.

<u>Early identification and intervention</u>

Objective 5: Develop capacity within the voluntary and community sector increasing opportunities for early intervention.

Objective 6: Improve access to family support and interventions for children at the earliest opportunity.

Objective 7: Increase early identification through screening and improved response to dual needs.

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<u>Improve the care of people with dual needs</u>

Objective 9: Ensure ease of access to services through referral pathways and clear joint working arrangements including agreement of the Lead Professional role.

Objective 10**:** Adopt a 'whole family approach' when offering interventions including support for carers and pathways for parental dual needs.

<u>Recovery</u>

Objective 11: Promote long term recovery and empowerment of the individual by developing community projects including mentoring and a visible recovery community.

Objective 12: Develop a person centred recovery approach when agreeing care/interventions which includes involvement of individuals, families and carers to ensure services are coordinated and responsive to their needs (including children within the family).

To achieve these objectives the strategy will work towards:

Developing partnerships across agencies which promote integrated care to ensure positive outcomes for service users, carers and families;

Adopt a whole family approach and ensure interventions are available at the earliest opportunities for the individual their partner, carers and children;

Improve the commissioning of specialist services to develop integrated dual needs approach;

Agree local care pathways which comprehensively address complex needs reflecting multi agency health and social care;

3. National Policy Drivers

This strategy has been guided by the following policy and guidance documents.

Department of Health (2002) published 'Dual Diagnosis Good Practice Guide', providing a framework to help strengthen services. This guidance advises services to view dual diagnosis as 'usual rather than exceptional' and outlines the need to ensure that mainstream service providers are prepared and equipped to work with Dual Diagnosis.

'Dual Diagnosis in mental health inpatient and day hospital settings' (Department of Health, 2006) provides guidance on assessment and clinical management of patients with mental illness primarily being cared for in psychiatric inpatient or day care settings who also use or misuse alcohol and/or illicit or other drugs. However, some issues will be of relevance to community services, such as community mental health teams and to other settings, for example prisons. It covers organisational and management issues to help mental health services manage service users who also use alcohol or drugs.

A key recommendation is that the assessment and management of substance misuse are core competences required by clinical staff in mental health services. It encourages integration of substance misuse expertise and related training into mental health service provision. It provides suggestions and guidance to front-line staff and managers to help them provide the most effective therapeutic environments, and advocates closer working relationships between mental health services and the police.

The Bradley Report (2009) was commissioned by the Ministry of Justice following an independent review of the experience of people with mental ill-health and people with learning disabilities in the criminal justice system. The aim is to divert individuals away from the criminal justice system and into services to support their recovery. One of the 82 recommendations for change was improved services for prisoners who have dual needs of mental health and substance misuse and suggests that these services be developed.

The Ministry of Justice and Department of Health produced 'Guidance for the management of dual diagnosis in prisons' (2009) recognised that the prevalence of substance misuse and mental ill-health in the prison population is high. Specific guidance was produced for use by all services within prisons, including primary care, mental health and substance misuse services.

In 2009 Department of Health published 'Valuing People Now: a new three year strategy for people with learning disabilities'. The strategy continues the vision of 'Valuing People: a new strategy for the 21st Century' (2001), that all people with a learning disability have the right to independent living, social inclusion and choice and control over their lives. People with learning disabilities have poorer health and are more likely to die at a younger age than the general population. A key objective of 'Valuing People Now' is that all people with learning disabilities receive the health care they need. Although the strategy does not refer specifically to dual needs, it identifies the priority for inclusion of those groups who are most often excluded from society, this includes people with more complex needs and offenders in custody and in the community.

Lord Patel was commissioned to chair the Prison Drug Treatment Strategy Review Group to review drug treatment and interventions for people in prison, people moving between prisons and the continuity of care for people on release from prison. The Patel Report was published in 2010. It acknowledges that dual needs have become far more common in both the community and prisons.

Over the last few years recovery has become a key concept in substance misuse services. The UK Government Drug Strategy (2010), states that it has 'recovery at its heart'. This new approach offers support for people to choose recovery as an achievable route out of dependency. The Government has made clear their determination to break the cycle of dependence on drugs and alcohol. Although it does not specifically refer to dual needs, it emphasises that services should work together to enable recovery.

In November 2010, a national refresh of the 2008 carers strategy was announced 'Recognised, valued and supported: Next steps for the carers strategy', which includes health, education, social care and employment for carers. The refresh built on the previous national strategy, reaffirming the support for the vision and outcomes for carers in the previous strategy but also making new commitments to carers. The strategy refresh identified the following four priority areas:

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

The Social Care Institute for Excellence (SCIE) has produced a guide 'Families that have alcohol and mental health problems: A template for partnership working' and an Ofsted report, 'What about the children?' which outlines key messages that adult services should implement to ensure the needs of young people within the family are considered.

In February 2011 the Government introduced its new strategy for mental health ‘No Health without Mental Health’. The strategy stresses the interconnections between mental health, housing, employment, the criminal justice system and substance misuse provision. It outlines six objectives to improve the mental health and wellbeing of the nation and improve outcomes through high quality services.

The six objectives are:

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

Additionally the Government launched the National Improving Access to Psychological Therapies (IAPT) programme which represented a significant investment in improving access to talking therapies. ‘Talking therapies: a four year plan of action’ outlined the Government’s commitment to expanding access to psychological therapies in the four years from April 2011. The programme aims to ensure every adult who requires it should have access to psychological therapies to treat anxiety disorders or depression. The ‘Four Year Plan’ will see the IAPT provision extended to older people, children and young people, people with long term health conditions, people with medically unexplained symptoms and people with severe mental illness.

The UK Governments Alcohol Strategy was published in 2012 and cites dual diagnosis as a key issue. It acknowledges the clear association between having a mental illness and increased risk of alcohol dependence. It states that promoting good mental health in children and adults can help prevent alcohol misuse.

‘Transforming Care: A national response to Winterbourne View Hospital**’** was published by Department of Health in 2012. This is the final report of the review of events at Winterbourne View, a private hospital in South Gloucestershire, where patients with learning disabilities and autism were subject to sustained abuse, ill- treatment and neglect. These events triggered a wider review of care across England for people with challenging behaviours. The report sets out a programme of actions to transform care and support for people with learning disabilities or autism who also have mental health conditions or challenging behaviours. These include actions to transform the way services are commissioned and delivered so that people with challenging behaviours no longer live inappropriately in hospitals but receive care based on their individual needs. Although the report does not specifically refer to dual diagnosis there are lessons to be learnt regarding the planning and delivery of care and the need to strengthen adult safeguarding arrangements.

Preventing Suicide in England: A cross government outcomes strategy to save lives (2012) focusses on six main areas for action:

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

The National Institute of Clinical Excellence (NICE) produce evidence-based guidance, advice and quality standards for health, public health and social care practitioners to implement within their area of work thus improving health and wellbeing. Appendix 2 details examples of guidance and quality standards that should be implemented when working with individuals with mental ill-health, learning disabilities, behavioural disorders and substance misuse.

'Drug Misuse and Dependence, UK Guidelines on Clinical Management' (2007) concluded that 'there is still a need for more collaborative planning, delivery and accountability of services for people with co-morbidity, including those with mild to moderate mental ill-health, early traumatic experiences and personality traits and disorders'. It expressed concern about lack of specified core competencies, inadequate assessment and co-ordination of services, and only limited progress on the development of integrated care.

4. Local Policy Drivers

As well as national policy and strategy it is important that key linkages are made to local policies and strategies including:

- The County Durham Alcohol Harm Reduction Strategy 2015 - 2017
- County Durham Drug Strategy 2014 - 2017
- County Durham Joint Health and Wellbeing Strategy 2014-2017
- County Durham Public Mental Health Strategy 2013-2017
- Safe Durham Reducing Reoffending Strategy 2011-2014
- County Durham and Darlington Dementia Strategy 2014-2016
- Safe Durham Partnership Plan 2014-17
- Joint Protocol for Tackling Anti Social Behaviour where Mental Health is an issue (2013)

5. Dual Needs County Durham Profile

There is limited data available at both national and local level in relation to rates of dual needs. The data which is available does not provide a picture of dual needs over a period of time however does provide information for specific contributing factors at a County Durham level compared to North East and England.

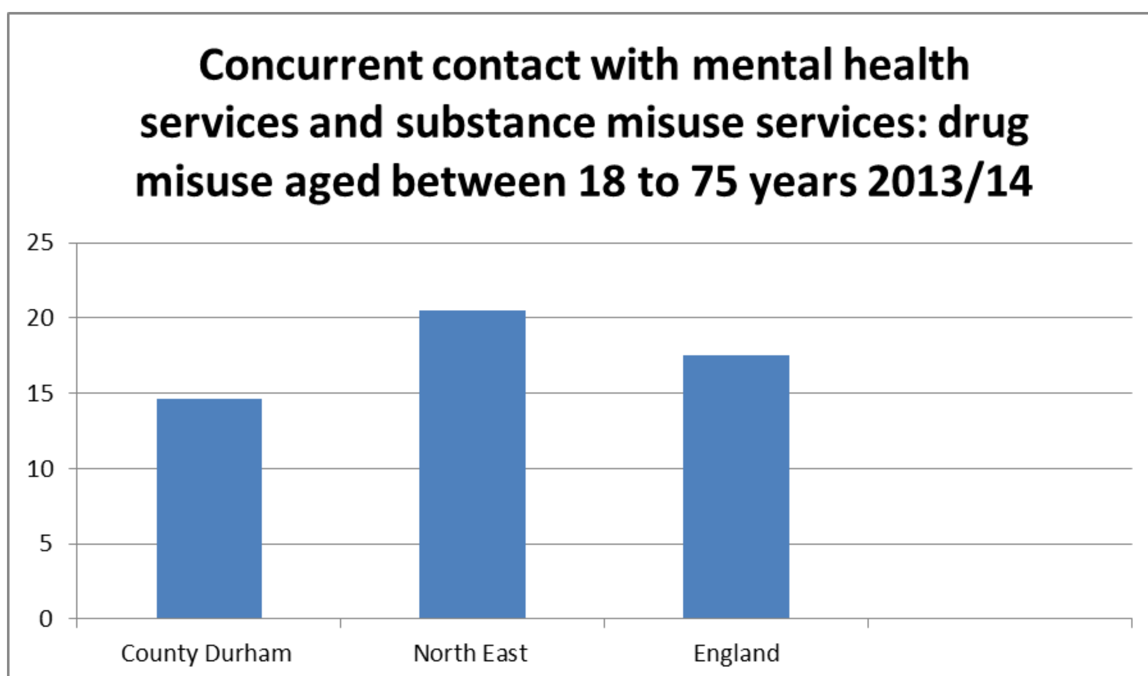
Although direct indicators of dual needs are currently largely unavailable mental ill-health is very common among those in treatment for drug use.

Graph 1 shows the proportion of people aged from 18 to 75 years who, when assessed for drug treatment, were receiving treatment from mental health services for reasons other than substance misuse, as a proportion of all individuals in specialist drug misuse services.

The measure is indicative of levels of co-existing mental ill-health in the drug treatment population. However, it should not be regarded as a comprehensive measure of dual needs as it only captures whether a person is receiving mental health treatment at a given point in time.

County Durham has a lower proportion of people with concurrent contact with mental health services and substance misuse: drug services aged between 18 to 75 years during 2013/14 compared to North East and England estimates.

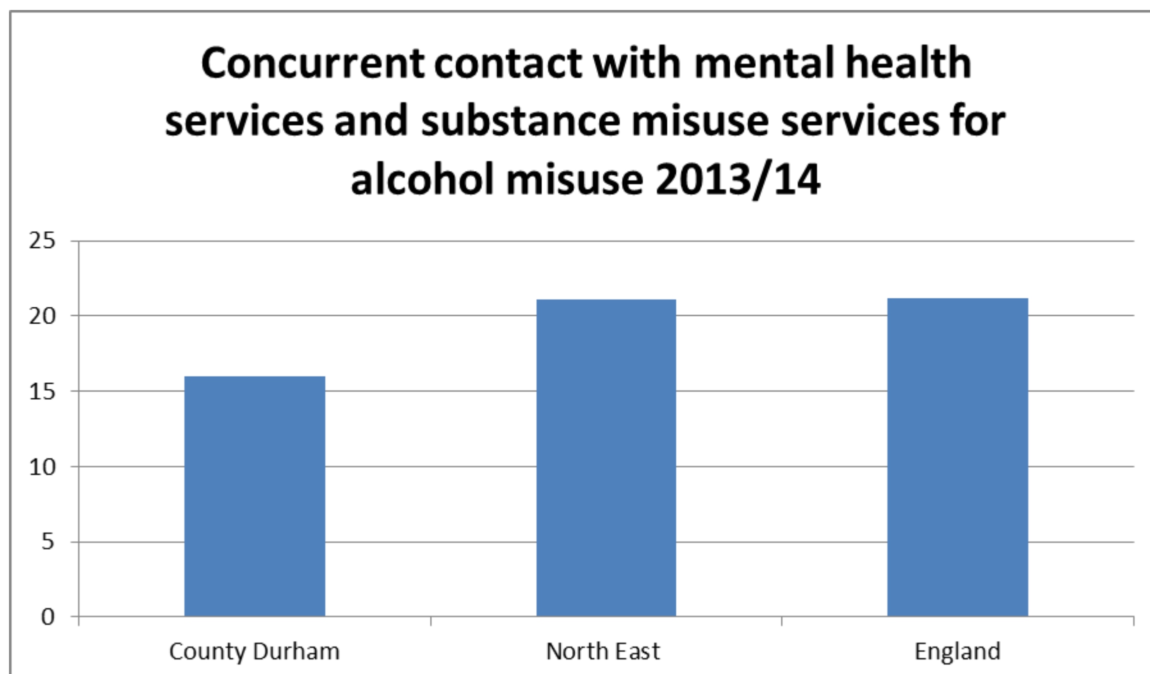
Graph1: Concurrent contact with mental health services and substance misuse services (Drug services) for those aged 18 to 75 years 1st April 2013 to 31st March 14.



Graph 2: shows the number of individuals who received treatment at a specialist alcohol misuse service and were currently in receipt of treatment from mental health services for a reason other than substance misuse at the time of assessment, as a proportion of all individuals in specialist alcohol misuse services.

County Durham has a lower proportion of people with concurrent contact with mental health services and substance misuse, alcohol services aged between 18 to 75 years during 2013/14 compared to North East and England estimates.

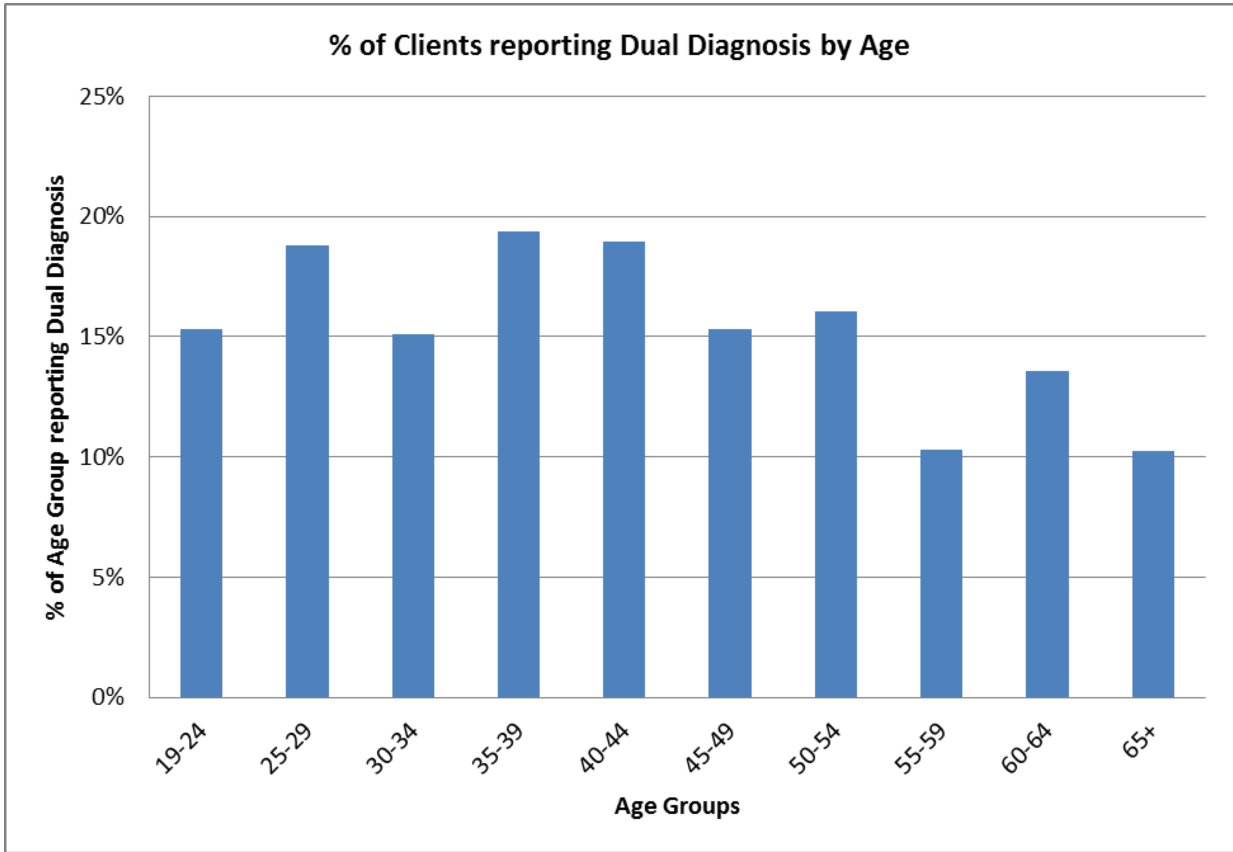
Graph 2: Concurrent contact with mental health services and substance misuse for alcohol misuse aged between 18 to 75 years 1st April 2013 to 31st March 20 2014.



County Durham Community Alcohol Service (CAS)
From 1st April 2013 to 31st March 2014, 1666 Individuals have been recorded as accessing treatment with the Community Alcohol Service in County Durham.

Of the 1666 individuals accessing CAS, 266 (16.0%) have reported dual needs. The gender split for reported dual needs within the Community Alcohol Service is 62.8% male and 37.2% female.

Graph 3: Percentage of clients reporting dual diagnosis into CAS by age 1st April 2013 to 31st March 2014.



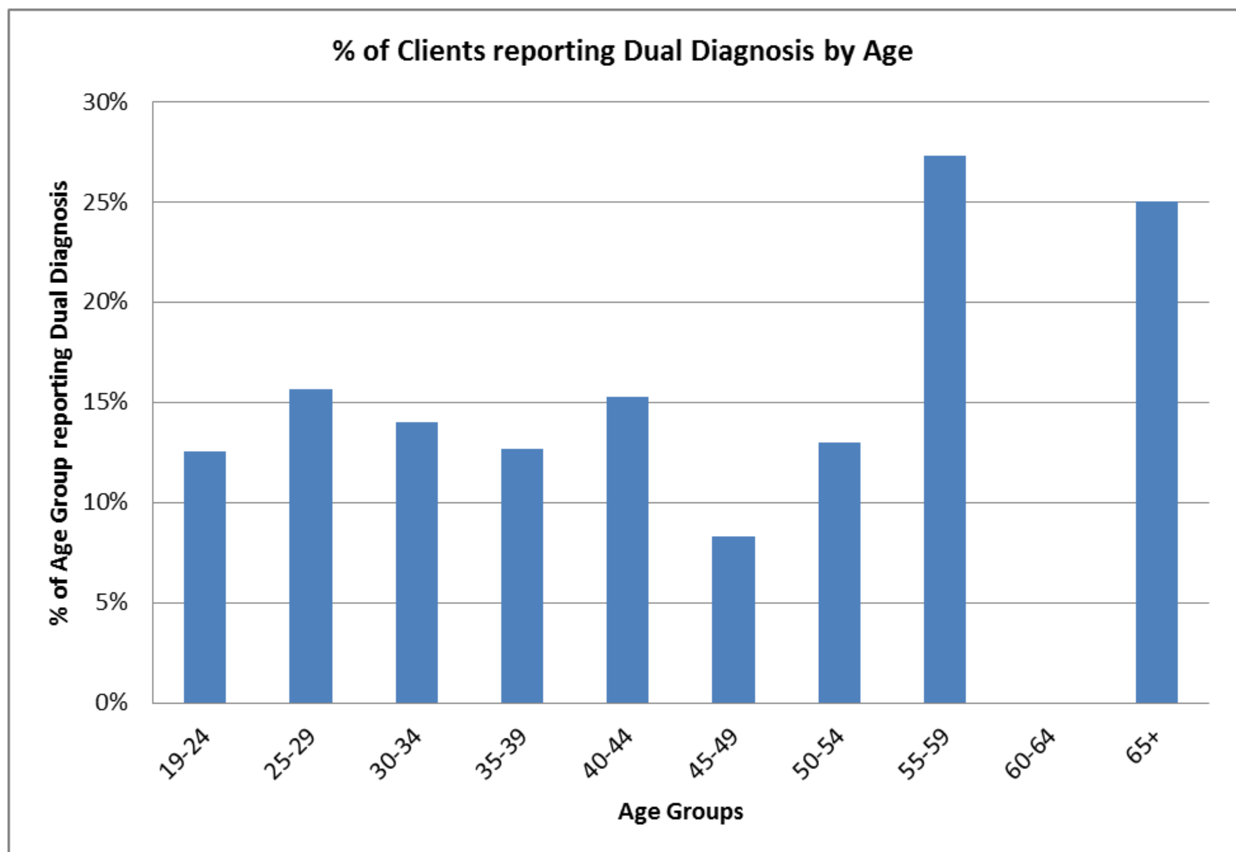
County Durham Drug Service (CDS)
From 1st April 2013 to 31st March 2014, 1981 Individuals have been recorded as accessing treatment with the Community Drug Service in County Durham.

