Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Friday 9 October 2015**
Time	**9.30 am**
Venue	**Council Chamber, 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. Minutes of the meeting held on 30 June and of the special meeting held on 1 September 2015 (Pages 1 - 14)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. Media Issues
7. County Durham and Darlington Urgent Care Strategy - Report and presentation by Anita Porter, NHS North East Commissioning Support Unit (Pages 15 - 92)
8. Review of Care Connect - Joint Report of the Assistant Chief Executive and Corporate Director of Regeneration and Economic Development presented by Adrian White, Head of Transport and Contract Services, Regeneration and Economic Development (Pages 93 - 110)
9. Health and Wellbeing Board Annual Report- Report of the Corporate Director for Children and Adults Services, presented by Andrea Petty, Strategic Manager - Policy, Planning & Partnerships, Children and Adults Services (Pages 111 - 144)

10. NHS England 5 Year Forward View Update - Joint Report of North Durham Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group presented by Nicola Bailey, Chief Operating Officer, North Durham Clinical Commissioning Group and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 145 - 156)
11. Care Act 2014 Update - Report of the Corporate Director for Children and Adults Services, presented by Paul Copeland, Strategic Programme Manager Care Act, Children and Adults Services (Pages 157 - 164)
12. Quarter 1 2015/16 Performance Management Report - Report of the Assistant Chief Executive, presented by Keith Forster, Strategic Manager Performance and Information Management, Children and Adults Services (Pages 165 - 178)
13. 2014/15 General Fund Revenue & Capital Final Outturn Report and Forecast of Revenue Outturn Quarter 1, 2015/16 - Report of Head of Finance, Financial Services. Presented by Andrew Gilmore, Finance Manager, Resources (Pages 179 - 194)
14. 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
1 October 2015

To: **The Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee:**

Councillor J Robinson (Chairman)
Councillor S Forster (Vice-Chairman)

Councillors J Armstrong, R Bell, P Brookes, J Chaplow, P Crathorne, M Davinson, K Hopper, E Huntington, P Lawton, H Liddle, J Lindsay, O Milburn, M Nicholls, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:

Mrs B Carr and Mrs R Hassoon

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

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Tuesday 30 June 2015 at 9.30 am**

Present:

Councillor S Forster in the Chair

Members of the Committee:
Councillors J Chaplow, M Davinson, K Hopper, H Liddle, J Lindsay, O Milburn, M Nicholls, L Pounder, P Stradling, O Temple and T Henderson (substitute for R Bell)

Co-opted Members:
Mrs B Carr and Mrs R Hassoon

Also Present:
Councillors L Hovvels and O Johnson

At the commencement of the meeting, Councillor Forster reminded members that this was the first meeting of the Adults Wellbeing and Health Overview and Scrutiny Committee since the death of the former Chair of the Committee Councillor Robin Todd. The Committee observed a minute's silence as a mark of respect.

1 Apologies

Apologies for absence were received from Councillors J Armstrong, P Brookes, P Crathorne, E Huntington, P Lawton, A Savory and W Stelling

2 Substitute Members

Councillor T Henderson for Councillor R Bell.

3 Minutes

The minutes of the meeting held on 2 March 2015, the Joint meeting with Children and Young Peoples' Overview and Scrutiny Committee held on 21 April 2015 and the special meeting held on 11 May 2015 were submitted for approval.

Councillor J Chaplow referred to the list of members present at the Committee's meeting held on 2 March 2015 and indicated that her name had been omitted from the list and requested that this be amended. With this amendment, the minutes of these meetings were agreed as a correct record and signed by the Chairman of the meeting.

4 Declarations of Interest, if any

There were no declarations of interest.

5 Any Items from Co-opted Members or Interested Parties

There were no items from Co-opted Members or Interested Parties.

The Principal Scrutiny Officer advised that Mr P Taylor, Healthwatch County Durham had resigned as a co-opted member. He assured the Committee that we still had links with Healthwatch and arrangements to seek a replacement were underway.