Of the 1981 individuals accessing CDS, 271 (13.7%) have reported dual needs. The gender split for reported dual needs within the Community Drug Service is 67.9% male and 32.1% female.

Graph 4 shows that within age bands of 55-59 and 65+ years have a high percentage reported having dual needs.

- Within age band 55-59, 3 out of every 11 clients reported having dual needs.
- For individuals aged 65 and over, 1out of every 4 clients reported having dual needs.

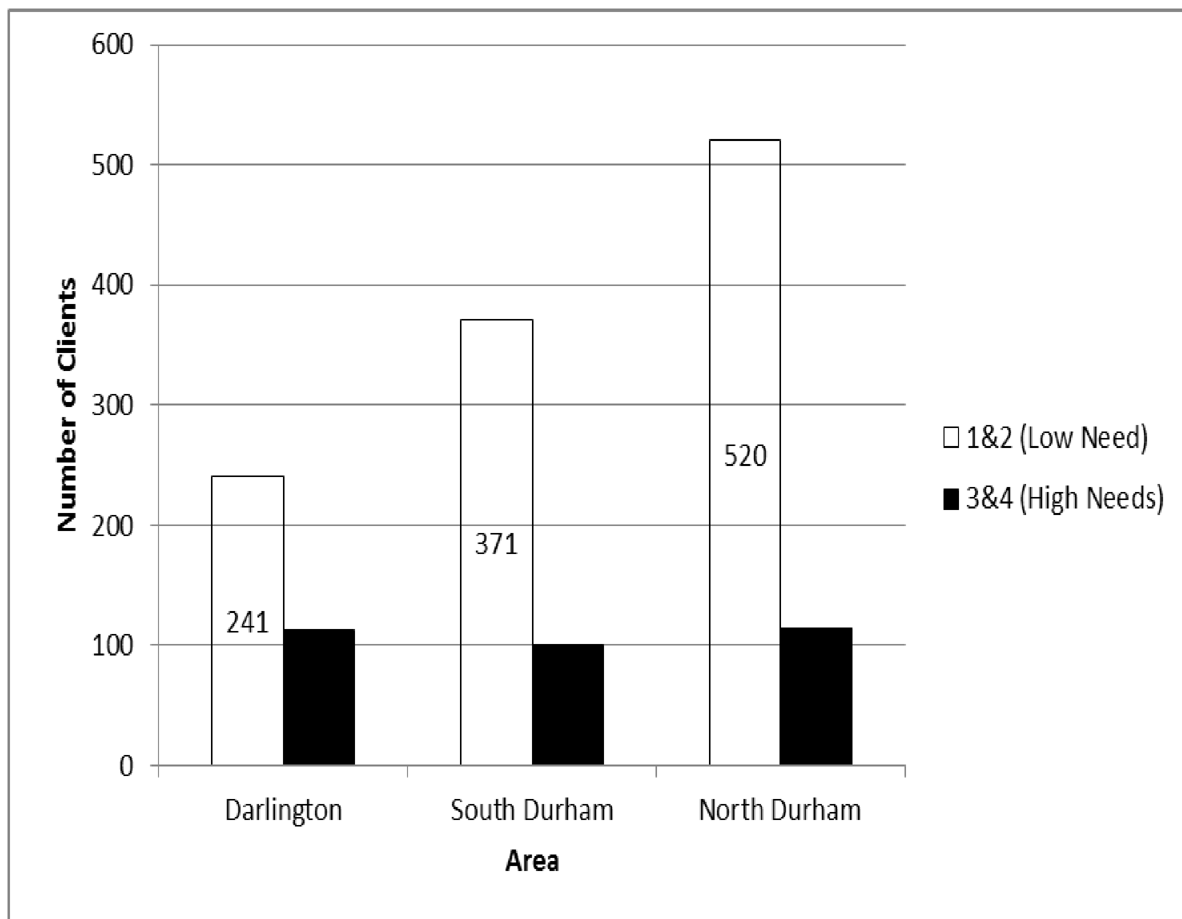
Graph 4: Percentage of clients reporting dual diagnosis to CDS by age (1st April 2013 to 31st March 2014)



Adult mental health services (Durham and Darlington)
Graph 5 shows the number of service users in adult inpatient and community mental health teams in Tees, Esk and Wear Valleys NHS Foundation Trust (TEWVFT) who have dual needs.

White indicates low level needs that are managed by staff within the individual clinical settings, accessing community substance misuse services for advice and support if necessary. Black indicates service users with higher level dual needs which require support and intervention from community substance misuse services as well as other community services depending on the level of complexity.

Graph 5: Individuals engaged with TEWV Mental Health Trust with dual needs 1st April 2012 to 31st March 2013



People with a personality Disorder
There is no local prevalence data for people with personality disorder. Service users with a Personality Disorder can be care coordinated within Community Mental Health Services. Research indicates that prevalence of personality disorder in clients attending substance misuse services is higher than expected. Proposals to improve provision within mainstream mental health services for those with personality disorder are compatible with this strategy and will reduce people with dual needs being excluded from mental health services.

Dementia
Dementia presents a significant and urgent challenge to health and social care in County Durham in terms of both numbers of people affected and costs.
It is a clinical syndrome characterised by a widespread loss of mental function, including memory loss, language impairment, disorientation, change in personality, self-neglect and behaviour which is out of character. One of the main causes of disability in later life, it has a huge impact on capacity for independent living.

Projections suggested that an estimated 6,153 people affected in 2011 could almost double to 10,951 by 2030 (POPPI, 2011). Typical of the situation across the country, the observed prevalence in GP surgeries, in other words the number of people registered with dementia, (around 3,000 in County Durham) is around half the expected prevalence. This has implications in terms of lack of treatment, care and unmet need.

There is limited local data available about people with dementia who are also engaged in substance misuse services. People with learning disabilities have an increased risk of developing dementia and usually develop the condition at a younger age. This is particularly true of people with Down's syndrome, one in three of whom will develop dementia in their 50s (The Rising Costs of dementia in the UK, Alzheimer's Society, 2007).

Criminal Justice System
Within County Durham and Darlington Constabulary records between 1st April 2012 and 31st March 2013 show 841 reported incidents who had mental ill-health and alcohol jointly identified and 193 that had mental ill-health and drugs jointly identified.

During 2012, there were around 16,400 detentions in County Durham custody suites. The 2013 Durham Police Custody Needs Assessment found that an arrest for a drug offence was a significant (independent) predictor of whether a person sees a Custody Care Practitioner or a Forensic Medical Examiner.

People in prison are more likely than the general population to have a mental illness. Some 90% of all prisoners are estimated to have a diagnosable mental illness (including personality disorder) and/or substance misuse. The Prison Reform Trust Bromley Briefing (2010) reports that 75% of all prisoners have a dual diagnosis. In prison 72% of men and 70% of women suffer from two or more mental illnesses compared to 5% of men and 2% of women in the general population.

A Prison Health Needs Assessment in County Durham (2009) identified that prison officers cited drug and alcohol problems as the most pressing health need of prisoners. However the risk assessments are based on self-report in an environment which may be conducive to under reporting of health problems which carry a stigma. Furthermore, detainees are often admitted under the influence of drugs and/or alcohol, making identifying other health problems problematic.

Between 1st April 2012 and 31st March 2013 there were 37 offenders identified as having dual needs in the Durham Tees Valley Probation Trust living in County Durham and Darlington. This is approximately 2% of the overall caseload and is likely to be an under-recording.

Veterans
Mental illness in serving and ex-service personnel is similar to the general population, with depression, anxiety and alcohol misuse being the most common problems. In particular those who leave services early and are young are up to three times more likely to take their own life than the general population.

Self-harm
Substance misuse has been identified as a significant factor in some incidents of self-harm, particularly in relation to use of alcohol. 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 for subsequent suicide.

The directly standardised rate for emergency hospital admissions for self- harm in County Durham 1st April 2012 to 31st March 2013 was significantly worse than the England average.
Data is available by Clinical Commissioning Group area compared to England rate:

- Durham, Dales, Easington and Sedgefield Clinical Commissioning Group 316 hospital admissions for self harm per 100,000 population.
- North Durham Clinical Commissioning Group 217 hospital admissions for self harm per 100,000 population.
- England 191 hospital admissions for self harm per 100,000 population.

Suicide
Substance misuse increases the risk of suicide attempt and death by suicide. The risk associated for mixed intravenous drug use is greater than that for alcohol misuse.

A suicide audit undertaken in County Durham for the period 2005-2012 found that 81% of those who took their own life were male, with a peak age of 40-49 years. 62.8% were divorced, 32.3% lived alone and 30% were found to be unemployed. A significant number of those who took their own life were found to have diagnosed mental health problems (58.9%). Furthermore, 30% were recorded as alcohol dependent, 13% were recorded as users of illicit drugs and 39.2% had a history of self-harm.

Eating disorders
There is no local prevalence data for eating disorders. Figures from NICE suggest that 1.6 million people in the UK are affected by an eating disorder. Health & Social Care Information Centre (HSCIC) data show that hospitals recorded 2,290 eating disorder admissions in the 12 months to June 2012; a 16% increase on the previous 12 month period. Women accounted for 91% (2,080) of all eating disorder admissions, compared to 88% (1,740) in the previous 12 months. Regionally, the highest number of eating disorder admissions by population size occurred in the North East at 5.8 per 100,000 (150 admissions).

Eating disorders often co-exist or co-present alongside mental ill-health or substance misuse. Individuals with an eating disorder are highly vulnerable in developing substance misuse issues. The national Eating Disorder Association identifies self harming behaviour, drug addiction, alcohol abuse and tranquilliser addiction as being consequences of an eating disorder.

Lesbian, gay, bisexual and transgender community (LGBT)
The National Lesbian, Gay, Bi-sexual (LGB) Drug & Alcohol Database for England reports high levels of binge drinking amongst this community and a quarter of the sample showing signs of alcohol or drug dependency. Currently local data on dual needs in the LGBT community is not systematically collected.

Voluntary Sector
There are a wide range of services within the voluntary sector, across County Durham that provide services to people with Dual Diagnosis. Services are available to people with dual needs, ranging from counselling, group therapy, activities, training and one to one support. Additionally from the range of supported accommodation provision within County Durham between April 2012- March 2013, 147 clients recorded with dual needs were supported.

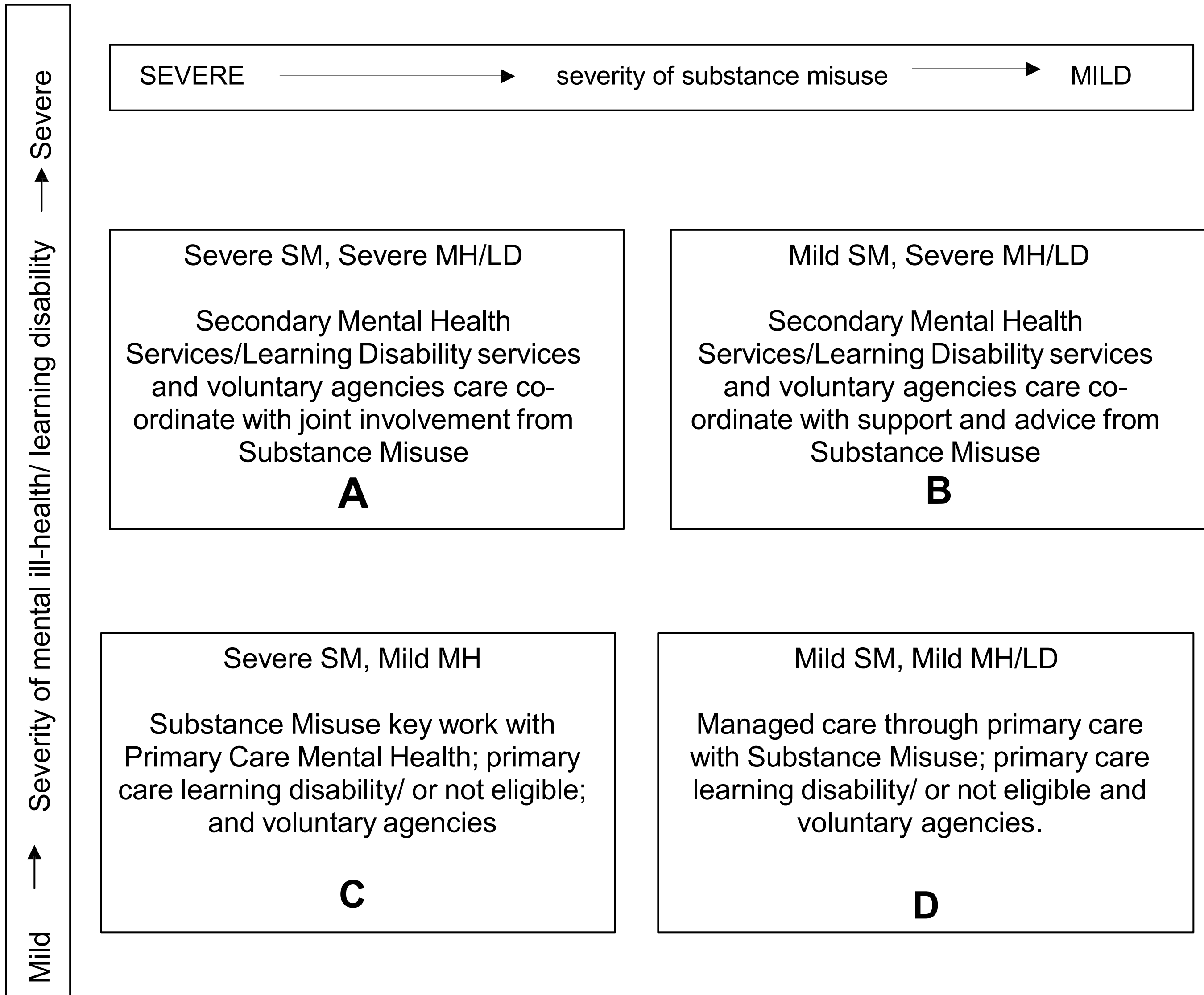
Carers
In County Durham there are over 57,000 carers. Durham County Carers Support has over 11,000 carers registered for support.

'Liberty from Addiction' support families living with substance misuse in County Durham. Between 1st January 2013 to 31st March 2013 the service supported 35 carers looking after a family member with a both a mental ill-health and substance misuse and 19 carers looking after a family member with both a learning disability and substance misuse.

7. A needs led service provision framework

This framework provides guidance for coordinating the care of individuals based upon severity of users need rather than diagnosis. An individual's most prevalent need determines which agency takes the lead in a joint care plan. **A commitment has been made that any individual whose first contact with services is supported and safely handed over to the appropriate lead agency rather than simply signposting to other services.**

Collaborative dual needs working matrix



8. Where are we now?

The County Durham Protocol for Working Together (April 2012) provides a framework that sets out the expectation by all agencies that their staff will work collaboratively in the direct provision of services to individuals (including both adults and children) and family units. Adults and children should be assessed for services in a holistic manner and not in isolation from their family or social context. The protocol is applicable to all health, social care, educational and community statutory, private and voluntary sector services and organisations working in County Durham with children, adults and all vulnerable members of society.

Examples of good practice in County Durham

- A dedicated Dual Diagnosis posts exist within Tees Esk & Wear Valleys NHS Foundation Trust (TEWVFT) along with a local practitioner network who meet four times a year.
- Significant investment into recovery orientated substance misuse and mental health services.
- Care and recovery co-ordination between mental health and substance misuse is now well established.
- Liaison and Diversion service is available within Durham Constabulary. This service will assess and offer support to all individuals coming into contact with criminal justice system.

Service models

Those with dual needs report that they receive services delivered in a 'serial' or 'parallel' way. 'Serial' refers to the person having to resolve their substance misuse before mental health services become involved. 'Parallel' refers to mental health and/or learning disability and substance use services providing care at the same time, yet not collaborating effectively. The Collaborative Dual Needs working matrix refers to services working together, each bringing their specialised skills to implementing a single plan of care and providing mutual staff support. Services within County Durham are committed to working in a collaborative model.

Culture

There is currently a paradigm shift towards recovery orientated drug, alcohol and mental health services. Individuals with dual needs sometimes experience anxiety and difficulties when accessing recovery orientated treatment settings such as self-help groups and there is a risk that people with a dual needs miss out on essential elements of care. It is therefore necessary that the needs of people, their families and carers are taken into account whenever recovery orientated treatment services are developed. Staff experience, beliefs and values are challenged in a way that ensures an individual's needs are central to care and support and that this delivery is flexible.

Dual Diagnosis policy and guidelines (Department of Health, 2002; NIMHE, 2007) promote the development of local and regional networks as an important part of good practice for people with dual needs, their families and carers and that strong collaborative working between agencies and opportunities for shared learning and networking is required.

The value that the independent, voluntary and community sector bring are crucial in developing a Dual Needs network. There is much to be gained from collaboration, sharing of resources and ideas as well as the opportunity to participate in peer support programmes.

9. Commissioning arrangements

As a result of the Health and Social Care Act (2012), the commissioning arrangements have changed significantly. It is therefore critical that joint commissioning opportunities and pathway design is undertaken collaboratively between commissioners and providers. County Durham Mental Health and Learning Disability Joint Commissioning Group is established to progress implementation of County Durham Mental Health Framework which includes the Dual Needs Strategy.

10. User & carer involvement

Service users, their families and carers have a lot to contribute to service development, including peer support and staff training. This strategy will work towards strengthening this relationship creating opportunities for meaningful engagement.

11. Equality and diversity

Services recognise that some groups with diverse needs have problems with certain addictions and can experience difficulties in accessing treatment services. Over recent years access to services has been greatly improved e.g. by women only clinics or initiatives that work with Black and Minority Ethnic (BME) or lesbian, gay, bisexual, and transgender community (LGBT) communities.

Commissioners and providers continue to stay committed to fair and equal access for all its diverse populations regardless of:

- age,
- gender,
- sexual orientation,
- race,
- gender reassignment,
- religion and belief,
- disability,
- marriage and civil partnership; and
- pregnancy and maternity

12. Governance - Strategic framework performance measures

The performance management framework aligns to the priorities identified within No Health Without Mental Health (2012). The Dual Needs Strategy is accountable to the County Durham Mental Health Partnership Board (appendix 3). The Dual Needs Strategy Implementation Group will develop and monitor a local action plan and is accountable to the No Health Without Mental Health implementation group. Any key issues will be

escalated to the County Durham Mental Health Partnership Board/County Durham Learning Disability/Mental Health Joint Commissioning Group

Progress on delivery of the strategic objectives and action plan will also be reported to the Health and Wellbeing Board.

A performance framework is under development. In year one of strategy implementation process measures will be used to ensure there is a better understanding of the level of need. Key performance indicators will include:

- Numbers of people in substance misuse treatment services recorded with dual needs.
- Numbers of people in acute mental health services recorded with needs.
- Number of people in community based mental health services recorded with dual needs.
- Number of people in older people mental health services recorded with dual needs.
- Number of people in primary care recorded with dual needs.
- Number of people accessing learning disability services with substance misuse.
- Number of offenders (both community and prison) who are recorded as having dual needs.
- Number of carers (including young carers) receiving a carers assessment in relation to caring for an individual with dual needs.
- Numbers of staff trained in working with individuals with dual needs their families and carers.
- Numbers of clients who haven't had a formal diagnosis but are experiencing dual needs.

Appendix 1

Glossary of terms/Abbreviations

A&E or ED	Accident and Emergency Department or Emergency Department of a hospital
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
Clinical Commissioning Groups (CCGs)	Groups of GP practices, including other health professionals who will commission the majority of NHS services for patients
CMHT	Community Mental Health Teams
CPA	Care Programme Approach
CSIP	Care Services Improvement Partnership
DART	Drug and Alcohol Recovery Teams
DCC	Durham County Council
Diagnosis	The identification of the nature of an illness or other problem by examination of the symptoms.
DoH	Department of Health
GP	General practitioner also known as family doctors who provide primary care
HSCIC	Health and Social Care Information Centre
Joint Strategic Needs Assessment (JSNA)	Health and Social Care Act 2012 states the purpose of the JSNA is a statistical profile used to improve the health and wellbeing of the local community and reduce inequalities for all ages
Learning Disability	Learning disability is defined as a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning) which started before adulthood with a lasting effect on development. This definition encompasses people with a broad range of disabilities, including mild, moderate, severe and profound learning disabilities.
LGBT	Lesbian, gay, bisexual and transgender

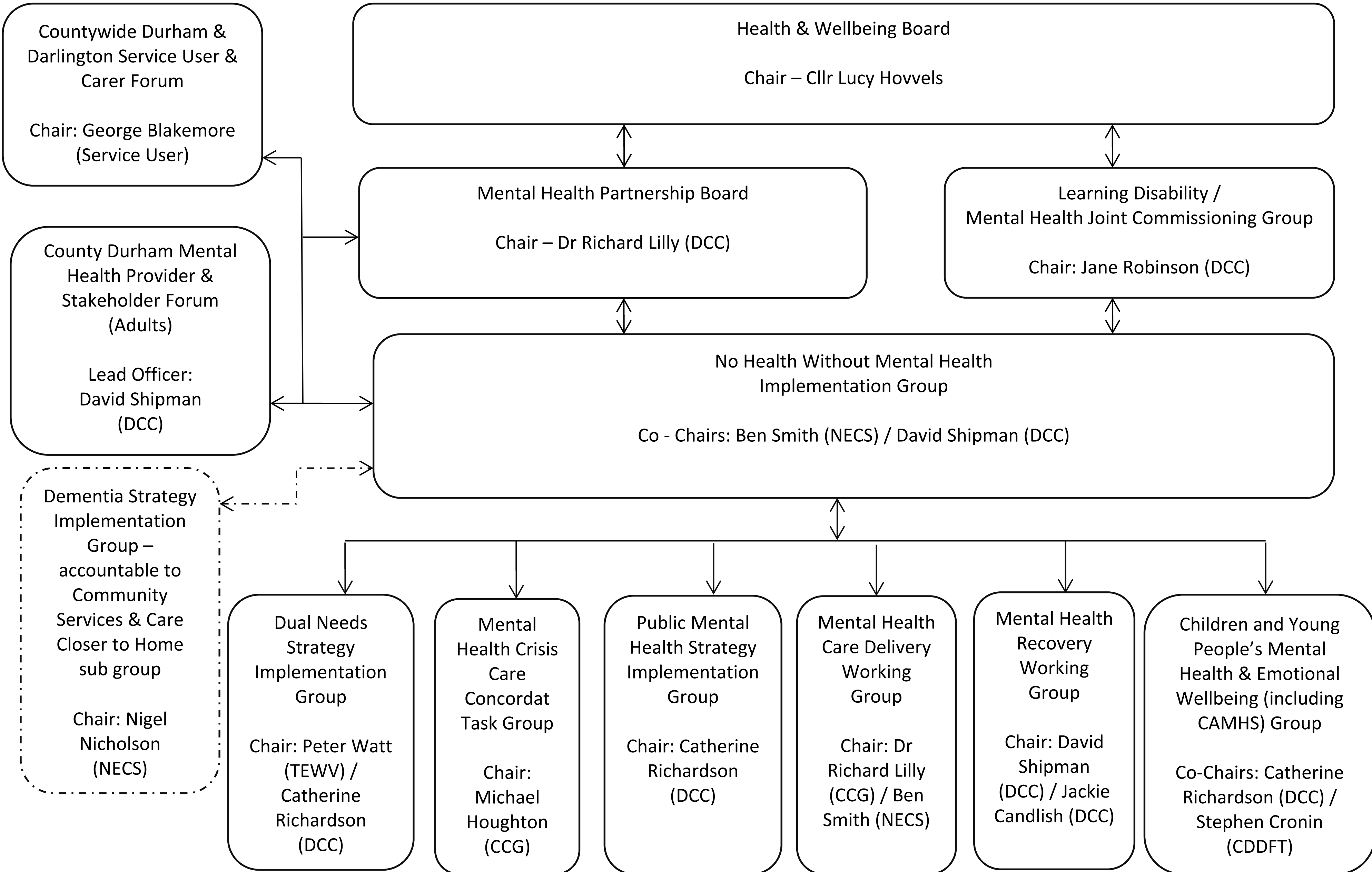
Mental and Behavioural Disorders	Mental and behavioural disorders includes all mental disorders, dementia, eating disorders, personality disorders, autism, aspergers and conduct disorders.
NICE	National Institute of Clinical Excellence
NIMHE	National Institute for Mental Health in England
POPPIE	The patient information system used by Adult Community Substance Misuse Services in County Durham.
SCIE	Social Care Institute for Excellence
Self-harm	Self-harm is when somebody intentionally damages or injures their body. It is a way of coping with or expressing overwhelming emotional distress.
Substance Misuse	Substance misuse is defined as intoxication by, or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal (including alcohol) and illegal drugs.(NICE 2007)
TEWV NHS FT	Tees Esk and Wear Valleys NHS Foundation Trust

Appendix 2

NICE guidance used to inform this strategy:-

CG 16 – Self Harm
CG 26 – Post-traumatic stress disorder (PTSD)
CG 51 – Drug misuse: Psychosocial interventions
CG 52 – Drug misuse: opioid detoxification
CG 115 – Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
CG 100 – Alcohol- use disorders: Diagnosis and clinical management of alcohol related physical complications
CG 120 – Psychosis with coexisting substance misuse
CG 133 – Self harm (longer term management)
CG 78 – Borderline Personality Disorder: Treatment and management
CG 77 – Anti social Personality Disorder: treatment, management and prevention.

Appendix 3



Health and Wellbeing Board

14 May 2015

Feedback from County Durham's Health and Wellbeing Peer Challenge

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

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Purpose of the Report

1. The purpose of this report is to provide an update to the Health and Wellbeing Board on the Local Government Association's Health and Wellbeing Peer Challenge in County Durham.

Background

2. To support the implementation of Health and Wellbeing Boards, the Department of Health funded the Local Government Association (LGA) to develop a Health and Wellbeing System Improvement Programme. The Peer Challenge is part of the wider offer of the Health and Wellbeing System Improvement Programme.

County Durham's Health and Wellbeing Peer Challenge

3. County Durham's Health and Wellbeing Peer Challenge took place between Tuesday 24th and Friday 27th February. In four days the peer challenge team met with 6 Councillors, 66 staff and 40 partners, through 36 interviews, focus groups and were in attendance at the Health and Wellbeing Board (HWB) meeting in January 2015.

4. The Peer Challenge consisted of five headline questions:

   - Is there a clear and appropriate and achievable approach to improving the health and wellbeing of local residents?

   - Is the Health & Wellbeing Board at the heart of an effective governance system? Does leadership work well across the local system?

   - Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?

   - Are there effective arrangements for evaluating impacts of the Health and Wellbeing Strategy?

- Are there effective arrangements for ensuring accountability to the public?

5. The feedback report from the Peer Team is attached as Appendix 2, with a summary of the key areas outlined below.

6. Feedback from the peer challenge stated that County Durham's Health and Wellbeing Board is in a very strong place. Several partner organisations who attend multiple Health and Wellbeing Boards said it was, "the best Health and Wellbeing Board in the region", if not in the North.

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

8. The Peer Challenge team stated that the strength of partnership relationships was striking and they are clearly mature. 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.

9. The team commented that distributed leadership had developed from well-established relationships, trust and well managed organisations. An example of this is the leadership of the Mental Health Partnership Board with a CCG nominated GP chair.

10. 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 Health and Wellbeing agenda. This is particularly notable as the report states that the 'voice of the child' is not well developed across the country.

11. Area Action Partnerships were described in the final presentation by the lead peer Andrew Kerr, Chief Executive of Cornwall Council as "one of the best forms of localism I have seen in a long time". The report states that they clearly link to the Health and Wellbeing Board and allow for service models to be locally determined.

12. Involving providers as members of the Health and Wellbeing Board was also commended as this is not uniform across other Health and Wellbeing Boards.

13. The team state that there is a good performance management framework which is very clear on the delivery of priorities and that direction of travel is good.

14. The report states that there is a strong Public Health Team which is purposefully led and well-resourced compared with others nationally. The 'Wellbeing for Life' Service was highlighted for its innovative, evidence based model that involves acute and voluntary and community sector services. The

Healthy Weight Alliance was commended for its simple structures and relationship with the Health and Wellbeing Board and it was suggested that this was a model that could be repeated for other Joint Health and Wellbeing Outcomes.

15. The clear governance arrangement between the HWB and Scrutiny was identified as among the best in the country.

16. 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.

17. The peer challenge team identified a number of areas for consideration, including:

    - 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 e.g. the voluntary and community sector, 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.

18. The peer challenge report will be published on the national Local Government Association website.

Next Steps

19. An action plan will be developed to take forward any areas for consideration by the Health and Wellbeing Board and it is proposed that this is considered as part of a wider Health and Wellbeing Board Development session to take place in July 2015.

Recommendations

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

    - Note 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.

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

Appendix 1 - Implications

Finance
No implications

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
No implications

Disability Issues
No implications

Legal Implication
No implications

APPENDIX 2

Local Government Association

George Garlick
Chief Executive
Durham County Council
County Hall
Durham
DH1 5NB
cc: Cllr. Lucy Hovvels

12th March 2015

Dear George

Health and Wellbeing peer challenge 24 – 27 February 2015

On behalf of the peer challenge team, I would like to say what a pleasure and privilege it was to be invited into Durham County Council to deliver a health and wellbeing peer challenge as part of the LGA's health and wellbeing system improvement programme. This programme is based on the principles of sector led improvement, i.e. that health and wellbeing boards (HWBs) will be confident in their system wide strategic leadership role, have the capability to deliver transformational change and through the development of effective strategies, drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

Peer challenges are delivered by experienced elected member and officer peers. The make-up of the peer team reflected your requirements and the focus of the peer challenge. Peers were selected on the basis of their relevant experience and expertise and agreed with you. The peers who delivered the peer challenge in Durham were:

- Andrew Kerr – Chief Executive Cornwall Council, Lead Peer
- Councillor Alex Norris – Cabinet Member for Health and Social Care Nottingham City Council and Chair Nottingham HWB
- Dr Anita Parkin – Director of Public Health, Bradford Metropolitan Council
- Katie Summers - Director of Operations, Wokingham CCG
- Terry Rich – LGA Regional Adults Improvement Adviser (East of England & East Midlands)
- Caroline Bosdet – Challenge Manager, LGA

Scope and focus of the peer challenge

The LGA peer review team consisted of 7 team members with a breadth of experience and professional backgrounds. In four days the peer challenge team met with 6 Councillors, 66 staff and 40 partners, through 36 interviews, focus groups and were in attendance at the HWB.

The purpose of the health and wellbeing peer challenge is to support HWBs and councils to implement their statutory responsibilities in health, by way of a systematic challenge through sector peers in order to improve local practice

Our framework for the challenge consisted of five headline questions:

1. Is there a clear and appropriate and achievable approach to improving the health and wellbeing of local residents?

2. Is the Health & Wellbeing Board at the heart of an effective governance system? Does leadership work well across the local system?

3. Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?

4. Are there effective arrangements for evaluating impacts of the Health and Wellbeing Strategy?

5. Are there effective arrangements for ensuring accountability to the public?

This letter provides a summary of the peer challenge team's findings. It builds on the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the peer challenge team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this will help provide recognition of the progress Durham County Council and its HWB have made whilst stimulating debate and thinking about future challenges.

It needs to be stressed that Durham HWB is in a very strong place. Several partner organisations who attend multiple HWBs said it was, "the best HWB in the region", if not in the north. In terms of the very recent national research commissioned by the LGA on the state of play with HWBs, Durham is clearly at the forefront of HWB progress and impact nationally. All areas for considerable in the report need to be put into this context.

1. Headline messages

Strengths

- Strong well-established partnership relationships
- Distributed leadership
- Shared agenda
- Community engagement – Big Tent, Learning Difficulties Forum – feeding into the work of the HWB
- 'Voice of the child' influences HWB agenda
- Area Action Partnerships
- Engagement of providers
- Focus on health inequalities
- Effective systems and clear linkages, in most areas, supporting the HWB
- Sound performance
- Partners are committed to the HWB
- Highly regarded officers
- Strong Public Health Team
- Evidence based approach
- Innovative approach e.g. 'Wellbeing for Life' initiative and Healthy Weight Alliance

The strength of your partnership relationships was striking and they are clearly mature. The system of leadership the HWB operates, the peer challenge team described as, 'distributed

leadership'. This has obviously developed from your well-established relationships, trust and well managed organisations. Partners across the system are evidently very committed to the HWB. There is a genuinely shared agenda with a clear focus on health inequalities.

The peer challenge team were impressed by your community engagement and how this influences the work of the HWB e.g. Big Tent, learning difficulties. How the 'voice of the child' influences the HWB agenda is also notable as this is not well developed across the country.

The Area Action Partnerships are a major strength. They are well resourced and clearly link into the HWB. They allow for local determination of services and feed up into strategic discussions.

The engagement of acute providers is also worthy of note as this is not uniform across HWBs nationally. Durham embraced the value of having providers on the HWB from the start taking a strategic view.

Your systems and processes are effective and there are clear linkages (in most areas). Your performance is sound and your direction of travel positive. Your evidence based approach is well-embedded.

Durham County Council has very highly regarded senior officers and a very strong Public Health Team.

We saw examples of innovation most notably the 'Wellbeing for Life' initiative and the Healthy Weight Alliance.

Areas for consideration

- Can you clearly articulate the 'how' and the' what' of your Vision?
- You are good - do you want to be excellent? Ambition?
- Durham £ - greater integration and joint commissioning
- Sustainable leadership
- Can you demonstrate a causal link between activity and outcome?
- Does the data drive priorities?
- There has been considerable change – need for sustainability?
- Opportunity to make closer links with housing and maximise their contribution to health inequality and wider determinants
- Is the balance of the HWB membership right?
- Consider reviewing your supporting governance and engagement structures
- Are you considering working across HWB boundaries?

In the on-site feedback, whilst reflecting that everybody is clear on the overarching Vision, we challenged you to think about how clear your articulation of what the Vision actually means for residents of Durham, what would be different and, leading on from that, how you would get there – what is the Durham way? You are confident that you can answer this challenge through the strategic actions and specific outcomes and measures in the Joint Health and Wellbeing Strategy and the Delivery Plan, which provides the 'how' of the Vision. The underpinning performance management framework identifies interventions that are making a difference to residents in Durham's complex geography e.g. rurality and deprivation.

Furthermore, community engagement through 'Big Tent', for example, ensures residents are involved in decisions on the 'how'; of the Vision.

Accepting that you are high performing HWB do you want to stretch your ambition?

"The strengths of our partnership arrangements are that we don't need to be over ambitious." (Interviewee).

We acknowledge the great deal of work already undertaken towards integrated working through joint commissioning strategies such as; Dementia Strategy, End of Life Care Strategy and the Children and Adolescent Mental Health Interim Strategy. Perhaps the strengths of the partnership and the maturity of the HWB provides the ideal preconditions for Durham to be exploring how to push boundaries and look for more radical options of extending health and social care integration such as a Durham commissioning pound.

Given the complexity of the area, a concern for the peer challenge team was if you had considered how to make your HWB governance system and its support sustainable. How would it survive if a few key individuals were removed? Would the system sustain itself? Are you consciously developing new talent and preparing them for approaching new challenges? We acknowledge that your style of distributed leadership does mitigate against this risk e.g. sub-groups chaired by partners from across the spectrum of health and social care including GPs, CCG colleagues and council officers. The annual review of governance arrangements will provide some assurance that the arrangements remain fit for purpose.

Demonstrating a causal link between activity and outcome is very challenging. Have you considered this?

You have a wealth of expertise and data and could have more confidence and boldness to use it to drive very local prioritisation of health inequalities and associated action and intervention. The considerable epidemiological and knowledge and intelligence skills of the Public Health team compliment an already robust performance management function in the council.

We are aware that you have been through considerable change e.g. moving to a unitary arrangement and ongoing Council budget reductions to name but a few. Are you looking for a period of relative stability to build sustainability in what you have achieved? There was a mixed message from those interviewees on your level of ambition.

There is a good opportunity to make more explicit links with housing and ensure you maximise their contribution to health inequality and the wider determinants of health.

The HWB clearly works for Durham but the peer challenge team reflected on the balance of the membership, specifically; would the voluntary sector voice give a more rounded perspective? Is wellbeing sufficiently covered? e.g. housing

You have a very comprehensive and broad supporting governance structure where, in most cases, the linkages are very clear to the HWB. It may be sensible to give some thought to the definition of the role of the HWB in this complex system.

We are aware of the regional working and the networks that you engage with but reflected on whether you work strategically across the health economy when looking at service re-design and patient flows and whether this necessitates more dialogue with relevant HWBs? An outward-looking perspective would enhance an already strong system.

2. **Is there a clear and appropriate and achievable approach to improving the health and wellbeing of local residents?**

Strengths

- Whole system approach
- Engagement and HWB membership is inclusive!
- Health and Wellbeing Strategy is a well embedded and influential document
- Very clear links from the JSNA to the Strategy
- Very clear performance management of priorities and Strategy delivery
- The Strategy emphasises health inequalities
- CYP issues are reflected in the HWB agenda and influence Strategy development e.g. Self-harm and mental health
- IC PLUS is a positive initiative for sustaining services and avoiding duplication
- Area Action Partnerships annual profile influences planning
- Public Health are integrated into the Council
- Consistency between LSCB and HWB priorities
- Public Health moving away from single issues to holistic approaches for individuals, families and communities
- Positive partnership approach to BCF process
- EOL – clear approach and focus on improvement through an integrated model
- Drug and alcohol LEAN approach to commissioning new service – new recovery based model
- Innovative model for Wellbeing for Life – strong evidence base and consortium
- Clear approach to Healthy Weight – now need to implement and embed

Partners articulated “a whole systems approach”, where “achieving outcomes is not the job of one organisation”. This is clearly a well-embedded way of working.

What characterises Durham is how inclusive you are in terms of your very strong community engagement. You are also inclusive in the memberships of the HWB, e.g. providers, and you are also very comfortable with not having a Council majority on the HWB. This shows a confidence in your approach to partnerships.

The Health and Wellbeing Strategy is clearly owned and valued by partners and has influence. The Joint Strategic Needs Assessment (JSNA) underpins the Strategy and there is a very clear understanding of the needs of the population and the complex geography. The Strategy emphasises health inequalities. There is a good performance management framework which is very clear on the delivery of priorities and the Strategy. These are very firm foundations.

There is a clear read across from the Local Safeguarding Children Board (LCSB) and the Children and Families Partnership to the HWB. It is a major strength that children and young people’s issues have a very strong join up and are high on the HWB agenda and influence the development of Strategy e.g. self-harm and mental health. These were issues brought forward through Investing in Children and their engagement activities.

The BCF was seen as a positive partnership approach overseen by the HWB. Intermediate Care Plus (ICPLUS) is presented as a significant BCF success and brings together a number

of services and initiatives under a single umbrella. The benefits are seen as securing longer term funding for services that already existed and are operating and avoiding duplication. Each element is both valid and positive but would be seen in the majority of health and social care economies – e.g. extended intermediate care, step up/down beds, enhancing re-ablement services.

The Area Action Partnerships, which are a great strength in the Durham system, are closely linked to strategic planning through their annual profiles. This allows for service models to be locally determined.

There is clear evidence that Public Health is well integrated in to the Council and is starting to impact across other departments such as; leisure, transport and there is potential to go further in areas such as planning and housing. The peer challenge team were told; "Public Health join up the front line". There is also a more creative and holistic approach to service delivery evidenced from the move away from single issue contracts towards wellbeing.

There are several impressive specific examples of the strength of your approach;

There is a clear approach to End of Life (EOL) care. Following a population needs assessment and a NICE Review there has been investment and a focus on improvement through an integrated model.

The LEAN approach to Drugs and Alcohol Services involved a two year review and user consultation. This resulted in a new recovery based model.

'Wellbeing for Life' is a great example of innovation. This is evidence based using the health trainer model and deals with the whole person's needs and supporting and signposting them through the system. Delivery is through a consortium including voluntary sector and acute providers which has great potential.

The peer challenge team were impressed by the Healthy Weight Alliance. It has simple structures and a simple relationship to the HWB. This is a model that could be repeated for other Health and Wellbeing Strategy themes.

Areas for consideration

- The Vision needs clarity and the 'how' could be clearer
- Opportunity to make clear links to housing and the new Housing Strategy
- Low risk approach to the scope of the BCF
- What is the ambition for ICPLUS and service integration e.g. single point of contact?

As noted in the Headline Messages section, we challenged you on whether the Vision could be clearer, what will be different for residents of Durham? You are confident that through your engagement and robust processes you are able to do this. Another example of what will be different for residents is the move from single issue Public Health contracts towards wellbeing, where the specific outcomes clearly demonstrate what will be different for people in Durham.

There is more opportunity to be exploited by strengthening the HWB's links to housing and the wider determinants of health. Unitary Council status has removed a layer of complexity in terms of this service. Both the current stock transfer and development of the Housing Strategy

are timely. On a specific point There is an acknowledged need to do more in relation to accommodation needs for people with or recovering from mental ill health.
The Peer Challenge Team saw a relatively cautious approach to the scope of the BCF. . From your point of view this was a balanced and proportionate approach given reasonable concerns about increased activity in the Foundation Trusts. The funding available through the BCF enabled Durham to push forward with ICPLUS at a fast pace. The positive contribution of ICPLUS was highlighted to the peer Challenge Team and there are significant opportunities to enhance the ICPLUS model and it is envisaged that consideration will be given in the future to further integration of referral functions. A clear "integrated pathway" that existed as a consequence of ICPLUS could not be described to the Peer Challenge Team. That having been said, there is clearly great potential for this initiative, and the input of a Programme Manager for BCF should support performance management and ensure modifications and enhancements are understood and implemented.

There was limited evidence of integration with the acute trust discharge teams and presence of Durham County Council social workers within the Acute hospitals e.g. there are adult social workers at North Tees General Hospital and work is currently underway to enhance the role and function of University Hospital North Durham Discharge Management Teams with social worker presence.