6 Media Issues

The Principal Scrutiny Officer provided the Committee with details of the following items which had appeared in the press:-

- Rumours that Darlington Hospital's A&E department is to close are quashed – Darlington & Stockton Times – 23 June 2015
  Mr Edmund Lovell would be presenting the Trust's clinical strategy that would highlight the investments being made for both Darlington and Durham hospitals.
- Hospital in superbug treatment trial – Northern Echo – 19 May 2015
  University Hospital Durham have introduced an antibiotic to combat superbugs.
- Proposed public health cuts could impact on North East children and crime – Journal – 22 June 2015
  Raising concerns about cuts impacting on local children.
- Positive inspection for mental health trust – Northern Echo – 25 May 2015
  A care Quality Commission Inspection report had classified Tees, Esk and Wear Valleys NHS Foundation Trust as good and the Committee was advised that a detailed report would be brought to a future meeting of the Committee.

7 Care Quality Commission

The Committee received a report of the Assistant Chief Executive that gave background information on the Care Quality Commission (for copy see file of Minutes).

Imogen Hall, Inspection Manager and Suzanne McLeod, Inspector, Care Quality Commission were in attendance. The Inspection Manager gave a detailed presentation about scrutiny and regulation working together, that included information on:-

- CQC strategy 2013-16
- CQC purpose and role
- Raising standards; putting people first 2013-16
- Chief Inspectors and their teams
- Services regulated
- New approach to inspecting services
- Ratings and reports
- What CQC would continue to do
- New regulations and responsibilities
- CSC and Centre for Public Scrutiny
- Main contacts

- New guide for councillors and scrutiny committees
- Top tips for scrutiny committees
- How CQC would feed into scrutiny meetings

The Chairman thanked the Inspection Manager for her presentation.

The Inspection Manager explained that they do carry out checks on their own work and were scrutinised by their board on functions and outcomes of each report, following a question from Councillor M Nicholls.

Councillor O Johnson asked what maximum time was allowed between inspections, and was advised that the new methods of working began in April 2015 so they were still in the process of completion of the first round of inspections for each trust following the organisational review of the Care Quality Commission. The Inspection Manager went on to explain that if a trust or body had not met standards an action plan would be produced and they would make a return visit when required.

Referring to the new enforcement powers following a question from Councillor Johnson, the Inspection Manager advised that they could apply fixed penalties and could act more quickly than previously. She added that mostly the enforcement powers applied to the management of registration.

Councillor O Temple welcomed the involvement of the CQC and said that this was a positive sign for the Committee.

Councillor P Stradling said that the report and presentation were very concise and informative and emphasised the importance for the Council to have this relationship. He asked how scrutiny could hold the commission to account, for example, if an inspection was held and CQC approved and the Council did not agree to this. The Inspection Manager explained that all information about a planned inspection would be raised beforehand and received in advance and the CQC would respond to any concerns raised.

The Principal Scrutiny Officer gave assurance that evidence portfolios are submitted in respect of inspections to the CQC which set out key issues identified by the Committee in respect of the NHS Foundation Trust/organisation being inspected. He added that the Council received notification of planned inspections via the Corporate Director of Children and Adults Services and this is then communicated to the Chair of this Committee. He referenced the recent inspections of County Durham and Darlington NHS FT and Tees Esk and Wear Valleys NHS Foundation Trust and indicated that relevant issues such as the Breast Clinic at Bishop Auckland, the Ambulance Service Review with Durham, Dales, Easington and Sedgefield Clinical Commissioning Group and the Review of mental health services for older people in South Durham and Darlington had been submitted to the CQC.

In response to a question from Councillor J Chaplow about how much notice is given for an inspection, the Inspection Manager said that 20 weeks are given for a hospital inspection. The Inspector advised that unannounced inspections do take place in adult social care and primary care services, and will look at historical data. This would pick up on staffing levels and rotas for a few months before the inspection takes place. She

advised that the CQC do want services to improve and follow up inspections do take place to encourage services to be sustained.

The Chairman asked if the public were included in the assessments carried out and was advised that they do include members of the public who have had experience of receiving extensive contact with health care and have a good understanding.