The CREST (access to a geriatrician assessment direct from A&E) and COPE (a GP managed older people assessment facility) are both "under the umbrella" but remain distinct with their own referral pathways. You are reviewing the effectiveness of CREST and OPAS, giving consideration to them coming within the remit of intermediate care. You are also planning to review the pathways between COPE, CREST, OPAS and the Multi-Disciplinary Team to identify where improved flows can be developed. Going forward there is a clear need for a more fundamental look at the model of integration between mainstream health and social care teams in County Durham, so that the benefits sought via ICPLUS can be seen as part of the mainstream

3. Is the Health and Wellbeing Board at the heart of an effective governance system? Does leadership work well across the local system?

Strengths

- Distributed leadership model
- Very strong relationships and well embedded partnership architecture
- Providers on the HWB have been embraced from the start
- Very clear strong process supporting the HWB – Strategy, action plan and monitoring
- The Integration Board is a forum for stakeholders – good un-blocker and where 'honest conversations' can take place
- 14 Area Action partnerships – funding, local decision making, well supported and linked into the HWB
- HWB deals with the wider strategic agenda and has a co-ordinating role
- Safeguarding Framework describes the link between the safeguarding boards and the HWB
- Clear governance between Scrutiny and HWB

Durham HWB clearly demonstrate consistent and effective distributed leadership, with both chief officers, members and management team sharing the skills and attributes to deliver the

objectives and outcomes of the Health and Wellbeing Strategy. The HWB clearly presents leadership responsibilities that are dissociated from formal organisational roles, and the action and influence of people at all levels is recognised as integral to the overall direction and functioning of the board. You are comfortable with the Council not having a majority and the balance of officer and democratic leadership is clear.

An example of this style of leadership is the leadership of the Mental Health Partnership. This sits with a CCG nominated GP was seen as a positive development and has added strength to previous partnership arrangements. There is effective working between the Durham County Council Mental Health commissioning posts and the NECSU officer. Partners appear positive with the current arrangements and say that the HWB has enabled Mental Health to get "a voice to the top" The Police particularly are positive about both co-operation strategically and practically.

It was strongly evident that the partnership architecture is well-embedded and partnership relationships strong. An example of this is the engagement of providers on the HWB. They were welcomed from the beginning. This is certainly not the case in many other HWBs. This demonstrates a mature approach. Providers value their inclusion and the opportunity to contribute to the strategic debates. There is strong commitment from providers to attend and contribute.

Your underpinning processes are clear and well- established; strategy, action plans and monitoring. This contributes to effective governance.

There is a belief at management level that blockages in the system could be removed by escalating them to the Integration Board. Partners find it a useful forum to have 'honest conversations'. The group appears to contribute well to the effectiveness of the HWB.

There was universal belief that the AAPs were a bold and useful structure for devolving power from what is a big Unitary Council area down to neighbourhood level. This is popular and effective, with health and wellbeing forming a priority for 10 of 14 AAPs. This is a very good model and there is scope in our view to put even more work out at this level.
The HWB is clearly working at an appropriate strategic level. It appears to be effective in co-ordinating and linking strategy and priorities.

There is a Safeguarding Framework which describes the relationship between the HWB and the LSCB and Safeguarding Adults Board (SAB). This properly makes the point that "the LSCB should not be subordinate to or be subsumed within local structure…." Many areas have developed a specific protocol governing the relationship between LSCB/SAB/children's partnership and HWB and describe the way in which each are required to take account of the responsibilities of the other. Many provide for the Chair of the LSCB / SAB to be a member or co-opted member of the HWB to ensure that at strategic points they have a right of audience to ensure that safeguarding issues are appropriately reflected on the work of the board. An example of this is on the issue of Child Sexual Exploitation which is properly within the remit of the LSCB but requires a response from all areas of the Council/NHS and HWB partners. The LSCB may require the HWB to consider what additional actions may be needed from across partners.

The clear governance arrangement between the HWB and Scrutiny are amongst the best in the country.

Areas for consideration

- How strong is the HWB in the governance system?
- Balance of professional and democratic leadership
- Clarification needed on links from the Community Wellbeing Partnership to the HWB and the Strategy
- Share good practice across the 14 AAPs

We understand that at each County Durham Partnership meeting the work of the HWB is shared and there are links into several areas of business of this overarching partnership e.g. Think Family, Inequalities, Alcohol etc.. The peer challenge team reflected on how strong the HWB is in the governance system Is it how you would wish it to be?

The Integration Board is where a lot of business takes place and this seems to work for Durham. The peer challenge team raise it purely as a point to reflect on in terms of how well linked lead members are into this group and how aware they are of the issues discussed and agreed there.

The Community Wellbeing Partnership is relatively new. There is an opportunity to be explicit about the linkages to the HWB and the Strategy.

Consideration should be given to the sharing of learning and good practice across the 14 APPs.

4. **Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?**

Strengths

- Confident HWB Chair secure in the role
- Well respected officers
- Very strong and well-resourced Public Health Team
- Public Health's new direction endorsed by the HWB – best start in life and wellbeing
- Health economy is relatively financially robust and well managed
- Delegations to officers at AAPs
- Key council officers are members of CCG governing bodies
- Public Health Team and CCG reps are on AAPs
- HWB is relatively well resourced
- Transformational approach to school nursing service – shift to mental wellbeing
- 0 – 19 service planning is mature
- Inclusion of Public Health services in the council has allowed efficiency and effectiveness not formerly possible in the NHS
- Strong history of integrated working e.g. One Point
- Innovative collaborative work on tobacco control and alcohol control with other North East authorities
- BCF/ICPLUS brings stability to a range of positive initiatives

The HWB Chair has a strong grasp of the agenda, is clear how she influences the system, where her intervention is useful and where it is not. The HWB is well resourced.

The Council's senior officers are well respected by partners. Funding is granted to the AAPs through delegation to officers. Key Council officers are also members of CCG governing bodies. The Public Health Team and CCGs have representatives on the AAPs.

The Public Health Team is is purposefully led, is well-resourced compared with others nationally. The HWB has endorsed the new direction Public Health has taken to focus on wellbeing and the best start in life. It has shifted focus to a wellbeing service. This has meant decommissioning of some services and pathways using GP service delivery. There is a transformational approach to the school nursing service. The planning for the 0-19 service is mature. The contracting of Public Health services in the Council has allowed efficiencies and effectiveness that would not have been previously possible in the NHS.

The fact that the health economy is relatively financially stable and well managed is a great benefit to Durham HWB.

The collaborative work on tobacco control with other North East authorities funded until 2017 is worthy of mention.

The BCF was described as a "natural step for us" and there appears to have been a broad level of agreement about its scope and content. The overriding impression is that the BCF has been well managed and has been the product of partners acting together and achieving a consensus. Finance leads were all well engaged and working together around the issues and how they would manage tracking costs and savings.

Areas for consideration

- Complex Interdependencies across HWB boundaries
- Succession planning/system resilience – "The Jenga piece"
- CCG may share priorities but implementation varies
- Stability in the system rather than a more expanded BCF?

The HWB may want to more explicitly consider the interdependencies of the health economy across HWB boundaries e.g. patient flows and service re-design. This will be important in terms of future service sustainability. The HWB may want to consider how it works strategically with neighbouring HWBs and the footprint it influences.

The HWB and partnership working are reliant on some key individuals. It would be prudent to do some succession planning and also look at how resilient the system actually is were key individuals to leave and to take steps to anticipate this. This is raised in the headline issues and we acknowledge that your system of distributed leadership and annual review of governance arrangements does in some way mitigate this concern.

Although the CCGs do share the priorities in the Strategy, implementation varies. This is linked to resources and it may be worth being clearer on scale and pace of delivery expected.

The size of the overall BCF appears to be no greater than the minimum expected of the local NHS and Council. It appears not to have been taken as an opportunity to stretch the boundaries and include a wider range of budgets and services. This decision you view as balanced and proportionate in relation to the increased activity in the acute sector. The schemes described do not appear to be other than ones that consolidate and "bring under a

single umbrella" a range of existing services and/or initiatives e.g. pooling resources for community equipment is valuable but should not have needed BCF to achieve and is seen as fairly mainstream in many parts of the country. There is a strong history of integrated working and the Better Care Fund is a key foundation for the delivery of integration. But further opportunity could exist in truly improving and integrating health and care in Durham. The peer challenge team appreciated that a number of schemes were running in pilot form, however the HWB may wish to re-examine the integration vision and provide a clear picture for how the resident of Durham can expect health and care services to meet their expectation for now and the future.

5. Are there effective arrangements for evaluating impacts of the Health and Wellbeing Strategy?

Strengths

- Data dashboard
- Performance improvement and DoT in teenage pregnancy rates and NEETs (impact on MH)
- HWB is making a difference with CYP issues – non-smoking areas in parks
- Clear methodology for evaluation e.g. partnership with universities to evaluate projects on travellers and Children
- Evaluation of Alcohol Liaison Team – decision to decommission – "being bold"

You are data-rich and the quarterly reporting mechanism means that the HWB is sighted on it e.g. lots of data on long term conditions, early help, learning disabilities and local indicators. However what was less clear was how you then connected into the priorities.

Durham's direction of travel is very positive and you are able to evidence some key long term improvements impacting on health and wellbeing such as the reduction in teenage pregnancies and reductions in the numbers of NEETS.

As previously mentioned children and young people's health and wellbeing issues are brought to the HWB. The peer challenge team were given a specific example of a service change by Investing in Children, which was stopping smoking in parks.

You have a clear methodology for evaluation. There are complex interrelationships between all the interventions in the Strategy. You have demonstrated a willingness to involve Durham and other academic institutions to help work out what it is that is working so that your activities are clearly evidence based.

A specific example of evaluating impact is with the Alcohol Liaison Team at one of the foundation trusts. The evaluation showed poor outcomes and the decision was made to not continue with the service. This was described as "being bold".

Areas for consideration

- Drug and Alcohol integrated recovery project – could it increase emphasis on stretch to prevention?

6. Are there effective arrangements for ensuring accountability to the public?

Strengths

- Big Tent events – very inclusive approach
- HWB meets in the community and links to AAPs
- HWB is wired into internal democratic accountabilities – Full Council, Cabinet and across depts.
- Clear lines of accountability at partner level
- Objectives has clear lines of accountability to officers
- HWB ensures transparency, builds trust and holds partners to account e.g. CYP Awards
- Voluntary sector feel valued
- Healthwatch doing some good work e.g. dementia and LTC
- Overview and Scrutiny have a clear connection with the HWB and are proactive e.g. key role in challenging Drugs and Alcohol Service

We heard a multitude of endorsements for the Big Tent events from stakeholders, partners, members and officers. These certainly work for Durham. We gathered a lot of evidence of your inclusive approach most notably with children and young people, people with learning disabilities and those with mental health issues.

There is clearly positive engagement and involvement work being undertaken and investment being made on facilitating people with learning difficulties to be able to articulate their needs. The Learning Disability Engagement Forum have broadened engagement and have access to over 2000 carers of people with learning disability and there have been two successful events. There was a strong emphasis on addressing health inequalities of people with learning disabilities demonstrated by both planning /commissioning staff and the engagement groups. (But it was less clear how the impact of this work was being measured and being reported up to the Public Health team and HWB).

There is evidence of significant resources and commitment being in place for a considerable time to support Carers and an effective third sector provider delivering across the whole of Durham. There is positive work in relation to young carers, influencing the Dementia Strategy, and specific posts to support carers of people with mental health problems are all positive signs. Carers spoke highly of the services and accessibility of help and support.

Another example of your inclusivity is having HWB meetings in the community. Not many HWBs do this. The HWB is also clearly linked to the AAPs.

The HWB is in very clear sight of all the other structures across the Council and the system in General, meaning there is good accountability. There are also clear lines of accountability from the objectives in the Strategy to officers. It was evident that the HWB ensure transparency, builds trust and holds partners to account. The HWB itself is held to account by the Investing in Children award system.

It was evident that the voluntary sector feels valued. Healthwatch are known to be doing some very good work on dementia and long term conditions.

There is a closer relationship between the HWB and Scrutiny than in the majority of areas. The agendas are related, work flows back and forth and partners take scrutiny seriously e.g. Scrutiny played a key role in challenging the Drugs and Alcohol Service. This

effective working is advanced in national terms.

Areas for consideration

- Developing the role of Healthwatch
- HWB does not hear the carers perspective – Carers Strategy is an opportunity
- Lack of assurance provided to HWB by NHS England e.g. screening and vaccinations and impact on health inequalities in County Durham
- Communication and early referral into the system e.g. mental health

There has been a challenging period with Healthwatch but they are showing signs of development and there is a broad commitment to supporting them develop which is clear across partnership.

There is a question around how visible and heard are the needs or the voice of carers at the HWB. There is no voluntary sector/service user/ carer representative/voice on the HWB, nor a Carer Partnership Board which can report in to the HWB, and the view that carers are included on all other planning groups may not be sufficient to ensure that a the carer perspective is fully reflected in priorities and strategies. Neither is there a member champion for Carers. Where these have been appointed it adds a valuable voice for carers, supporting the work of the lead cabinet members and championing the needs of carers across the system. Carers are only mentioned briefly in both the JSNA and HWB Strategy and lack of evidence that the HWB had received reports on any issues relating to Carers.

There is a new Joint Carers Strategy. However it would benefit from input from an effective carer forum (or Partnership Board) a vision for what it is seeking to achieve for carers and some measurable targets. It wold also benefit from demonstrating how it links in to other strategies and how it supports the HWB strategy. The peer challenge team found little evidence that carer's organisation and carers had been involved in drafting the document

There has been a change in approach to partnership working with the dissolution of the Learning Disability Partnership Board and its replacement with "Engagement Forums". Although we acknowledge the many positive benefits this has brought there could be a gap in the voice of people with learning disabilities feeding directly into the workings of the HWB in the absence of a formal partnership board arrangement. Also, there could be a risk in the ability to gather a comprehensive picture of the needs and issues of people with learning disabilities – this is particularly relevant in respect of people with more profound disabilities and multiple disabilities who may not be engaged. However, very recently the engagement service has established a task and finish group to explore and address issues of concern for this group of people with learning disabilities and their carers.

We understand that DPHs have regular information through their networks from NHS England but the HWB needs to improve assurance around the screening and vaccination services and their impact on health inequalities provided by NHS England. We understand that there will now be a report to the July HWB. Mental health service user also raised the issue that communication on services could be improved and early referral into the system should be a priority.

7. Moving forward

You have a really strong, well-resourced base and strong partnerships on which to move forward.

If you can be clearer about the 'how' and 'what' of your Strategy, then decide how and if you want to stretch your ambition in key areas e.g. AAPs, the extent to which you want to accelerate the integration of health and social care.

Then be clear about the role of the HWB going forward. You will have an even stronger base to improve rapidly

8. Next steps

The Council's political leadership, senior management and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how to take things forward. As part of the peer challenge process, there is an offer of follow up support. In the meantime we are keen to continue the relationship we have formed with you and colleagues through the peer challenge to date. Mark Edgell, Principal Adviser (East Midlands, Yorkshire & Humber and North East) is the main contact between your authority and the Local Government Association. Mark can be contacted at (07747 636 910) mark.edgell@local.gov.uk and can provide access to our resources and any further support.

We have identified the following areas of best practice that we would like to follow up with you and share with the sector:

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

In the meantime, all of us connected with the peer challenge would like to wish Durham HWB every success going forward. Once again, many thanks for inviting the peer challenge and to everyone involved for their participation.

Yours sincerely,

Caroline Bosdet
Peer Challenge Manager
Local Government Association

Tel: 07876 106183
Caroline.bosdet@local.gov.uk

Health and Wellbeing Board

14 May 2015

Healthwatch County Durham - Update

Report of Judith Mashiter, Chair, Healthwatch County Durham

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the organisation, activities and outcomes of Healthwatch County Durham during the period October 2014 to March 2015.

Background

2. Since the previous update report was presented to the Health and Wellbeing Board in January 2015 there has been an intense period of preparation for organisational independence.

3. Between April 2013 and March 2015 Healthwatch County Durham was operated under contract to Carers Federation, commissioned by Durham County Durham. On 1 April 2015 Healthwatch County Durham Community Interest Company, an independent social enterprise, took on the delivery of the local Healthwatch contract for the county.

4. The board, staff and volunteer team of Healthwatch County Durham continues to evolve and develop in response to experience and better understanding of the stakeholder landscape.

   - An Advisory Board of five new members has been appointed to strengthen and extend the skills base of the organisation.
   - In a previous report the roles of Healthwatcher, Helper and Enter & View Authorised Representatives have been described; the number within each category is now 17, 41 and 11 respectively. Healthwatcher venues are diverse and include a busy hair salon, a Down Syndrome Education Centre, a Dales rural café and a city-centre coffee house.

5. The three strands of local Healthwatch work are:

   - 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.

6. The strategic priorities for 2014/15 to 2016/17 are:

   - Integrated health and social care.
   - Making sense of it all' (knowledge, understanding, accessibility and navigation around the systems).

7. The three priority groups of people with whom Healthwatch County Durham will engage are:

   - Those seldom heard.
   - Children and young people.
   - The elderly and those with dementia.

Activities and outcomes, October 2014 to March 2015

8. Listening.

   - Healthwatch County Durham has engaged with 1,533 people.
   - This engagement was through a variety of events, workshops, drop-ins etc and included activities with:

     - The Health and Wellbeing Board's Big Tent event
     - The Tees Esk and Wear Valley Mental Health Trust Leaning Disability Conference
     - Teesdale School and Sixth Form
     - Police and Fire Service safety carousel
     - 2D Christmas Fair
     - Carers' Rights event
     - Youth Focus 'Change your mind'
     - Health awareness (Shotton)
     - People's Parliament
     - Durham Sixth Form Centre
     - 'Just for Women' group in Stanley (mental health and domestic violence focus)
     - Spennymoor Youth Council
     - Learning Disability Carers Forum (led by Inclusion North)
     - Whitworth Park School, Spennymoor (social care students)
     - Cubs/Beavers (8-10 year olds, at Coxhoe)
     - Children and Young People's Network
     - Tin Arts (Learning Disability Day service)
     - LGBT group at DISC
     - North East Education Centre for Children with Down Syndrome
     - GOALS (learning disability group run by DISC)

- *Children and Young People Engagement Report* was published in January 2015 (attached at Appendix 2). This collated all the comments Healthwatch County Durham received from young people during 2014 and highlights what young people think and need in respect of health and social care services. The report was widely distributed and its contents and recommendations warmly and positively received: by the Primary Quality Surveillance group, whose General Practitioners (GPs) and Care Quality Commission representatives committed to using the findings to help with communication with children and young people; and by the local professional networks, especially the Ophthalmology Chair. A follow-up report will collate all the feedback received from service providers in response to the report.
- *Young Carers: their thoughts on health and social care needs* was published in December 2014 (attached at Appendix 3). The report was widely distributed and its contents and recommendations warmly and positively received by: North Durham Clinical Commissioning Group (ND CCG) engagement team; and by Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) who will use the findings to help promote Healthwatch to school nurses and health visitors and to inform their roll-out of the Young Carers' Charter in GP practices and to raise awareness of young carers.
- Healthwatch County Durham conducted face-to-face surveys with 38 Intermediate Care Plus service users in nursing homes across the county. This piece of work contributed to the wider review of the service by Durham County Council Children and Adults Services. In addition to the completed questionnaires, observations of the engagement staff, relating to the physical environment, and of comments made to them by residents, relating to medication administration, were reported.
- The staff team, support by volunteers, engaged with patients waiting at the four Urgent Care Centres within the DDES CCG area. Visits took place on all seven days of the week and the schedule included morning, afternoon and evening visits. Responses to the 167 questionnaires completed are being analysed by DDES CCG as part of its wider review of Urgent Care. In addition to the completed questionnaires, observations relating to confusion over signage and terminology and public perception and understanding of the care system (Urgent Care, Accident & Emergency, GP access), were reported.
- A separate piece of work engaged young people about the features and functions they would like to see in any app, which Healthwatch might develop, targeted at their age group. Over 200 responses were received. Work on this is pending and progress will depend on a further review of what is currently available or being developed, available funds and staff resources for development.

- A drop-in schedule for 2015 has been publicised and includes a variety of venues including acute hospitals, community hospitals, Citizens Advice Bureaux and leisure centres. The leisure centre sessions are to date proving very fruitful as people are willing to stop to chat.
- Promotion of the Freephone telephone number as the main route to signposting continues.
- Healthwatch County Durham has joined the Durham Advice Network to raise awareness of its signposting service amongst other advisers and so increase referrals.
- Requests from local councillors for ad hoc drop-in provision are responded to appropriately.

9. Speaking up.

- Issues which Healthwatch County Durham gathered views and information about, and about which it then spoke up, included:

    - Ambulance response times and requests for ambulances. The Chief Executive of North East Ambulance Service (NEAS) has met with Healthwatch County Durham to learn more detail and a statement of response and action plan to address the issues is awaited.
    - On-going issues with access to appointments at three GP surgeries are being monitored and proactively pursued.
    - A letter reporting positive comments about the GP Exercise on Referral Scheme was issued to the service provider and commissioner.
    - Problems with the physical environment and waiting times at Bishop Auckland Hospital Eye Clinic. Healthwatch County Durham carried out an Enter & View visit and received an action plan in response from the Foundation Trust. Monitoring will take place to assess any impact of our work. (Healthwatch County Durham - Enter & View Ophthalmology Report is attached at Appendix 4).
    - Providing comments based on the Healthwatch County Durham evidence base (including a specific ‘call for comments via social media which elicited 41 responses) to the Care Quality Commission prior to its inspections at both County Durham and Darlington Foundation Trust and Tees Esk and Wear Valleys Mental Health Trust.