Mrs R Hassoon referred to the TEWV inspection report whereby they scored highly for 52 of the 60 areas. She asked how the 8 areas that required improvement would be monitored and was advised that the CQC have continued engagement with the trust and the action plan would continue to be monitored.

The Chairman thanked everyone for their comments and welcomed the opportunity to be part of a strengthening partnership.

Resolved:
That the information contained within the report and presentation be noted.

8 County Durham and Darlington NHS Foundation Trust Clinical Strategy Update

The Committee received a report of the Assistant Chief Executive that provided an update on developments in respect of County Durham and Darlington NHS Foundation Trust's emerging Clinical Strategy (for copy see file of Minutes).

Mr E Lovell, County Durham and Darlington NHS Foundation Trust informed Members about a piece of work being carried out by the trust called 'Quality First' – one of seven key projects being taken forward this year. Significant investments are planned with a new emergency department of the University Hospital North Durham and the integration of emergency care at Darlington Memorial Hospital. Theatres would be upgraded at Bishop Auckland Hospital and mobile working in the community would be supported.

He went to explain that the service had been under immense pressure and for the first time the trust would have a deficit of £17m by the year end.

The Chairman thanked Mr Lovell for his report and recognised the importance of this consultation.

Councillor Stradling agreed that it would essential to have full consultation and early notification.

Referring to the shortfall of finances, Councillor Johnson asked if the trust had enough reserves to cover this and was advised that it was important to spend the reserves wisely as they could only be spent once. He emphasised the need to invest as the buildings at Durham and Bishop Auckland needed upgrading and the hospital at Darlington was over 40 years old. He advised that the trust would make transformative investments.

Resolved:
That the recommendations contained within the report be noted.

9 Health and Wellbeing Board Peer Review Findings

The Committee received a report of the Corporate Director for Children and Adults Services that gave an update on the Local Government Association's Health and Wellbeing Peer Challenge (for copy see file of Minutes).

The Senior Partnership Officer, CAS reported that feedback had been very positive and the LGA had said County Durham was the best in the region and the leadership had been commended. He went on to say that the close relationship with scrutiny had been highlighted as an example of best practice nationally.

Mrs Hassoon was pleased with the excellent report however, was disappointed that there was little reference to mental health issues. She had attended interviews with members of the Peer Review to explain what was being carried out in County Durham.

Councillor Stradling thanked the Senior Partnership Officer for a very positive report.

Resolved:
That the information contained within the report be noted.

10 Draft Alcohol Harm Reduction Strategy

The Committee received a report of the Director of Public Health that informed of the draft proposals for the Alcohol Harm Reduction Strategy 2015-20 (for copy see file of Minutes).

The Alcohol Harm Reduction Co-ordinator highlighted the key objectives relating to the Altogether themes and asked for feedback by 12 July 2015.

The Principal Scrutiny Officer advised that the strategy had been received by other Scrutiny Committees and he asked Members to give consideration to the terms of reference and key issues identified within the draft strategy within this Committees remit. He suggested that a response be submitted on behalf of the Committee in relation to relevant health related issues and the associated benefit of alcohol reduction.

Resolved:
That the Draft Alcohol Harm Reduction Strategy be noted and the Committee submit its feedback to the Alcohol Harm Reduction Co-ordinator by 12 July 2015.

11 Quarter 4 2014/15 Performance Management Report

The Committee considered a report of the Assistant Chief Executive, presented by the Strategic Manager Performance and Information Management, Children and Adults Services that updated on progress against the Council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for 2014/15 (for copy see file of Minutes).

The Strategic Manager, Performance and Information, highlighted the key achievements and key performance improvements issues and gave a detailed analysis of the figures within the report.

In response to a question from Councillor Stradling about the increase in the number of winter deaths, the Strategic Manager, Performance and Information advised that these were compared from the summer to the winter months and the increase covered the cold winters from 2010-2013.

Referring to people supported by Durham County Council and the increase of people being admitted on a permanent basis from residential and nursing care, Councillor Temple queried what proportion of people in the County are using the County's support. The Strategic Manager, Performance and Information advised that there were a range of services available and would depend on the support required. He said that the 836 people being admitted was not a huge number but that there had been a definite increase and reflected that people's needs had changed. Councillor Temple asked if there had been an increase in the number of people qualifying from the Council and was advised that financial support and assessment service numbers were decreasing.

Councillor J Chaplow expressed concern about people not receiving appropriate care if they were not buying it in themselves. The Strategic Manager, Performance and Information said he would provide feedback on the direct payments information following the meeting.

Resolved:
That the report be received.

12 NHS Foundation Trust 2014/15 Quality Accounts

The Committee considered a report of the Assistant Chief Executive which provided details of the responses made on behalf of the Committee in respect of NHS Partners' Draft Quality Accounts for 2014/15 (for copy see file of Minutes).

The Principal Scrutiny Officer advised that the further to the presentations received on 11 May 2015, responses to each partner had been provided within the timeframes with concerns of the Committee expressed and signed by the Chairman.

Resolved:
That the report be noted and the responses to NHS Organisations' draft Quality Accounts be endorsed.

13 Council Plan 2015/2018 - Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee

The Committee considered a report of the Assistant Chief Executive which presented an updated work programme for the Committee for 2015-16 (for copy see file of Minutes).

The Principal Scrutiny Officer highlighted areas of the work programme and informed the Committee that any statutory consultations that may arise would be factored in.

Resolved:
That the work programme be approved.

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Tuesday 1 September 2015 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, P Brookes, S Forster, E Huntington, J Lindsay, M Nicholls, L Pounder, A Savory, W Stelling, P Stradling and O Temple

Co-opted Members:
Mrs R Hassoon

Also Present:
Councillors L Hovvels, T Henderson and J Shuttleworth and J Mashiter (Local Healthwatch)

1 Apologies

Apologies for absence were received from Councillors J Chaplow, P Crathorne, M Davinson, K Hopper, P Lawton, H Liddle, O Milburn and Mrs B Carr

2 Substitute Members

There were no substitute Members in attendance.

3 Declarations of Interest, if any

Councillor S Forster declared an interest as Chair of Malborough Patient Reference Group.

4 Any Items from Co-opted Members or Interested Parties

There were no items from Co-opted Members or Interested Parties.

5 Durham Dales, Easington and Sedgefield Clinical Commissioning Group Review of Accident and Emergency Ambulance Services - Findings of the Independent Review by the North East Clinical Senate

The Committee received a report of the Assistant Chief Executive that provided the key findings of the Independent Review by the North East Clinical Senate in respect of the Accident and Emergency Ambulance Services (for copy see file of Minutes).

Dr S Findlay, Chief Clinical Officer DDES CCG referred Members to the independent report of the Clinical Senate and advised that a decision would be made on the findings at the DDES CCG governing body meeting on 8 September 2015. The Clinical Senate were to inform the CCG as to whether it was unsafe to implement changes and the change of the skills mix for the ambulance crew. The independent review had been detailed and extensive and considered questions out forward by the CCG. He advised that the information had been shared with the Rural Ambulance Monitoring Group but that the CCG had no further involvement with the review from that point onwards. Members were informed that paramedics had had the chance to submit evidence and that a small number had been received. Dr Findlay advised that the Review team had considered all key issues and issued their report including their conclusions, details of which could be found in section 6 of the Clinical Senates report.

Dr Findlay reminded the Committee that the CCG covered the whole of the DDES area and that the Independent Panel decided upon which questions to ask. He advised that no funding had been withdrawn and that there was adequate funding within the NEAS contract. He assured the Committee that there was no dispute with NEAS and that a signed contract was in place. In relation to the withdrawal of data, work was ongoing to decide what could be disclosed without risking patient identity.

In relation to the statement provided from the Rural Ambulance Monitoring Group about what the 'experts' say Dr Findlay said that the consultant at James Cook Hospital who had addressed one of the Engagement Meetings had been contacted on three separate occasions to seek confirmation of back up his statement but this had not been forthcoming.

The Chairman invited questions from Members of the Committee:-

Councillor W Stelling referred to the data and said he understood the associated risks but asked where the data collected from the Clinical Senate was held.