- Healthwatch has worked directly with numerous stakeholders to champion consumers' views. For example:

    - Healthwatch continues its involvement with the dementia strategy implementation group and the health needs assessment working group. Healthwatch will attend GPs' protected learning time to share its dementia signposting information, including the Dementia Road Map tool. Healthwatch was pleased to influence recent public engagement including a drama production from Durham University that highlighted dementia issues and stimulated discussion groups.
    - Healthwatch County Durham actively contributes to the work of: the County Durham and Darlington Foundation Trust Patient Experience Forum; the Securing Quality in Hospital Services project; the University Hospital of North Durham Unscheduled Care Project Board and the recently formed joint CCG Primary Care Commissioning Group.

- The Healthwatch England Special Inquiry into Unsafe Discharge for hospital, specifically as it relates to the elderly, to homeless people and to those with mental health issues, will be published in June. This national major piece of work will form a framework for a strong focus locally by Healthwatch County Durham on this issue.

10. Advising.

- Healthwatch County Durham received 80 calls to its Freephone Information and Signposting service between October and March. A recent informal survey across local Healthwatch showed that the national average number of calls per month was 10.
- Requests for signposting and information have included: several related to dental services (mobile provision, urgent dental care provision and transport to urgent dental care); help in changing GP; challenges to and issues caused by changes to patient transport eligibility criteria application; healthy activities for children; the speech and language team, Stepping Stones (CAB family mediation); MIND; Talking Changes and the Pioneering Care Partnership.
- Healthwatch has signposted people to a wide range of services for a wide range of issues, including: Citizens Advice, Independent Complaints Advocacy, British Tinnitus Society, NHS England, Age UK, NHS Choices, local authority complaints team, British Red Cross, podiatry services, Durham Family Information Service and NEAS Patient Transport. Several requests have related to information about mobile dental services.

Recommendations

11. The Health and Wellbeing Board is recommended to:

    - Note 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.
    - Note that Healthwatch County Durham Community Interest Company is now operating as an independent social enterprise.

Contact: Judith Mashiter, Chair, Healthwatch County Durham
Tel: 01325 375960.

Appendix 1: Implications

Finance
No implications

Staffing
No implications for Durham County Council

Risk
None

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 for Durham County Council

Disability Issues
No implications

Legal Implications
No implications

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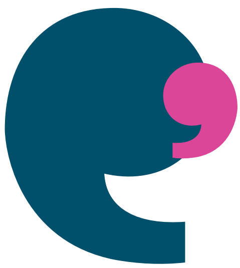
healthwatch County Durham

Children and Young People Engagement Report

We Listen, We advise, We speak up

Healthwatch County Durham
January 2015



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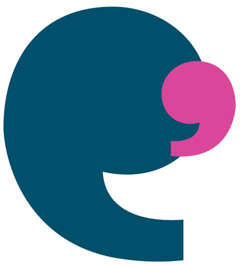
About Healthwatch County Durham

Healthwatch is the independent consumer champion for health and social care. Our job is to promote the consumer interest for everyone who uses health and social care services. We gather the views and experiences of local people through a multitude of methods including surveys, and by listening to the concerns, comments and compliments of people we meet at events, drop-in points, engagement events and workshops, and by monitoring calls to our office.

Healthwatch County Durham is keen to engage with children and young people; this is one of our priority areas for 2015-2017 (see 'Our Plan').[1] We want to hear how children and young people feel about accessing health services.

[1] http://www.healthwatchcountydurham.co.uk/sites/default/files/our_plan.pdf



Summary

This report focuses on the views and experiences of children and young people when they access health services across County Durham. During 2014 Healthwatch County Durham staff attended a number of events across the county with the main aim of engaging with children and young people. The young people we engaged with ranged from **4 to 17 years old.** In total we collected 268 comments from 5 events between March and October 2014.

Based on the comments collected we were able to identify a number of commonalities about each health service; however common themes also emerged across all health services:

- Friendliness of staff is pivotal in ensuring a positive experience for children and young people.

- Waiting times to both fix an appointment and on attending an appointment are often too long.

- Clear communication between patient and health professional is crucial in order for children and young people to have a positive experience when visiting a health service. This relates to terminology used by staff and explanations around waiting times.

Healthwatch County Durham intends to 'speak up' to service providers, commissioners, stakeholders and patient representatives based on the findings from this report.

Where and when we listened

- 20th March 2014: 'Inspire Day' organised by the Area Action 3 Towns Partnership for Year 10's at Parkside School in Willington (secondary school). 56 comments collected.

- 13th August 2014: 'Fun Day' hosted by North Durham Clinical Commissioning Group and facilitated by Durham Community Action specifically for children and young people in Durham. The event was for Year 10 and 11 students but we also gathered comments from younger children. 36 comments collected.

- 14th August 2014: 'Celebration Event' organised by Woodhouse Close Community Centre at Auckland Youth and Community Centre in Bishop Auckland for children and young people of all ages. 36 comments collected.

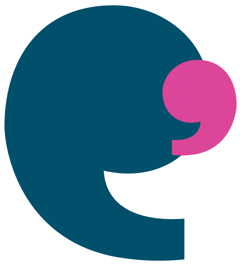
- 28th August 2014: Healthwatch organised an event at the Auckland Youth and Community Children's Day Centre in Bishop Auckland. We engaged with 10 young people aged from 7 to 13 and made badges with them, however no comments were received.

- October 2014: Community Safety Event throughout October with secondary schools from across County Durham. This event was held at The Work Place in Newton Aycliffe. We collected 140 comments.

How we listened

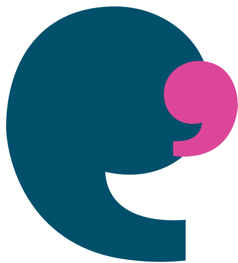
Over the five events we gathered over 250 comments, some of which could be tagged to a named health service (a specific GP/Hospital etc); other comments, especially those from younger children, were comments about the service area generally.

We used various creative methods of engagement attractive to children and young people such as a 'lucky dip' box whereby children and young people select a prize with a label attached of a name of a health service such as 'GP' or 'hospital'. The 'chosen' service is then used as the focus of face-to-face discussion between the participant and the Healthwatch member of staff.



What we asked

We asked the children and young people discussion prompts such as 'when was the last time you went to the hospital?' and 'could you tell me a bit about what it was like?' We noted down the responses, and asked the young person the name of the service they spoke to us about (although as can be seen from the findings in this report, many of the children and young people did not know the name of the health service they spoke about). We also asked the young people to provide the first part of their home postcode in order that we could identify where in County Durham we collected our responses.



What we heard

The 268 comments collected were then categorised based on the type of health service the children and young people commented on:

- Dentist
- Optician
- Hospital
- Pharmacist
- GP ('doctor')

Analysis of the children and young people's responses revealed the following:

Dentist

The majority of children and young people commented that they are happy to go to their dentist, and that the staff there are usually friendly and welcoming. One nine-year-old commented:

"My dentist has a blue door but I don't know the name of it. It's very nice and I'm not scared to go."

Another nine-year-old commented:

"I kind of like going to the dentist, they give me stickers."

These comments suggest that young people's experience of visiting the dentist is shaped by positive, but environmental, rather than clincial or care-related, factors such as a 'blue door' that is bright and memorable, or a sticker scheme which rewards young people for having their teeth checked and encourages them to return.

One young person (fourteen years old) highlighted how the dentist explained what they would do in the check-up:

"The dentist is okay, she explains things and I'm happy go on my own."

When children and young people go to the dentist for the first time, they may be unaware of what to expect before a check-up and an explanation and reassurance by staff might be appropriate.

From the seven negative comments we collected, the word '*scary*' was used four times. A twelve-year-old said:

"I don't go to the dentist, it's scary."

Generally in our society there is a certain stigma attached to 'going to the dentist' and indeed many adults are in fear of having their routine check-up. Maybe any fear children and young people have about visiting the dentist is learned from parents, or maybe the young person has had a negative experience, or heard of someone else's bad experience. However, on the whole, the feedback collected was very positive. Two comments described how a dentist had made the young person feel better by 'reassuring' them and how they 'talk you through

everything'. A reward system, such as stickers, seems to be an effective way of encouraging young people to return to the dentist.

Based on the feedback Healthwatch County Durham has gathered about dental practices across County Durham, staff should be praised for their good customer service and attitude towards young people in acknowledging the 'fear' that some have about the visit.

Optician

Many of the children and young people we spoke to had never been to an optician or had their eyes tested. One six-year-old commented:

"I don't know what an optician is."

A seven-year-old made a similar comment:

"I've never had my eyes tested and would not know where to go."

Parents who were with these children when we asked about their experience at the optician said they had never thought about taking their child to an independent optician as they assumed eye tests took place at school, although many were not confident that this actually happened. Some parents commented that our discussions had made them think about eye care and they would seek further clarification on whether eye tests were carried out at school. The 'high street' optician 'Vision Express' states on its website that only 60% of primary schools provide eye tests. The Association of Optometrists has brought out a campaign to include eye tests in the 'back to school routine', rather than parents just focusing on material factors when preparing their child for school; they encourage parents to also think about health factors such as an eye test and dental check-up.

Of those participants who had been to an optician, we received a fairly even split of positive and negative statements. An eight-year-old commented:

"I didn't like it; I had to answer lots of questions and it wasn't very fun."

An older child, of twelve, said:

"I go to the opticians but get scared about it."

Similar to dental check-ups, children and young people get anxious over what to expect from their eye test.

Many older children (those over 11 years old), made positive comments about their optician. One child who wore glasses commented:

"I love going as there are lots of glasses to choose from."

The NHS recommends that young people should have their eyes checked every two years. Eye tests are free for children under 16 and for those aged 16, 17 and 18 who are in full-time education. They may (subject to certain eligibility criteria) also be entitled to an NHS optical voucher of a certain value (at the least £38.30) to help towards the cost of glasses. In many 'high street' opticians there are always various deals such as 'buy-one-get-one-free' and as the young person quoted above said, a range of glasses to choose from. These factors make eye tests more appealing, which is important as the earlier and more often people have their eyes tested, the better the chances are of picking up any eye health conditions (not just vision tests).

Hospital

Of those children we asked about hospital services, many could not name their local hospital or even state where it was in relation to their home. This was not age-specific; one five-year-old stated that he did not know the name of his local hospital, as did a fifteen-year-old. Many parents prompted the children by asking if they remembered visiting an elderly relative for example, which then helped the young person to recall the visit. From those children who had visited someone or been a patient themselves, the comments collected were generally positive:

"The children's ward was very good, the play room was good. The nurses were friendly and I had a good time."

"The doctors are kind and help you the best they can."

Most of the comments collected from children and young people mentioned the words ‘kind’ and ‘friendly’ to describe the staff. The nature of the service received from staff seems to be a common aspect that young people reflect on after visiting a health service. Therefore ensuring staff maintain a positive attitude for both young people *and* adults is pivotal to maintaining consumer satisfaction and positive attitudes towards health services.

The few negative comments we received included a statement from an eleven-year-old who commented about her stay in hospital:

“It’s strange, there are loads of different rooms and you could catch a bug.”

A nine-year-old said that her local hospital was:

“Scary, smelly and full of sick people.”

Another common response was based around appointment waiting times – both in getting an appointment and also after arriving at the hospital. One young person commented:

“The service was slow! I was meant to receive an injection at 8:30 and I didn’t get it until 11:30.”

If people are waiting a long time for an appointment, it may be helpful to patients to be kept informed if there is likely to be a delay with their allocated appointment time. Prior to appointments it is common for people to feel anxious, and if they are required to wait longer than they anticipate it only increases this anxiety further. If hospital staff were to explain to patients why they are waiting longer than expected for their appointment and do this in a friendly manner, it might help to maintain a positive experience for patients, despite the prolonged wait.

Pharmacist

Many of the children and young people we spoke to did not know where their local pharmacist was or what happened at a pharmacy. These comments were not age-specific – older children in their teens were not aware that a pharmacy dispensed medicines etc. A common thread was:

"I don't know what a chemist/pharmacy is or where it's at."

Another young person commented:

"I don't know what other services they provide."

Most pharmacies offer a private and confidential area in which a customer can speak to a pharmacist, and some pharmacies offer a range of health checks. In response to the various demand pressures on the whole of the NHS system, through public information campaigns and through the 111 service people are now encouraged to consider seeing a pharmacist rather than booking an appointment with a GP if this is appropriate. It is therefore important for young people to know about the role of pharmacists and of the services that are offered within their local pharmacy.

Of those who were familiar with pharmacy services, many children and young people stated that they went with their parents and identified that it is where *"tablets are given out"*. Other young people also identified that it was 'next to' their GP practice. Negative comments related to how long they had to wait for their prescription. One pharmacy received two negative comments about the waiting time:

"I had quite a long wait. I put in the prescription, went back later and then still had to wait 15 minutes."

"I waited a long time – half an hour. I had to go and ask for the prescription after leaving and going back later."

This echoes the comments received around hospital waiting times in that communication from staff is important so that customers understand why they wait a long time for their prescription.

However, there were many young people who commented on the good service they had received from their pharmacist:

"I picked up Mam's prescription; excellent staff; it's always a good service."

As previously mentioned, it is important for people to feel comfortable with staff within the health service as they are confiding in them with a health problem that may be worrying or embarrassing to them. It is therefore important for staff to be helpful, approachable and empathetic towards patients, whatever their age.

GP/doctor

Most of the comments collected from children and young people through this engagement period were about their local GP surgery, and most comments were positive. Although many of the children and young people could not name their GP surgery, they reported a good experience. One twelve-year-old commented:

"I don't really go to the doctor's much but last time I went I was really nervous but I came out laughing because the doctor was nice."

A six-year-old commented:

"I always know that the doctor is going to make me feel better."

Another young person said:

"I didn't wait long for an appointment and I see the same GP as he's awesome."

Highlighted here is the importance of a positive relationship between doctor and patient. Comments from these children and young people reveal that they feel better about going to their GP surgery if they have had a positive experience. One young person comments that they like to see the same GP as 'he's awesome'. This is a really positive attitude to have towards a GP, especially as people confide in them for personal matters and therefore feeling comfortable with your GP is important – both to young people and adults.

Although the name of the practice/surgery was unknown to many of the young people in this survey, they were able to identify the location or what other building it was next to. One young person commented:

"I don't know what the surgery is called but know where it is, I haven't been lately."

Whether it is important for children and young people to know the name of their GP surgery or practice is a matter for debate; if it's considered not to be important, then when does it become necessary for young people to know about the ***services*** on offer (as distinct from the name of the premises or the personnel)? The majority of young people Healthwatch spoke to attend their GP surgery with one of their parents, although some older ones stated they would be happy to visit on their own.

There were a number of negative experiences noted in relation to GPs; most comments were based on the following themes:

- Lack of things to do in the waiting area
- No available appointments
- Wouldn't go on their own
- Only one doctor on duty
- Long waiting time
- Language barrier
- Unappealing
- Slow service
- Embarrassment
- Put on the spot answering questions
- Seeing a different doctor on every visit

One negative comment received was from a twelve-year-old who stated:

"I feel nervous about going to the doctor. I feel they don't really talk in a language I understand."

Another young person also commented on the problem with language:

"Has to write things clearer, there can be a language barrier."

A lack of clear communication and the overuse of medical jargon is a common problem throughout the health service. On leaflets, letters and in consultations, language can be a barrier for people who access the health service. Healthwatch County Durham is looking into creating a 'Jargon Buster' (as one of our priority areas in Our Plan)[2] to overcome the barriers around communication between patients and health professionals.

Another common problem for people who had visited their local GP practice was around long waiting times to fix an appointment:

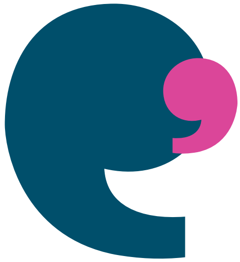
"It took 3 days to get an appointment...I then waited four months for the results. There was no help over the concerns I had while waiting."

"Large time to wait for non-emergency appointments."

As previously highlighted in this report, communication is key between patients and GP staff. If patients are told why they have to wait a long time to get an appointment to see their GP, and why there is a long waiting time when they arrive for their appointment, such as understaffing, then patients would perhaps be more understanding.

It is clear that, on the whole, children and young people were happy to talk about their GP surgery and did not show any hesitation or fear when discussing their experiences.

[2] http://www.healthwatchcountydurham.co.uk/sites/default/files/our_plan.pdf



There are a number of points to highlight based on what children and young people told us in this engagement:

- Perhaps surprisingly, the most unexpected comments were those regarding dentists. The majority of children and young people we spoke to were happy to visit their dentist. Most of the children also mentioned, without any prompting from parents, the fact that they go for a routine check-up every six months. This shows that education surrounding oral hygiene has had a positive effect. Interestingly, it was the only health service mentioned where an incentive for the child/young person was also mentioned (a number of children and young people commented that they received 'stickers' following their appointment). Another possible incentive (for parents!) is that regular dental check–ups are free of charge for children under the age of 16.

- It was interesting to hear that many children did not know the name of the hospital or even where it was in relation to where they live. In some cases, the child/young person would know where the hospital was but not what it was called. Many children recalled, when prompted, that they had visited a relative in hospital and did not seem daunted or put off by this experience. The few people we spoke to who had received hospital care themselves reported receiving a positive service.

- Similarly, comments regarding accessing a GP were of the same vein. Many respondents could not name their GP, but on the whole did not find the process unsettling when they did attend. Lack of knowledge surrounding hospital and GP names and locations could simply be because children and young people do not often need to access these services alone and so therefore have no need to know their location or how to reference them. Further enquiry could address whether it is important for children and young people to know the name of their GP practice. Healthwatch County Durham is also planning to create a 'Jargon Buster' to help break down the communication barrier between patients and health professionals

and the needs of children and young people will be borne in mind when this is created.

- There was a lack of knowledge surrounding pharmacies and the role of a pharmacist. Although the children and young people knew exactly what happened at a hospital and at a doctor's surgery, they did not know what a chemist or pharmacist did or where their closest one was located. Is this because medicines etc are readily available in local shops and supermarkets therefore reducing the need for parents to use the specialist pharmacy? Is it because information about pharmacies is not shared at school?

- The process of Healthwatch gathering comments regarding opticians made parents think more about their child's healthcare. There seemed to be some confusion as to whether it was the responsibility of the school or parent to get their child's eyes tested. Comments from those who had attended an optician were mixed, with some saying they were happy to go and others saying the experience was quite 'scary'.

Common themes which emerged across all health services:

- Children and young people place great importance on the friendliness of staff in health services, and this helps to ensure a positive experience for them.

- Long waiting times – both to fix an appointment and in waiting to be seen at the appointment itself – are frustrating and lead to a negative experience.

- Good, clear communication between patients and health professionals is of paramount importance and can help to create a positive experience.

Next Steps

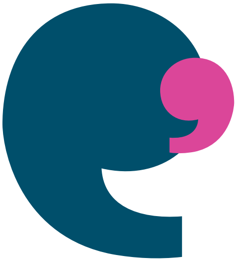
- Healthwatch County Durham will inform the Local Pharmaceutical Network that our engagement work has highlighted how little children and young people know about the services a pharmacist provides and will ask whether information can be shared through schools.

- Clarity will be sought on the local practices for children and young people having their eyes tested. Does every school bring in professionals to perform this function (and if so, at what age, and how frequently?) or is it the responsibility of the parent to make sure their child's eyes are regularly tested? Healthwatch County Durham will promote the Association of Optometrists' campaign for eye tests to be included in the 'back to school' routine.

- Healthwatch County Durham will inform the Local Dental Network that, on the whole, children seem happy to have their teeth looked at. We will also make a suggestion that the distribution of stickers, or a similar 'incentive' scheme, is rolled out throughout all dental surgeries in County Durham (for the younger children).

- Healthwatch County Durham is planning to create a 'Jargon Buster' to break down the communication barrier between health service consumers and health professionals.

- Healthwatch County Durham will notify service providers about the information collected in this report and in particular highlight the importance of clear communication between patients and health services (for example around appointment waiting times).



Thank you

Thank you to all the children and young people who told us about their experiences of local health services in County Durham. We will 'speak up' to service providers and recommend changes based on the comments we have received so far from children and young people.

Healthwatch County Durham will continue to listen to children and young people; collecting their views and experiences on local health services and supporting them to find their voice and realise that they have choices about their health needs.

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APPENDIX 3

healthwatch
County Durham

Young Carers

Their thoughts on health and social care needs

Survey Report
November 2014

Background

Healthwatch is the independent consumer champion for health and social care. Our job is to promote the consumer interest for everyone who uses health and social care services. We gather the views and experiences of local people through a multitude of methods including surveys, research, and by listening to the concerns, comments and compliments of people we meet at events, drop-in points and workshops, and by monitoring calls to our office.

Healthwatch County Durham wanted to find out the experiences of young carers (aged 5 to 18) and young adult carers (aged 16 to 25) when they accessed local health services, in order to identify whether services and professionals are meeting the needs of young carers. To explore this, Healthwatch County Durham created a survey for young carers which asked what they thought about their local health services based on their own experiences. In total we collected *41* responses from two young carer organisations — Family Action's The Bridge Young Carers Project and Disc's Horizon project who support young adult carers. We entered all completed surveys into a prize draw and two young people won a £25 voucher of their choice.