Councillor R Bell said that the decision of the PCT to have a double paramedic crew in 2008 and said that there was no evidence to suggest that this should change. He referred to the data not being provided to the Rural Ambulance Monitoring Group and felt that NEAS were not honouring a long standing commitment. He felt that it was too late to "waive the confidential" flag after a ten year period. He asked what we as a scrutiny committee were doing to hold DDES CCG to account as there was evidence to show that the ambulance that was supposed to be based in the Dales spent half its time travelling around the County.

Councillor A Savory reported that there were 32,000 residents in the Durham Dales and that they should be satisfied with the scrutiny process. She believed that the Committee should be requesting more details for the benefit of the residents.

Dr Findlay advised that the CCG's role was to increase response times to rural areas and any ring fenced investments would remain. He advised that the extra rapid response vehicle was used in the Darlington and North Durham areas and stated that an ambulance cannot pass an emergency. Therefore, Dr Findlay informed the Committee that there would be investment for more vehicles in the rural areas. He advised that the CCG are monitored and that the CCG monitor NEAS. He assured the Committee that the

evidence gathered showed that mixed crews were safe and that paramedic skilled crews were not needed. He recognised that handover times needed to decrease and that they were working with NEAS, County Durham and Darlington NHS Foundation Trust and Sunderland Foundation Trust on making improvements.

Mark Cotton, Assistant Director of Communications, NEAS informed Members that it had been brought to their attention that they could be breaching data protection legislation in providing the data in its previous format to the Rural Ambulance Monitoring Group and that the Trust's Information Governance they had a team that were looking into this area. Once issues were agreed the data would be provided and he assured Members that something would be available towards the end of the month. He reminded the Committee that Durham Dales was not the only rural are covered by them as they also covered Northumberland and Cleveland.

Dr Findlay added that there were two types of data, one for the public and one for the CCG to use. He assured Members that there had not been any change in the amount and level of data that they had received from NEAS.

The Chairman informed the Committee that the main topic covered at the Regional Scrutiny meetings was Ambulances and assured Members that work was being carried out by Scrutiny.

Councillor O Temple asked if NEAS or the CCG had data relating to mortality rates of being transported in rural and urban areas.

Dr Findlay stressed the arrangements were not working at present hence the need to change. He advised that the mortality rate data was based on distance.

The Chairman invited questions from other County Councillors:-

Referring to page 9 of the Clinical Senate's report, Councillor Henderson asked why the need for change. Dr Findley explained that the report goes into detail about why they do not think the skills mix would make a difference and that there was no evidence that the outcome would be any different when CPR or similar interventions were used. Dr Findlay was confident that the report adequately responded to all points raised.

The Chairman invited questions from members of the public:-

Joy Urwin, Rural Ambulance Monitoring Group passed on her condolences at the loss of former Chairman, Councillor Robin Todd, who she said would be sadly missed.

She went on to refer to the information circulated to the Committee (for copy see file of minutes) and explained that the role of the Group was to monitor performance within the Dales. She advised that a unique model should be used for a unique area and that performance had improved up until the Accident and Emergency Unit at Bishop Auckland Hospital had closed. She said that 28 different postcodes had been used in the Clinical Senates Review but that 19 of those were not based in the Dales. She said that the Audit had only lasted 28 days and that no clinical evidence had been presented. The Group believed that it was a serious flaw not to allow contributions from clinicians and in the absence of clinical and scientific evidence it was just opinions. She went to explain that

the double paramedic crew designed by the former PCT recognised that one size did not fit all.
In relation to mortality she informed the Committee that the risk of mortality had increased by 8% from Westgate to James Cook Hospital. Breathing difficulties had increased to 16%. She believes that this evidence has been dismissed and omitted from the report.
Ms Urwin said that Easington and Sedgefield would not benefit from an extra vehicle and that the service would deteriorate. The Group believed that no-one was holding NEAS to account and that a dangerous situation would emerge.

She concluded that the Scrutiny body had become a lifeline and asked the Committee to step up to their role. She asked that the data is re-instated and that the Committee reject the recommendations.

Mr John Guy asked why the report did not look at Quality Technicians (QTR).

Mark Cotton advised that there was not much to add to the point about data other than he was looking into putting data back into the information disclosed but stressed that it was applicable to residents of other rural areas and not just the Dales. He added that NEAS was not a failing organisation and was only one of three ambulance services hitting their performance targets. He added that the service was under a lot of pressure with rise in demand.

Ms Urwin said that she stood by everything she had stated and thought do think that the omission of data was a red herring.

Councillor P Brookes asked for confirmation that one extra vehicle would be made available and the Operations Manager said that there were plans to increase the number of vehicles and to add a rapid response vehicle to the Dales area.

The Chairman thanked everyone for their questions and for the responses provided.

Councillor J Armstrong also thanked everyone for their contributions and the Clinical Senate for their report and findings. He reminded the Committee that the decision to proceed with the implementation of the proposals was one for the DDES CCG Governing Body to make at their meeting on 8 September 2015. He referred Members to paragraph 6 of the report of the Assistant Chief Executive and in particular recommendations 2 and 4 that were made subject to the findings of the North East Clinical Senate's Independent review, reported back this morning.

He invited the Committee to agree the following comments be passed back to the DDES CCG's governing body on 8 September 2015:-

(i) The Adults, Wellbeing and Health Overview and Scrutiny Committee reaffirms its previous agreement that the case for change has been demonstrated by the CCG, given that the North East Clinical Senate had concluded that:-
   (i) There was no evidence of any difference in patient outcomes between an ambulance staffed by a paramedic and an Emergency Care Assistant and one staffed by two paramedics, and
   (ii) The Review team felt that personnel resources would likely be better utilised by moving to the mixed crew model.

(ii) The Adults, Wellbeing and Health Overview and Scrutiny Committee would request that post implementation monitoring of the proposals be undertaken and that an update report be provided to the Committee 6-12 months after the proposed commencement of the new service model on 1 April 2016.

(iii) In view of the Clinical Senate's conclusion 5 within the Independent Review report, the Adults, Wellbeing and Health Overview and Scrutiny Committee would welcome the proposals detailed 'to develop a set of services and relationships that would improve the resilience of rural populations' and would again request that an update on these issues be brought back to this Committee in due course.

Councillor S Forster seconded the comments.

Councillor J Armstrong said that the new ambulance in the Dales area would be welcomed and he added that the release of data should be investigated and reported back.

Councillor R Bell felt that there were mixed messages with the data as he was aware that the CCG do receive the data and would hope that NEAS could provide it once again. This would enable the Patient Reference Group to meet again. He believed that the skills mix model in the clinical senate report lacked data. He said that the former PCT felt it necessary to have a double paramedic crew in 2008 and felt that there was no particular evidence submitted to remove that. He supported the recommendations in principal with the exception of the change in the skills mix paramedic crew.

Councillor O Temple said that the use of the additional vehicle would be useful but that the provision of data needs to improve from NEAS for the benefit of the people in County Durham. He added that the provision of data specific to the County should be sent to the Rural Ambulance Monitoring Group.

Resolved that:

1. The Adults, Wellbeing and Health Overview and Scrutiny Committee reaffirms its previous agreement that the case for change has been demonstrated by the CCG, given that the North East Clinical Senate had concluded that:-
   a. There was no evidence of any difference in patient outcomes between an ambulance staffed by a paramedic and an Emergency Care Assistant and one staffed by two paramedics, and
   b. The Review team felt that personnel resources would likely be better utilised by moving to the mixed crew model.

2. The Adults, Wellbeing and Health Overview and Scrutiny Committee would request that post implementation monitoring of the proposals be undertaken and that an update report be provided to the Committee 6-12 months after the proposed commencement of the new service model on 1 April 2016.

3. In view of the Clinical Senate's conclusion 5 within the Independent Review report, the Adults, Wellbeing and Health Overview and Scrutiny Committee would welcome the proposals detailed 'to develop a set of services and relationships that would improve the resilience of rural populations' and would again request that an update on these issues be brought back to this Committee in due course.