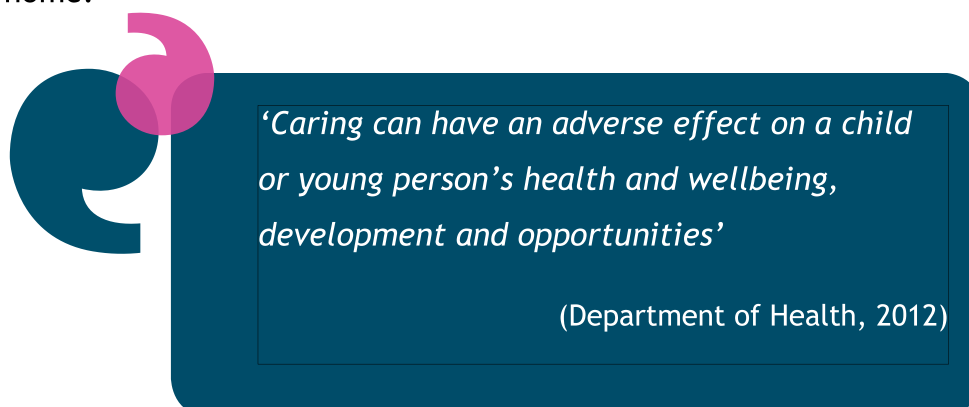
The following report describes what we asked young carers, what we found out and what health services might do better to support young carers in the future.

'Young carers are children and young people who often take on practical and/or emotional caring responsibilities that would normally be expected of an adult'

(Carers Trust, 2014)

What did we ask?

Healthwatch County Durham wanted to find out what young carers were experiencing when they visited their local health services. Literature suggests that close attention needs to be paid to young people who have caring responsibilities at home:



We asked young carers 20 questions about their caring role and their experience of visiting their GP practice, pharmacist/chemist, hospital, dentist, optician and social services (see survey at Appendix 1).

What did we find out?

We received 41 responses from young carers aged between 7 and 23. Most respondents were aged 10 and 14, were from East and North Durham and were part of The Bridge Young Carers Project. The majority of the young carers who completed the survey care for their mother or their father.

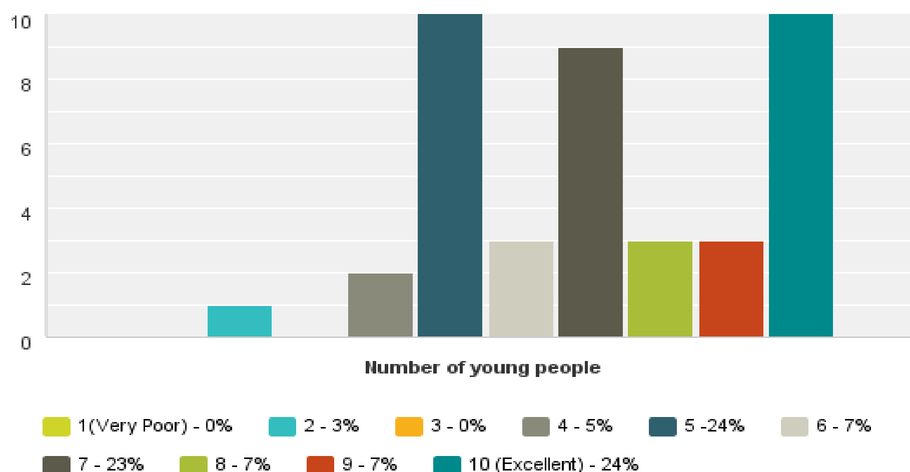
When asked, *'on a scale of 1 to 10, how do you think being a carer has impacted on your life?'* (10 having a huge impact) most respondents circled 6 and 9, highlighting that their caring responsibilities have a large impact on their life. In support of this when respondents were asked, *'how would you feel if this service (young carers) wasn't there?'* Most commented that they would have negative

feelings; *'upset', 'frustrated', 'unsupported, stressed'* and *'lonely'*. Only one young carer commented that they would be *'fine'* if the service wasn't there.

About their GP Surgery

We asked respondents 6 questions about their experiences of visiting their GP surgery, and we found out the following;

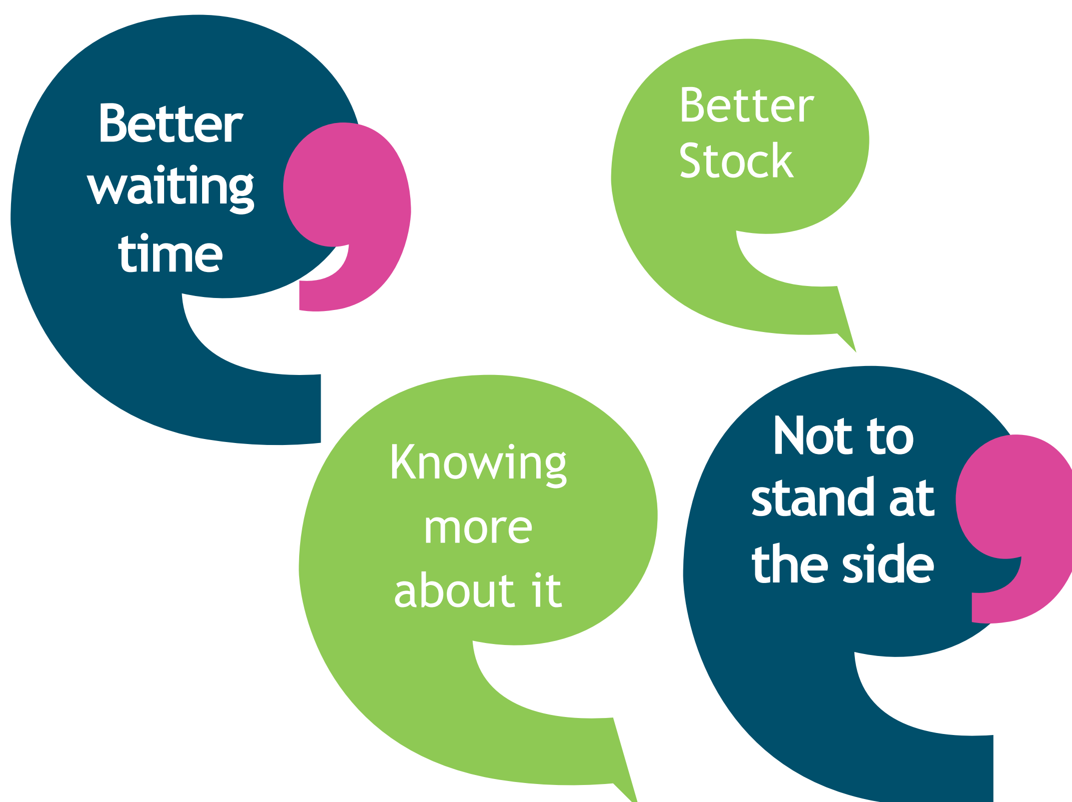
- 39% of young carers are not keen on calling their GP
- 44% of young carers are happy to speak to a receptionist
- 46% of young carers are happy to speak to their GP
- Nearly half of the respondents said their surgery was aware that they were a young carer (47%)
- Most young carers rated their GP surgery 5 or above (91%). (See graph below).
- 10 young carers said that 'nothing' would make their GP experience better. Other responses were, 'to understand more and not feel abandoned', 'more helpful on the phone', 'kinder staff' and 'more relaxed GPs' and 'more appointments'.



About their pharmacy/chemist

We asked respondents 4 questions about their experience of visiting their local pharmacy or chemist. We found out the following:

- Most young carers (75%) do use their local pharmacy/chemist
- 45% of young carers are happy to pick up prescriptions
- 45% of young carers are happy to speak to pharmacy staff
- Most young carers rated their chemist a 7 or above (68%)
- To make their experience of visiting their pharmacy/chemist better, 8 young people commented that there should be a 'better waiting time'. Other suggestions included:



Using other health and social care services

We asked young carers to rate their experience of other health and social care services on a scale of 1 to 10 (10 being excellent). We also asked them to state if there was a particular reason attached to their rating. We found the following:

Hospital

10 young carers rated their experience of visiting hospital as 'excellent'. All but 2 of the 41 respondents rated their experience of hospital as above 5. These were some of the responses collected:

'Misdiagnosis, lack of care' (rated 3, unknown hospital)

'Some of the staff are unprofessional' (rated 5, Bishop Auckland)

'Staff were lazy, not on time' (rated 7, Victoria Royal)

'Slow to come and see you and don't know what the pain you and your family are going through' (rated 9, Bishop Auckland)

'Kind and experienced staff' (rated 10, Peterlee)

'Short waiting time when there' (rated 7, Chester-le-Street)

Dentist

11 young carers rated their experience of visiting the dentist as 9 out of 10. All but 3 of the 41 responses were rated above 7; these were some of the responses collected:

'They understand you and your family, and talk to you not your mum and dad' (rated 10, Darlington)

'Made me feel comfortable' (rated 10, Peterlee)

'Friendly, they try to tell you all the information and options possible' (rated 10, Framwellgate Moor)

'Scared of dentists' (rated 8, Seaham Smile)

'I hate dentists' (rated 1, unknown)

'Nice and clean' (rated 9, Consett)

Optician

12 out of the 41 respondents did not answer the survey question about their experience of opticians. This may be because they had not yet visited an optician for a check-up. However, out of the 29 responses received most young carers rated their experience of visiting the optician as 10 (11 ratings). All but 2 responses were rated above 5, however 2 responses rated their opticians 1. One negative response from a young carer was collected:

'One of the opticians treated people disrespectfully' (rated 1, Village Optician in Newton Hall)

Those who did rate their optician fed back mainly positive comments, Specsavers in particular received good feedback:

'Excellent service' (rated 10, Specsavers Peterlee)

'Skilled and comfortable environment' (rated 10, Specsavers Peterlee)

'Fixed my eye sight' (rated 10, Specsavers Consett)

'Friendly, short waiting time' (rated 8, Framwellgate Moor)

'They talk to you and feel welcome to come again' (rated 10, Darlington)

'Staff are friendly' (rated 8, Shewans Optician)

Social Services

24 out of the 41 respondents did not answer the survey questions about their experiences of social services. This may be because they have no past experience with social services or because they were not familiar with the terminology. 17 young carers rated their experience of social services and there was no strong pattern to the results.

'Wasn't comfortable, not enough info' (rated 4, unknown)

'Deceitful and talk a load of rubbish' (rated 1, CIN)

'Poor relationships with child services, don't believe children should care for parents' (rated 3, unknown)

'Poor communication with GP and with organization which affected their agreement to keep my service with them confidential' (rated 4, Mental Health Talking Changes)

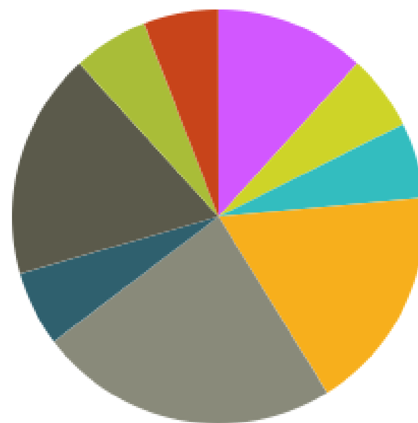
'Poor communication between settings' (rated 4, unknown)

'I can't get access to social services help, even though I need their help' (no rating)

The chart shows that what young carers rated their experience of social services. 6 comments were collected which were all negative:

Q20 **Please rate your experience from 1 to 10, with 1 being a very poor experience and 10 being an excellent experience.**

Answered: 17 Skipped: 24

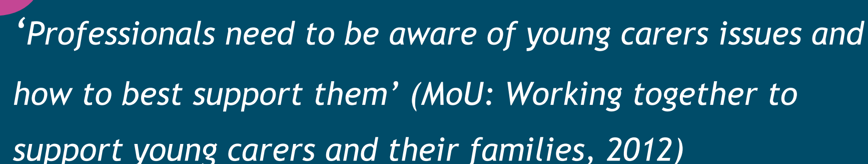


1 (Very Poor) - 6% 2 -6% 3 - 6% 4 - 18% 5 - 24% 6 - 6%
7 - 0% 8 - 18% 9 - 6% 10 (Excellent) - 6%

Conclusion

From our 2014 young carers survey, these were our main findings and suggestions as to how young carers could be better supported in County Durham:

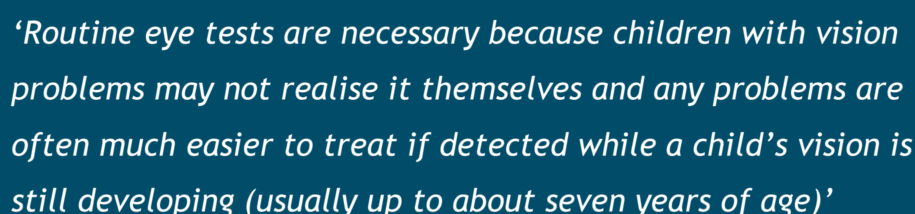
- Young carers do not like telephoning their GP practice; therefore another form of contact for young people, such as text messaging or social media may be more suitable and well used.
- GP practices should be aware if a young person has a caring responsibility at home. This is supported by a report by directors of children's and adult's services for a local Memorandum of Understanding (MoU) for young carers which states how:



'Professionals need to be aware of young carers issues and how to best support them' (MoU: Working together to support young carers and their families, 2012)

- If GPs are aware of a young carer's responsibilities, they can inform young carers of what further support is available in their community and to offer regular check-ups for young carers to prevent any mental or physical illnesses occurring. Healthwatch is able to help with signposting to community services and support.
- Having a named member of staff as the point of contact for young carers information (for colleagues and service users) should be put in place throughout all GP practices.

- Young people should be better informed about the roles of hospitals, opticians, pharmacists/chemists and GP surgeries, and at an early age. Some young carers in the survey were unaware of what the terms 'opticians', 'chemist' or 'GP' meant, and where their local service was. This is something that could be rolled out in schools; a 'health information' event.
- Young carers identified that there should be a better waiting time in pharmacies, and that it would be better if they didn't have to stand to the side.
- There were mixed responses of hospitals, but it was commented that staff can be unprofessional and had lack of care.
- Dentists –It is important for children and young people to be made to feel comfortable when visiting dental practices, and to be given information to put them at ease prior to their visit.
- Most young carers who responded to the survey did not feedback a response about their experience of visiting an optician. This may be because they are yet to have an eye test, they are unsure the name of their optician or that they can't remember. From this study Healthwatch is keen to explore what the average age is for young people to visit an optician and whether eye checks are carried out in schools at a particular age to prevent later eye problems. As highlighted by the NHS:



> *'Routine eye tests are necessary because children with vision problems may not realise it themselves and any problems are often much easier to treat if detected while a child's vision is still developing (usually up to about seven years of age)'*
>
> *(NHS Choices, 2014)*

- The most negative feedback reported in the survey was around young carers' experiences of social services. There needs to be better communication between services and more information for young people about what services of support are available in County Durham.

Thank you

Healthwatch County Durham would like to thank Family Action's The Bridge Young Carers Service and Disc's Horizon Young Adult Carers Project for participating in this research.

Healthwatch will continue collecting feedback from young carers groups in County Durham, and hopes to conduct another survey in the future to identify whether there have been any changes to health services to improve the experience for young carers and their families.

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- Department for Health (2012) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299270/Young_Carers_pathway_Interactive_FINAL.pdf
- Working together to support young carers and their families (2012) MoU http://www.youngcarer.com/sites/default/files/imce_user_files/PTP/mou_young_carers_2012.pdf
- NHS Choices (2014) 'Why hearing and vision tests for children are needed' http://www.nhs.uk/conditions/hearing-and-vision-tests-for-children/pages/why-it-is-necessary.aspx

Appendix 1

Healthwatch County Durham wants to know what you think about your local GP, pharmacy and other health services.

Please answer these questions from your own experience – whether you were using these services for yourself or for the person you care for.

Return the completed questionnaire in the envelope provided - no stamp needed. We must receive your entry by Friday 5 September 2014.

About you

1. How old are you? ....
2. Who are you the carer for? ....
3. Why does this person need your help? ....

   ....
4. Are you the only carer for this person, or does someone else help? ....
5. For how long (number of years or months) have you been a carer? ....
6. Roughly how many hours of care do you give?

   .... hours per day or .... hours per week
7. Which GP surgery are you registered with? ....
8. Are you a *registered* carer? ....
9. On a scale of 1 to 10, how do you think being a carer has impacted on your life?

no impact	>	>	>	>	>	>	>	>	huge impact
1	2	3	4	5	6	7	8	9	10

About your GP surgery:

	Happy to	Neutral	Not keen
10. How do you feel about calling your GP surgery?	○	○	○
11. How do you feel about speaking to a receptionist to arrange an appointment?	○	○	○
12. How comfortable are you in speaking to your GP?	○	○	○
13. Does your surgery know that you are a young carer?		Yes ○	No ○

14. On a scale of 1 to 10, how would you rate your GP surgery?

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

15. What would make your experience of visiting the GP better? ....

    ....

About your pharmacy/chemist

16. Do you use your local pharmacy/chemist (either a separate shop or at the GP surgery)? Yes ◯ No ◯

	Happy to	Neutral	Not keen
17. How do you feel about picking up prescriptions from your local pharmacy?	◯	◯	◯
Are you comfortable speaking to the pharmacy staff?	◯	◯	◯

18. On a scale of 1 to 10, how would you rate your pharmacy/chemist?

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

19. What would make your experience of visiting the pharmacy better? ....

....

Using other health and social care services

In the last year which of the following have you been to (either on your own or with the person you care for)? Please rate your experience from 1 to 10, with 1 being a poor experience and 10 being an excellent experience.

20. **Hospital** (which one?) ....

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

Any particular reason? ....

21. **Dentist** (which one?) ....

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

Any particular reason? ....

22. **Optician** (which one?) ....

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

Any particular reason? ....

23. **Social Services** (which department? ....

very poor	>	>	>	>	>	>	>	>	excellent
1	2	3	4	5	6	7	8	9	10

Any particular reason? ....

Finally

How can we contact you if you win the prize draw?

Email: .... **Tel.** ....

healthwatch County Durham

Healthwatch County Durham
The Work Place
Heighington Lane
Aycliffe Business Park
Newton Aycliffe
County Durham
DL5 6AH

Telephone: 01325 375967
Freephone: 0808 8010384

Email: info@healthwatchcountydurham.co.uk
Website: www.healthwatchcoutydurham.co.uk

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APPENDIX 4

healthwatch County Durham

Enter & View Report

Details of visit

Service Provider:	Ophthalmology Department, Bishop Auckland Hospital
Service Address:	Cockton Hill Road, Bishop Auckland DL14 6AD
Date and Time:	Thursday 16th October 2014 at 9am
Authorised Representatives:	Jean Lamb, Reg Davison, Sandra Cottrell
Contact details:	Healthwatch County Durham 01325 375960

Acknowledgments

Healthwatch County Durham would like to thank the service provider, service users and staff for their contribution to the Enter and View Visit.

Disclaimer

Please note that this report relates to findings observed on the above mentioned date. Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time.

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch Authorised Representatives to observe service delivery and talk to service users, their families and carers on premises such as Hospitals, Residential Homes, GP Practices, Dental Surgeries, Optometrists and Pharmacies. Enter and View visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation - so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an Authorised Representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the Service Manager, ending the visit.

Purpose of the visit

The purpose of the visit to Bishop Auckland Hospital Ophthalmology Department was to gather views of service users and staff at the eye clinic as well as make observations of accessibility and waiting areas.

Strategic drivers

Healthwatch County Durham had received several negative comments from patients attending the eye clinic. Common themes had emerged concerning the attitude of staff, poor patient experience, waiting area issues and waiting times.

The visit was pre-planned, arranged and agreed with the Department Manager.

Methodology

Enter and View Authorised Representatives met with a Healthwatch staff member two weeks before arranging a date to visit. This meeting allowed for discussion and agreement on the purpose of the visit, how it would be carried out, and to devise a format for recording the findings. Observation and semi-structured interview questions were decided upon. Observation sheets were prepared by the staff member for use on the day of the visit.

The staff member met with the Authorised Representatives on the day of the visit for a briefing before the observations took place. A staff nurse who was aware of the visit and purpose showed the team around the department and explained the clinic procedures. She also addressed those in the waiting area so they knew we would like to speak with them but only if they agreed.

The Authorised Representatives approached waiting patients and those accompanying them, explained why they were there and sought their agreement before further questioning took place. Healthwatch explanatory leaflets were given out.

The team spoke to two staff members and 13 patients, with people accompanying them. A total of 18 observation sheets were completed, copies of which are available on request.

The team discussed its findings with the staff nurse prior to leaving the department.

Summary of findings

- Patients were generally happy with the service they received from the staff at the clinic.
- The waiting room appeared adequate apart from: the environment was too hot, TVs were not switched on, and there was a lack of reading material and no drinking water available.
- Patients reported that the waiting room is usually very crowded and sometimes people have to stand as there are insufficient chairs.
- Treatment clinics for laser treatment and surgery tended to cause more problems than the out-patient clinics due to arrival times and length of time waiting to be seen.

Results of Visit

Description of Service

The department provides ophthalmology in-patient and out-patient services to the population of County Durham and Darlington for patients with eye conditions.

Patients requiring ophthalmic surgery are treated on a day case basis at Bishop Auckland Hospital in the recently opened Cataract Centre.

The department provides a range of consultant and nurse services such as nurse-led minor operations eg cyst removal.

The department also acts as a resource for those seeking support from 'Action for the Blind'.

Findings

The observations carried out and reported upon were from a Thursday morning visit to the out-patient ophthalmology clinic.

a) Department

It was difficult to find the Ophthalmology department as direction signs were not obvious.

Once in the department, the reception desk was easy to find and the department was clean and organised.

The toilets are near to the reception desk with clear signs on the doors. However there are no direction signs, in the corridor or waiting area, pointing to the toilets. A member of staff advised that the toilets are only checked by the cleaner in the morning. The men's toilet was in need of cleaning.

There was a notice in the reception area stating there had been 415 DNAs (did not attend) in a month. This gave the impression of that number applying just to the eye clinic; however when queried with the staff nurse the team was told it was

out-of-date but also that the figures applied across the whole Trust. The team felt that this was misleading.

b) Waiting Room

On observation the waiting room seemed adequate in size, with sufficient seating and space allowing for easy movement for wheelchairs. However, we were told that it was particularly quiet that morning: that usually there are lots more people waiting and some have to stand. This would make it difficult for wheelchair users to move around or get into the waiting room.

The room was extremely hot and there were no drinks or refreshments in the waiting area.

There were no magazines to read and the television was turned off.

c) Patient Experience

Of the 13 patients spoken to only two were there for their first visit to the clinic.

Five patients had seen the same consultant each time they had attended. Two of those who had seen different doctors at each visit would have preferred to see the same consultant.

Nurses and Reception staff were seen as helpful, friendly, good and patient with those attending the clinic. One patient commented that there is the "odd member of staff that can be less helpful than others".

Generally people were happy and stated the service they received was good.

No-one had waited for more than 20 minutes after their allotted appointment time; most had been seen within 5-10 minutes of the appointment time.

Negative comments heard were about the slow process through assessment – eye drops – treatment – tests. Patients also reported that there were usually many more people waiting and they would not normally be seen as quickly as they had been on this occasion.

Additional findings

Although not observed, as this was a day when ophthalmic surgery was not being carried out, the majority of concerns raised were about the day surgery.

There are two time slots when patients are asked to arrive - 8am and 12.30pm. Patients have to arrive at the same time as the whole list of patients are addressed by the doctor before he prepares for surgery. Patients can wait for several hours before they are seen. Reports from patients were of two, three, four and five hours waits. One patient, who is diabetic, waited three hours and was then

advised that the appointment was cancelled. Another diabetic patient waited four hours and was not offered anything to eat.

The staff nurse informed us that patients would be given refreshments if requested. Patients are given a drink and biscuit after surgery. Staff in the department are in the process of producing information to send out to patients prior to their surgery appointment. The intention is to inform them about what to expect and help them be better prepared when they attend for surgery.

Recommendations

- Consider comfort for those in the waiting room by checking room temperature, providing reading material and putting on TVs with sound and subtitles.
- Review signage for toilets and to the department, especially taking into consideration those who are visually impaired.
- Ensure patients receive information prior to their appointment for surgery so that they, and any person accompanying them, can be prepared eg how long they are likely to be there and how they can get a drink and food if needed.
- Review the surgery times so that people are not waiting for such long periods after their arrival. Ideally, have more specific appointment times rather than general 'morning' and 'afternoon' appointment times, with a nurse giving the preliminary talk to patients instead of the doctor.

Service Providers response

Consider comfort for those in the waiting room by checking room temperature, providing reading material and use of TV with sound and subtitles.
The environmental temperature will be monitored in line with Trust policy. The TV is on at patient request, but we do find that quite often the elderly people prefer this to be on silent. This is to be managed on an individual basis as appropriate. The use of reading materials will be addressed.

Review signage for toilets and to the department, especially taking into consideration those who are visually impaired.
The public toilets on Ward 9 are being upgraded to be more accessible and will include additional signage. The signage issue will be raised with the Facilities Department for their input.

Ensure patients receive information prior to their appointment for surgery so that they, and any person accompanying them, can be prepared e.g. how long they are likely to be there and how they can get a drink and food if needed.
We are currently in the process of updating the information given to the patient during their pre-op assessment appointment. This is to include not only the expected waiting time, but also the reasoning behind this as well as the availability of food and drink whilst they wait.

Review the surgery times so that people are not waiting for such long periods after their arrival. Ideally, have more specific appointment times rather than general 'morning' and 'afternoon' appointment times, with a nurse giving the preliminary talk to patients instead of the doctor.
Patients are asked to arrive at the same time to ensure the consultant has the opportunity to speak to each patient, give the patient ample time to ask questions and allay any fears which they may have about their surgery before entering the sterile theatre environment. This also gives the nursing team the opportunity to prepare patients for theatre which ensures the theatre session runs smoothly.

Health and Wellbeing Board

14 May 2015

Health and Wellbeing - Area Action Partnership Links

Report of Andy Coulthard, Area Action Partnership Coordinator, Assistant Chief Executive, Durham County Council

Purpose of the Report

1. The purpose of this report is to provide 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 priorities of the Partnerships.

Background

2. The last report on the work of AAPs was presented to the Health and Wellbeing Board on 3 September 2014. This report forms part of a six monthly update to the Board that reviews joint working between health and wellbeing partners and the 14 AAPs.

3. The September 2014 report highlighted the development of a working group including colleagues from Durham County Council (DCC), Clinical Commissioning Group (CCG), AAPs and the Voluntary and Community Sector (VCS) in relation to improving AAP/VCS interface with the Health and Wellbeing Board as well as the Children and Families Partnership. Specific consideration was given to identifying areas of potential duplication, enabling us to streamline these, where possible.

4. In June 2014 colleagues from the above partners developed the group's initial action plan identifying a number of key areas of work which would improve the alignment of AAP supported programmes with the priorities in the Joint Health and Wellbeing Strategy (JHWS) and the Children, Young People and Families Plan.

5. In December 2014 the action plan was updated and added to. The group identified the sharing of engagement and communication opportunities alongside the utilising and pooling of any external funding opportunities between partners as further key areas of work. This work has been taken forward by the following people:

   - Andrea Petty DCC (Planning & Service Strategy)
   - Julie Bradbrook DCC (Planning & Service Strategy)
   - Gordon Elliott DCC (Assistant Chief Executive's Office)
   - Sandy Denney 3 Towns AAP/AAP coordinator for CFP

- Andy Coulthard — Mid Durham AAP/AAP coordinator for HWB
- Phil Malyan — DCC (Commissioning)
- Denise Elliott — DCC (Commissioning)
- Sue Carty — DCC (Commissioning)
- Gary Stokoe — Voluntary and Community Sector
- Gill Eshelby — DCC (Youth Offending Service)
- Michael Houghton — North Durham CCG
- Chris Scorer — DCC (Public Health)

An update on the action plan

6. An updated action plan is included at Appendix 2. It is proposed that the ongoing and outstanding actions from the plan will be amalgamated within the agenda of the Community Wellbeing Partnership (CWP). The Community Wellbeing Partnership is a multidisciplinary group whose aim is to support transformational change that improves the health and wellbeing of the residents in County Durham and aims to reduce inequalities and social isolation.

7. These actions naturally align themselves to the work of the Partnership and will link closely to the Wellbeing for Life and preventative programmes including adult social care to meet the requirements of the Care Act 2014.

8. Further details are outlined below in relation to progress against specific actions.

Wellbeing for Life and local asset mapping

9. Asset mapping is a key activity of the 'Wellbeing for Life' programmes e.g. working on what already exists in communities and building community resilience. Area Action Partnerships have been an integral part of local asset mapping and information from this work will be shared with AAPs and relevant practitioners' as and when it becomes available.

10. There are two delivery programmes which come under the umbrella of 'Wellbeing for Life'. The first is entitled Wellbeing in Targeted Communities, with specific programmes currently taking place as part of a three year pilot scheme in partnership with the following AAPs:

    - Mid Durham — Older People
    - Stanley — Tobacco
    - Bishop Auckland & Shildon (BASH) — General health as part of Health Express

11. The wellbeing in targeted communities programmes focus on specific aspects of health using Public Health (PH)/AAP data to target key communities of need within each AAP area. Health trainers will deliver the work closely with PH, AAPs and Durham University identifying local volunteers who will be trained as 'Health Trainer Champions' who in turn will work with those individuals within the targeted communities who need the support most. The asset mapping exercise for the wellbeing in targeted communities programme is being carried out by Durham University.

12. The second programme is the overall Wellbeing for Life service which went live on the 1st of April 2015 and will be delivered by a consortium of providers based around three physical locations and one satellite base in:
    - North Durham
    - South west Durham
    - East Durham
    - Dales (satellite)

13. An update on the Wellbeing for Life Service was provided to the Health and Wellbeing Board at their meeting on 11th March 2015.

14. The Wellbeing for Life service will operate within the 30% most deprived communities and make a difference to the individual and their sense of community. The service will provide support to people to live well, by helping to address the factors which influence their health and build their capacity to be independent, resilient and maintain good health for themselves and those around them. The service will go beyond looking at single-issue services and a focus on illness, and instead will aim to take a whole-person and community approach to improving health. The service will be complementary to the existing wellbeing in targeted communities' initiative. The asset mapping for the wellbeing for life service will be carried out by Durham Community Action. The CWP will be responsible for developing, monitoring and the evaluation of the Wellbeing for Life approach (including academic input).

15. Relevant information from the mapping exercises will be published on 'Locate' for information. This enables groups to keep their own information up to date and available to the local and wider community.

Health and Wellbeing as an AAP priority

16. In the latter part of 2014, the AAP's consulted with their Forums and identified their priority areas of work for the 2015/16 period. A full list of AAP Priorities for 2015/16 is attached at Appendix 3.

17. Out of 14 AAP's 10 have identified health as a priority. In addition to this Mid Durham, Bishop Auckland and Shildon (BASH) and Stanley AAP's, as previously indicated in paragraph 9, are taking part in the Wellbeing in Targeted Communities pilots whilst the 4 Together AAP has health as an overarching theme across its three priority areas of older people, young people and employability.

18. In addition to the above paragraph PH has, for the second year running, provided £10,000 of funding to each AAP to spend on health priorities within their local area during 2015/16 therefore, making health and wellbeing an integral part of <u>all</u> 14 AAPs work during the 2015/16 period. A list of the AAP/PH funded projects from 2014/15 is attached at Appendix 4.

19. Board members should note that although we have highlighted PH funded projects the AAPs have funded, and will be funding a wide variety of local needs led health and wellbeing programmes. Currently the AAPs are focusing upon a number of mental health issues including suicide prevention and dementia awareness.

20. A nominated public health representative is aligned to each AAP providing support and advice in relation to the wider public health agenda, including guidance in relation to local health priorities, which alongside other local data influenced how the PH funding was allocated in 2014/15.

21. It should be noted that PH representatives are not members of the AAP Boards. Involvement of PH representatives is different across the AAP's with some representatives attending task and finish groups where appropriate, whilst others working directly with AAP coordinators. Further discussions between PH and AAPs will take place in May to evaluate the work that has taken place in 2014/15 work and how this can be built upon in 2015/16.

22. Health representation on AAP Boards is through the relevant CCGs.

23. To support the allocation of PH as well as the Durham Dales, Easington and Sedgefield CCG recent allocation of £300,000 across the 9 AAPs connected to their area of delivery it is proposed that closer work will take place between the PH representative and the CCG Board member to identify key local health issues as an AAP agenda item. These issues will be identified using evidence from the JSNA/JHWS, CCG patient and AAP Forum engagement feedback and PH profiles.

24. The need to share AAP best practice which impacts upon the wider wellbeing and prevention work across the County will be addressed through the following processes:

    - The AAPs have already placed 'learning from best practice' as a standard agenda item on their regular Coordinators meetings. This is being done under the County Durham Partnership (CDP) five 'Altogether Better' themes.
    - An annual 'AAP's Together' forum event will be planned for the end of 2015 which will allow AAPs to come together to discuss best practice and the sharing of ideas.
    - The regular CDP Forum events bring together AAPs and members of the thematic partnerships to discuss work that impact upon each of the 'Altogether Better' themes.
    - The Health Networks aligned to the Durham Dales, Easington and Sedgefield CCG as well as the North Durham Health Alliance (formerly Derwentside and Durham / Chester le Street Health Networks) will also offer multi partnership arenas for joined up discussion. As part of their role they will also seek to address wider health and wellbeing issues that cut across many of the AAPs.
    - The CWP will also enable AAPs and partners to share and learn from best practice

Commissioning arrangements

25. Discussions have taken place on how DCC can support smaller local VCS providers to bid for DCC contracts. This is being addressed through the Children and Adults Services, Durham County Council, Market Position Statement 2015/17 which sets out the direction of travel for Children and Adults Services over the next two years, which now includes information on supporting VCS consortia bids. A number of meetings have taken place with VCS representatives to forward this agenda and an AAP representative has been in attendance at each session.

Communication and Engagement

26. Discussions have taken place concerning several areas of work linked to shared communication and engagement.

27. Social media is used by a number of partners as a method of communication to share information and gather views. All 14 AAP's have a Facebook page.

28. The AAP Facebook pages have a wide local reach which makes them invaluable when local information needs to be communicated eg village or Parish specific. The AAPs can also communicate more general countywide information, such as the publication of plans and strategies which can be included in their regular AAP e-bulletins or newsletters.

29. In addition, DCC also hosts a Facebook page and has a twitter account to offer another way of communicating and engaging with members of the public. These can be a valuable interactive tool to help build online communities with shared interests, as well as enabling information sharing.

30. North Durham and Durham Dales, Easington and Sedgefield CCG's also have a Facebook page which they use to advertise events.

31. There is a wide range of engagement activity taking place across partner organisations; it may be useful to identify opportunities of how partners can collectively better utilise these events/mechanisms.

32. Several of the AAP's have excellent links to young people and use Facebook linked to survey monkey to find out young people's views (through schools as part of IT lessons). The AAP's hold forum events in October/November to identify the AAP priorities for the coming year and have utilised a variety of methods to engage residents so that they can base their decisions using the views of the people that live in their areas.

33. It is proposed that Communication and engagement becomes a standing item on the agenda of the CWP to allow partners to map out in advance the potential to coordinate engagement.

34. The Communication Plans 2015/16 for the Health and Wellbeing Board and Children and Families Partnership are currently being developed, they will seek to incorporate the above range of communication and engagement methods available across partner organisations (including the use of social media) to support the work of the Partnership Boards. The Communication Plans will be developed by June 2015.

Funding opportunities

35. There are a range of funding opportunities available, which different organisations can bid for. The CWP will explore opportunities to develop bids for funding opportunities to support and align to the the Joint Health and Wellbeing Strategy.

36. Resources should to be targeted to places which are most in need, and that AAP local expertise, PH and CCG data along with the Joint Strategic Needs Assessment should be used to identify these areas in order to provide a more targeted approach to funding bids. This again lends itself to alignment with the Wellbeing for Life and preventive programmes.

37. It is proposed that the development of this work should be through the CWP with all relevant partners in place.

Recommendations

38. The Health and Wellbeing Board is recommended to:

- Note the work that is taking place.
- Note the improved alignment of work of the AAP's to the Health and Wellbeing Board.
- That work will progress through the Community Wellbeing Partnership.
- The AAP/public health supported projects in 2014/15 (Appendix 4).

Contact:	**Andy Coulthard, Area Action Partnership Coordinator, Durham County Council**
Tel:	**07818 510370**
	Andrea Petty, Strategic Manager – Policy Planning & Partnerships, Durham County Council
Tel:	**03000 267312**

Appendix 1: Implications

Finance
Not applicable

Staffing
Not applicable

Risk
Not applicable

Equality and Diversity / Public Sector Equality Duty
Not applicable

Accommodation
Not applicable

Crime and Disorder
Not applicable

Human Rights
Not applicable

Consultation
Not applicable

Procurement
Not applicable

Disability Issues
Not applicable

Legal Implications
Not applicable

Appendix 2 - AAP interface with Health and Wellbeing Board action plan

Action		Lead	Timescale
Alignment of Priorities	AAPs will work on projects that are not already statutorily being provided in order to bring added value to the work of the H&W Board. AAP updates to be provided to H&W Board	Gordon Elliott / AAP Coordinators AAP Coordinators	Ongoing Six monthly
Asset based approach	Wellbeing in Targeted Communities - Local asset mapping is currently being undertaken in Mid Durham, Shildon and Stanley AAP areas as a three year pilot project which will be evaluated by Durham University	Public Health/Durham University	Ongoing with final evaluation December 2017
	Wellbeing for Life - Local asset mapping is currently being undertaken across the top 30% most deprived wards across the county by Durham Community Action	Durham Community Action	Ongoing
VCS Funding	VCS Market Engagement Events to be held across County Durham	Phil Malyan / Commissioning colleagues.	3 events annually
Links between Public Health, CCGs and AAPs	Convene AAP Co-ordinators meeting with Public Health aligned representatives to discuss key issues/ways of working across the AAP's	Andy Coulthard	May 2015
	CCG Board member (working with PH representative) to identify key local health issues as an agenda item (linked to evidence in JSNA/JHWS, public health profiles etc)	Public Health AAP lead/AAP coordinators/CCG Board members	Ongoing
Communication and Engagement	Develop Communications Plans for the Health and Wellbeing Board and Children and Families Partnership	Julie Bradbrook	June 2015
Funding Opportunities	Consider funding opportunities and develop appropriate bids	Community Wellbeing Partnership	June 2015 onwards

Appendix 3
Area Action Partnership Priorities 2015/16

Health related priority highlighted in red

AAP Area	AAP Priorities 2015-16
Teesdale	Older People (including health and wellbeing) Children and Young People (including health and wellbeing) Transport and Environment Supporting Community Organisations (Small Grants Fund)
Weardale	Support to Groups in Weardale Support and Activities for Children and Young People Employment, Jobs and Tourism Health and Wellbeing incl. Support and Care for the Elderly
Mid Durham Rural	Support for younger people (including Health and Wellbeing) Support for older people (including Health and Wellbeing) Support for the voluntary and community sector Employment and Job prospects Road safety Targeted Wellbeing Programme – Older People
East Durham Rural	Activities for Children and Young People Health and Wellbeing Older People With Crime and Community Safety running through
3 Towns (Crook, Willington, Tow Law)	Crime and Community Safety Health and Wellbeing Employment , Job Prospects, Education and Training With an overarching priority of Children and Young People
Derwent Valley	Activities for children and young people Employment, education, training and regeneration Older people and health and wellbeing Culture, art and tourism (cross cutting priority)
Chester le Street	Crime and Community Safety Opportunities for Children and Young People Health & Wellbeing (which includes and strengthens support for older people and carers) Improved Environment

AAP Area	AAP Priorities 2015-16
	Development of Town and Villages Employability and Welfare Reform
Durham City	Activities for Young people Older people Supporting Voluntary and Community Sector Health
East Durham	To be confirmed at AGM in May 2015. Likely to be: Maintaining the Social Fabric of our Communities Health, Mental health and Wellbeing Job Creation, Education and Training Children and Young People
4 Together (Chilton, Ferryhill, Cornforth, Bishop Middleham)	Older People Young People Employability (Health & Wellbeing overarches the priorities)
Great Aycliffe & Middridge	Activities for Young People Support to Community & Voluntary Sector including Older People Employment, Enterprise, Education & Training (Health & Wellbeing to be included when possible)
Bishop Auckland and Shildon	Employment, Education and Training, Children and Young People and Crime and Community Safety (with a cross cutting theme of raising Community Aspiration) Targeted Wellbeing Programme – General
Stanley	Opportunities and Activities for Young People Regeneration of Stanley and its Villages Support for the Elderly, Carers and Disability Groups Targeted Wellbeing Programme – Tobacco
Spennymoor	Safer, Stronger, and Healthier Communities Town Centre Regeneration Employment & Job Prospects (including Children and Young People)

Appendix 4 – Public Health and AAP Supported Projects 2014/15

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
4-Together AAP		
ASK Helpline – The Cornforth Partnership - The ASK helpline is a free confidential text service that has been delivered across County Durham by The Cornforth Partnership since 2011. The number of young people accessing this support service has grown massively year on year highlighting the need for the project. Current funding is running low and they are passionate about keeping this vital service alive for young people. The funds will enable the helpline to keep open from 10am to 9pm Monday to Friday. The helpline is staffed by professionally qualified youth workers with a range of training and specialisms in the issues raised by young people including self-harm, drug and alcohol use and sex and relationships amongst others. The project is ideally designed to reach out to young people at the most vulnerable and isolating times in their lives. ASK provides professional support and information which is available outside of traditional support service hours using the medium of texting which young people are comfortable and familiar with.	Total Project Cost: £38,134.36 Public Health: £10,000	**Outcomes** • Young people will have increased awareness of a confidential support service. • Young people will be better informed of youth issues and will have information needed to make better choices with regards to their own negative risk taking behaviour. **PI's** • 5 Voluntary groups supported • 4 community buildings supported • 600 young people involved in schemes to support healthier choices • 20 young people involved in schemes to reduce ASB • 20 young people involved in substance misuse initiatives • 1 scheme aimed at improving metal health and wellbeing
Bishop Auckland and Shildon AAP		
Flexible Emergency Packs Provision - Woodhouse Close Church - Flexible Emergency Packs are distributed to those in crisis and are tailored to suit their particular needs. For example: food supplies, fuel payments, personal hygiene items. The typical cost for a crisis pack is £35 per case. Provision	Total Project Cost: £10,250 Public Health: £5,000	**Outcomes** • local people with have structured support to take them out of the poverty cycle • More local people will have improved

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
complements the Furniture re-use scheme and Thrift Shop ran by the church. The scheme is supported by local organisations, community groups and volunteers.		opportunities to learn budgeting skills through robust partnership working • Low level crime, such as shop lifting, will decrease **PI's** • 5 Voluntary groups supported • 690 benefiting from schemes to reduce impact of welfare reform
Flexible emergency provision and crisis intervention - Shildon Alive - Funding will pay for the purchase of electricity and gas meter cards. This will aim to ensure families in crisis will stay warm and dry whilst at the same time teaching budgeting skills and supporting healthy choices. Part of the £5k will also support a "Guerrilla Gardening" programme of activities - 600 children will take part in targeting areas of Shildon that need "sprucing up". Funding will pay for plants and equipment and the employment of horticultural experts to support the activity. Ran successfully in 2014 the gardening programme developed individuals own sense of worth and community ownership.	Total Project Cost: £5,000 Public Health: £5,000	**Outcomes** • People can manage to eat without resorting to criminal activity • People's health will not be adversely affected by the cold or the worries about where the next meal will come from • Long term outcome is for regular saving, leading to better lifestyles • People will engage with other agencies who can help them to live better **PI's** • 7 voluntary groups supported • 400 benefiting from schemes to reduce impact of welfare reform
Chester-le-Street AAP		
Advice in County Durham – Chester-le-Street Advice Hub Pilot - Developing a joined up referral service, by having staff and volunteers from the partner organisations involved, on a rotation basis at the Foodbank, to assist and	Total Project Cost: £5,468 Public Health:	**Outcomes** • More people will be able to access the range of advice services benefitting from food parcels,

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
signpost clients to advice services. This will help resolve people's problems, and offer a more holistic approach to health and wellbeing. In addition Chester-le-Street & Durham City Mind will provide mental health training, enabling advice workers to identify and support people who require help and support with their mental health – who can then be signposted to other appropriate services.	£3,643	specialist advice resolving financial issues including: welfare benefits, debt and grants. • Staff and volunteers trained in mental health awareness enabling staff to identify and support people who require help with their mental health. • Volunteers will be given hands on training and supervision in all aspects of financial inclusion. • The partner organisations will benefit from new ways of working & delivering joined-up advice services. **PI's** • 5 Voluntary and community groups supported • 10 people engaged in voluntary work • 32 advice and guidance sessions • 20 people trained • 1 scheme aimed at improving support and outcomes for families • 3 schemes aimed at improving mental health and wellbeing • 165 people benefitting from schemes aimed at reducing health inequalities and early deaths
Aspire Learning Support and Wellbeing in partnership with DASS (Durham Alcohol Support Service) – Working in partnership with Durham Alcohol Service – a local voluntary organisation, working to support people in recovery from alcohol addiction. Due to the nature of their issues, many people are socially isolated, and DASS wishes to offer outings for the group,	Total Project Cost: £7,750 Public Health: £6,357	**Outcomes** • A whole system approach personalised to support a preventative/maintenance system to reduce isolation • Increased opportunities to reduce isolation for older people

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
providing diversionary activities. They also wish to develop weekly sessions, which will include; mindfulness – self-esteem building – confidence building – unlocking your potential – cultivating healthy thinking – plus other groups which will promote positivity in recovery and a pathway to other services and opportunities in the community.		• Improve the health and wellbeing of older women • Added value by providing access to a number of services and health professionals as part of the 'live well and keep well' service • Pathway to other services that can reduce social isolation and enhance wellbeing • Support people on their recovery from alcohol addiction **PI's** • 2 Voluntary and community groups supported • 2 Community buildings and facilities supported • 2 jobs safeguarded • 8 people trained • 6 weeks of training • 8 people benefitting from alcohol and substance misuse reduction initiatives • 2 schemes aimed at improving health and wellbeing • 40 people benefitting from schemes aimed at reducing health inequalities and early deaths
Derwent Valley AAP		
Derwent Valley Diners - Derwent Valley Diners is a pilot project which aims to benefit older people living in the Derwent Valley Partnership area, particularly those experiencing social isolation. It will promote the benefits of neighbourliness, seek to improve older people's health and quality of life and encourage local communities to be increasingly self-supportive by working	Total Project Cost: £18,543 Public Health: £2,500	**PI's** • 15 people engaged in voluntary work • 15 people trained • 1 scheme aimed at protecting vulnerable people from harm

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
together. Older people will benefit from a nutritious meal cooked and packaged by a local catering establishment and brought to their home weekly by a volunteer who will provide regular social contact. They will collect meal orders, deliver their meal to them and may stay for a while to keep them company. Age UK County Durham will negotiate best prices with catering providers. While older people will pay for their meal, the aim will be to provide a nutritious, good value for money meal. A simple referral process will operate and volunteers will be DBS checked, reimbursed for their travel and provided with relevant training and support, in addition to project related equipment. They will be given opportunities to acquire new skills and boost confidence which may also help them to gain employment.		• 1 scheme aimed at improving the quality of life, independence, care and support for people with long term conditions
Healthy Starts - In 2013, the Partnership supported the development and delivery of a number of Healthy Living Activity Sessions which were available to all toddler groups across the area. These sessions highlighted the importance of healthy food choices, portion sizes, regular mealtimes and keeping children active. Families also took part in hands on activities to reinforce the idea of making healthy choices and were involved in making their own healthy snack looking at different choices, expense of food, time for preparation and portion size. Based on the success of the previous project, the feedback and evaluation data obtained from the parents who took part and the opportunity for these sessions to now be delivered to children of nursery and reception age, the Partnership will be supporting the delivery of additional sessions aimed at nursery and primary school age children.	Total Project Cost: £6,160 Public Health: £4,000	**PI's** • 15 toddler groups engaged • 150 families engaged • 252 adult beneficiaries • 298 children beneficiaries
HAGGRID Branches Out - The HAGGRID project is based on three key steps namely education, community and activity. 13 young people have been referred from Consett Academy to take part in the project, all are key stage 3 and identified as lacking confidence, low aspirational/self-esteem and/or	Total Project Cost: £19,560 Public Health: £2,500	**PI's** • 1 community building/facility supported • 13 young people involved in schemes to help them make healthy choices and give them the

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
potential NEETs. The HAGGRID project delivers a full level 1 diploma in practical horticulture skills through City and Guilds and there are Police led citizenship/life skills lessons based around common local issues such as environment, drugs, alcohol, assault and domestic violence. The project intends to work with school staff and pupils to initially improve access and install new wheelchair friendly raised beds, continuing then with the development of a reflective/quiet area, sensory garden and vegetable growing patch to link to 'family cooking on a budget' sessions.		best start in life • 1 scheme aimed at improving support and outcomes for families • 60 children / young people to benefit from the project overall
Durham AAP		
'Open Art' Surgery - RT Projects designs – The project will target specific groups of vulnerable people across the Durham AAP areas that are experiencing mental health problems. This includes people with dementia, adults with a learning disability, people with multiple sclerosis, men at risk of suicide, and their families and carers. It will provide the opportunity for individuals to engage in meaningful creative activity, regular social interaction and to learn and share new skills. Integral to delivery is the community resource 'The Open Art Surgery' in Gilesgate, Durham. The surgery is a purpose-designed art studio for people with disabilities, containing all the necessary components for us to achieve the aims. Within each project they provide a range of activities in direct response to individual's interests and needs, incorporating woodcarving, printmaking, music, stained glass windows and puppetry. They have a comprehensive range of materials and equipment on site to enable staff to respond to each individual's needs and interests.	Total Project Cost: £13,100 Public Health: £10,000	**PI's** • 2 voluntary groups supported • 1 community building supported • 10 volunteers • 100 people benefitting from schemes aimed at reducing health inequalities and early deaths

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
East Durham AAP		
Centre of Excellence – The project is to employ a new Dementia Support Worker for 3 days a week to work in the East Durham area employed by the Alzheimer Society. The employee will be based at the Robin Todd Centre which will become a centre of excellence for East Durham. The development of this project will give comprehensive information, support and signposting to services for dementia patients and their families. This support will be one to one or group activities and will include emotional, financial and medical advice, developing support networks designed to give emotional support to those families and carers feeling isolated and alone.	Total Project cost £32,000 Public Health: £10,000	**Outcomes** • The creation of a centre of excellence in East Durham for families and sufferers of dementia. • Newly diagnosed Dementia patients and families receiving help and support from the start of their diagnosis. • Creation of Dementia Friendly East Durham with community activities and support delivered in local community centres and hubs. • Links created between groups/service providers with pathways to help/support clearly identified. **PI's** • 1 job created • 1 scheme created to tackle mental health and wellbeing • 50 people benefiting from a scheme aimed at reducing health inequalities and early deaths
East Durham Rural Corridor AAP		
Employability Pit Stop – Mental health and Wellbeing - The purpose of the project is to engage, motivate, increase confidence and provide employability skills development to East Durham residents. The project will target individuals of working age who require support to navigate the present Welfare reforms. In particular those residents who have poor access to formal learning opportunities, the support delivered through this project will focus upon developing skills to improve employment prospects. Progression will be	Total Cost: £41,879 Public Health; £10,000	**Outcomes** • 85% beneficiaries will report improved employment skills • 80% clients report increase in knowledge and skills • 85% clients demonstrate ability to conduct independent job search

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
supported through the provision of impartial Information, Advice & Guidance linking to a range of support agencies i.e. welfare support, economic, employment and skills services. Through encouraging work and job prospects as a viable option this pilot aims to reduce the concern and anxiety of local people in respect of welfare reform, in particular the introduction of universal credit.		**PI's** • 2 voluntary groups supported • 3 community facilities supported • 6 volunteers engaged • 1 job created • 1 job safeguarded • 10 people supported into employment • 180 advice and guidance sessions provided • 1 IT connectivity initiative supported • 40 people benefitting from schemes to reduce impact of welfare reform • 1 scheme aimed at improving mental health and wellbeing
Great Aycliffe and Middridge AAP		
Youth CREE project – Greenfield School - The project will engage young people in positive activity to help them feel good, cope better with pressures and help reduce self-harm. It is planned to bring in external experienced facilitators who will lead activities and promote wellbeing. Some sessions will take place in both Aycliffe Secondary Schools (Greenfield and Woodham), and also outside of school hours.	Total Project Cost: £14,500 Public Health: £10,000	**Outcome** • Support young people to improving their general wellbeing and to cope with pressure **PI's** • 200 young people involved in a scheme which will support them to make healthier choices and a better start in life • 1 scheme aimed at improving mental health and wellbeing
Mid Durham AAP		
Neighbourhood Networks – 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 more aware of	Total Cost: £32,000 Public Health: £10,000	**Outcomes** • Older people feel more secure, better cared for and have a better quality of life

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
the services in their village and the surrounding areas that they could access to improve their quality of life. The scheme will use and train local volunteers and will take place in Esh Winning, New Brancepeth and Cornsay Parish.	AAP AB: £2,000	• Increased access to information and advice which enable them to make informed decisions about their own wellbeing • Older people can be supported to help them remain in their homes and independent longer • Older people are involved in the development and implementation of this project **PI's** • 6 volunteer engaged • 1 scheme developed to improve mental health and wellbeing • Minimum of 60 people benefitting from schemes aimed at reducing health inequalities and early deaths
Spennymoor AAP		
To Be or Not To Be - The aim of the project is to design and deliver a course for young men that explore healthy relationships and the right time to have a baby. It will be a ten week course suitable for boys aged 11-13 yrs/ KS3. The project will deliver two courses per year over one year to groups of 15 boys, working with 30 boys and 1 school for the duration of the project. The programme will address issues young boys face with a holistic approach, giving them time to experience, explore and discuss the factors involved in being a 'good' boyfriend, partner and father in later life. It will have a major focus on healthy relationships, relationship abuse and violence as well as giving participants the skills and experience to break the cycle of poor parenting in the future by exploring the realities of becoming a father too soon.	Total Project Cost: £13,235 Public Health: £10,000	**Outcomes** • Increased awareness of fatherhood responsibility • Increased knowledge on relationships • Increase confidence and self esteem • Increased empathy and pro social behaviour **PI's** • 30 young people involved in schemes to help them make healthier choices and a better start in life • 1 scheme aimed at improving support and outcomes for families

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
		• 1 scheme aimed at protecting vulnerable people from harm
Stanley AAP:		
Stanley Crees Project (Not yet fully signed off) - East Durham Trust will expand the CREE project across the Stanley area with the development of two new groups. Working in partnership with two local community and voluntary groups, the first being the Just for Women Centre we will establish a designated space in an adjourning property which will offer a variety of activities in a male only environment. These activities will suit each individual's needs- allowing members to share ideas, interact, improve communication skills and make new friends. The space used will allow activities such as indoor horticulture, refurbishing and upcycling pieces of furniture, smaller woodwork projects such as toy making & window boxes, and other craft activities such as Proggy mats, mosaics, and hanging baskets as well as having space to relax and socialise. Future activities will be chosen by the men in the group. The second group will be either a Men's or Women's CREE and will be developed in partnership with local community and voluntary group outside of the Town Centre (as yet to be identified, but possibly in South Moor or Annfield Plain). The group will initially offer a variety of activities that could include; Bingo, Board and Card Games, beauty sessions, cookery, coffee mornings, trips to local attractions, fishing trips and also fundraising/sustainability activities. Once the group is established new activities will be developed as the men/women who attend are empowered to take ownership and develop their ideas. Both groups will be facilitated by volunteers trained in Mental Health First Aid	Total Project Cost: £10,000 Public Health: £10,000	**Outcomes** • Increase social activities for potentially vulnerable and reduce isolation. • Increase capacity within the community by training local volunteers in Mental Health First Aid and ASIST Suicide Intervention training. • Provide signposting and route into local support services (including Welfare Rights). **PI's** • 2 Voluntary groups supported • 30 people given access to new cultural/sporting/recreation opps • 2 volunteers engaged • 2.5 training weeks • 2 schemes aimed at improving mental health and wellbeing

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
and ASIST. They will provide signposting to potential referral agents as required including Relate, Welfare Rights or other health services. The volunteers are supported by their host CREE group, East Durham Trust and the overarching CREE network.		
Teesdale AAP		
Healthy Starts – Pre-School Learning Alliance - The project supports local families with information relating to health and wellbeing and supports the local volunteers who run the groups to do a more effective job in supporting the families in an ongoing capacity. The focus for the healthy starts project is based on preventing health issues by giving children the best start in life right from the weaning and crawling stage. The project will focus on giving families information and advice on various issues around healthy weaning and the importance of exercise for children.	Total Project Cost: £5,076 Public Health: £2,538	**Outcomes** • Supporting community volunteers to increase their skills in supporting families who attend their toddler groups • Supporting families in making healthier choices for their families • Providing children hands on activities to participate in **PI's** • 10 voluntary groups supported • 100 children involved in a scheme to help them make healthy choices • 100 people benefiting from schemes aimed at reducing health inequalities
Teesdale Retired Farmers Lucnhes/Socials – Upper Teesdale Agricultural Support Services Limited - Since September 2012 UTASS has been delivering a project to provide socially isolated men over 60 in Teesdale with hot, nutritious meals and the opportunity to socialise. The sessions have also been used to offer information, advice and guidance on a range of relevant topics such as benefit entitlement. The sessions have taken place on a monthly basis at Middleton in Teesdale and Barnard Castle Farmers Auction Marts.	Total Project Costs: £6,181	**Outcomes** • Socially isolated older men have improved wellbeing and mental health through participating in social activity • Socially isolated older men feel less isolated and more involved with their local communities.

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
		PI's • 1 voluntary group supported • 2 community facilities supported • 55 people given access to new cultural and recreational opportunities • 2 new volunteers engaged • 2 schemes aimed at improving mental health and wellbeing
Enriching Rural Lives – Teesdale YMCA - Focusing on mental and physical health the project will deliver a range of workshops and support sessions that engage communities members aged 10 – 85 years. There are 3 elements to this project; Intergenerational Project – A continuation of the work focusing on young people working with residents with dementia on heritage projects; Art workshops – the delivery of 12 workshops over the year that would bring a creative outlet to Teesdale for all ages; Access to sport and healthy lifestyles. 10 opportunities over the year enhanced by youth workers and including healthy eating projects and key messages.	Total Project Cost: £3,290 Public Health: £2,000	**Outcomes** • Developing local heritage skills • Increased access to opportunity, impacting on their physical health and wellbeing. • Enhance their emotional wellbeing through holistic workshops & increased learning based on nature, landscape and heritage **PI's** • 2 community facilities supported • 227 people given access to new cultural and recreational activity • 2 schemes aimed at improving health and wellbeing
Keeping in touch in Teesdale – Leap in Teesdale - To teach people over 50 to use computers in order to prevent social isolation, loneliness and depression. They will run 2 separate courses every week in term time, each running for two hours with a break in the middle. Each learner will fill out an initial assessment at the beginning of the course and will agree an individual	Total Project Cost: £7,634 Public Health: £3,462	**Outcomes:** • People will be able to word process simple documents • People will be able to use the internet • People will interact in a social environment, getting them out of their houses and

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
learning programme. They will also continue with the computer club at Charles Dickens Lodge but the reviewing of the achievement of the learners will be more informal.		preventing social isolation **PI's** • 1 voluntary group supported • 7 people engaged in voluntary work • 12 people trained • 3 schemes to improve mental health and wellbeing
Three Towns AAP		
Young People's CREE Project - The Young Peoples Cree project is based at St Cuthbert's centre in Crook, the initial funding for the project came from Durham County Council Public Health via East Durham Trust as part of their Countywide Cree initiative created to support mental health and emotional wellbeing for individuals with a specific role of reducing suicide. Jack Drum Arts were asked to pilot one of the County's first Young Peoples Cree projects as a direct response to the high risk of suicide amongst young people in Wear Valley. The project consists of a regular weekly session every Tuesday with staff being available during office hours each day. Currently 20 Young People aged 13-19 attend the sessions with over 45 accessing since July 2014. The cree is set up as a place for music making, film making, drama, circus skills and other creative activities that are appealing to the Young People as well as a space where individuals can come to chill out, make friends and access important information and guidance. The current funding ended on the 31st of March the Public Health money and Area Budget will ensure the service can continue and that is staffed correctly with both Artist and youth worker running the project particularly in terms of dealing with issues of disclosure, mental health and suicide and being able to be responsive to the needs of the most vulnerable people in the 3 Towns	Total Project cost: £27,618 Public Health: £10,000	**Outcomes** • A widening of the range of activities available with a specific focus on arts and wellbeing provision for young people at risk of self-harm, mental health problems and suicide. • Improved mental health and emotional wellbeing for Young People • Opportunities for young people to be signposted to the many other activities • A targeted number of participants receive training and mentoring from our staff **PI's** • 1 voluntary and community groups supported • 2 people engaged in voluntary work • 1 Job Created • 2 People trained • 1 Scheme aimed at improving support and outcomes for families • 1 scheme aimed at protecting vulnerable

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
Area.		people from harm • 1 scheme aimed at improving mental health and wellbeing • 25 total individual beneficiaries for the project
Weardale AAP		
Wheels to Meal's – The scheme will address the two issues of nutrition and rural isolation in older people. Using Community Transports fully accessible mini buses with volunteer drivers and passenger assistants, the scheme collects people from their doors and take them to local restaurants for a two course lunch or afternoon tea, and bring them home via a scenic drive. The scheme is widely promoted and the choice of venue is agreed from feedback and suggestions offered by the participants. To ensure an inclusive approach, a mailing group is set up of interested participants, and the Wheels to Meals programme for the month is despatched. Additional support is offer via a phone call to those members who have expressed an interest (around the 100 participants and growing). The phone call to the participant (made by a volunteer) is import and is designed to offer a friendly voice and a listening ear. The participant is charged £10 and this goes towards the cost of the meal, the food provider receives £7 per person. The balance of £3 is set against the transport and other costs. This scheme also has a discretionary payment element.	Total project cost : £27,750 Public Health: £5,000	**Outcomes** • Older people maintained longer in homes • Income for local restaurants • Volunteers have improved self-worth **PI's** • 8 people engaged in volunteering • 15 businesses supported • 1 scheme aimed at improving mental health • 75 beneficiaries
Wolsingham Recreation Association - are currently involved with Wolsingham Parish Council, in a joint venture to enhance the children's play area in the Village. This will enable the play area to become more inclusive, particularly for disabled users of the area. On two successive playground inspection reports, Disability Discrimination Act (DDA) questions have been raised. The plan is to install two tarmac paths, one from the car park to the	Total project cost: £29,763 Public Health: £5,000	**Outcomes** • Improve Health & Wellbeing • Help towards reducing obesity • Help to educate with educational in lay in path **PI** • 300 people given access to new

Outline of Scheme	Expenditure	Predicted Outcomes and PI's
play area, the other connecting all of the play apparatus. To complement the existing disability equipment, which is accessible for wheelchairs, and to be more inclusive, the plan will include two additional sets of swings with cradle and bucket seats.		cultural/sporting/recreational opportunities • 12 people involved in local decision making processes • 1 tourism initiatives supported

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By virtue of paragraph(s) 1, 2 of Part 1 of Schedule 12A
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