4. The Adults Wellbeing and Health welcomes the introduction of a further RRV ambulance into the DDES area following implementation of these proposals.

5. The Adults Wellbeing and Health Overview and Scrutiny Committee welcome the re-instatement of NEAS Ambulance Performance Information reports which set out performance across County Durham, including the Durham Dales, Easington and Sedgefield CCG area to the Committee and Rural Ambulance Monitoring Group, subject to compliance with Information and Data Governance legislation.

6 Securing Quality in Health Services (SeQIHS) Project Update

The Committee received a report of the Assistant Chief Executive that gave an update on the Securing Quality in Health Services (SeQIHS) project (for copy see file of Minutes).

Dr Boleslaw Posmyk, Programme Clinical Lead and Ali Wilson, Chief Officer Hartlepool and Stockton on Tees Clinical Commissioning Group (CCG) and CCG lead for the Programme gave an update on the progress made in respect of the various phases of the project and key messages and findings, including:-

- The challenge
- The partners – both commissioning organisations and provider organisations
- The services
- The work so far
- Next steps

Councillor J Armstrong commented that it had been timely that they were present at today's meeting and asked that all information provided be clear, concise and in a language that all could understand.

In relation to paragraph 7 of Appendix 2, Councillor R Bell accepted that it was important to have good transport links, and not just for ambulances. He stressed the need to have good parking for cars. Ms Wilson confirmed that car parking had been raised as a key issue.

Councillor P Brookes said that this important initiative was timely and asked that as the transformational change was taking place was the intention to take staff with them through the journey. Dr Posmyk said that the main focus from a clinical perspective was to get the best possible outcomes for patients. He added that all of the workforce have been informed throughout the process with reasons as to why things were changing.

The Chairman thanked Dr Posmyk and Ms Wilson for their presentation and welcomed the involvement from Scrutiny.

Resolved:
That the content of the report and the information detailed within the SeQIHS presentation be noted and that further updates being brought back to this Committee be agreed.

7 Tees, Esk and Wear Valleys NHS Foundation Trust - Care Quality Commission Inspection Report

The Committee received a report of the Assistant Chief Executive that provided background information in respect of the Care Quality Commission (CQC) inspection of Tees, Esk and Wear Valleys NHS Foundation Trust in conjunction and a presentation by representatives of Tees, Esk and Wear Valleys NHS Foundation Trust (for copy see file of Minutes).

Jo Dawson, Acting Director of Operations and Jennifer Illingworth, Director of Quality and Governance, Tees, Esk and Wear Valleys NHS Foundation Trust presented a detailed presentation highlighting the key findings and actions of the trustwide care quality commission inspection, including:-

- An overall summary – TEWV have challenged the safe rating and the CQC were reviewing this. An overall 'good' score was given and the trust was only 1 in 3 to receive this score at the time.
- Positive Outcome – outstanding or good rating received in 52 of 60 ratings
- Actions – an opportunity to learn and improve services has been shown in an action plan.
- Specific Issues in Durham
- Plans for Improvement
- Areas of work completed
- Additional work including reviewing, extending, rolling out, maintaining and implementing

Councillor S Forster thanked Ms Dawson and Ms Illingworth for an excellent presentation, centred around patient care.

In answering a question from Councillor P Brookes, Ms Dawson explained that the trust did have capacity but advised that demand does tend to increase rather than decrease. Referring to resources, Ms Dawson advised that this was not a question asked by the CQC and that there was no mention of staffing levels being inadequate. Ms Illingworth added that there has been increased pressure especially with the number of referrals in Adults and Childrens Services.

Mrs R Hassoon asked if there were enough Tier 4 beds available as she had concerns that as the demand increased we would not have enough care close to home. Ms Dawson advised that this was an area for NHS England but that the local units were based in Middlesborough or Newcastle. Mrs Hassoon asked if data was available for admissions for the County. The Principal Scrutiny Officer advised that a presentation from the CCG in respect of the Co-Commissioning status and the process had come forward to Scrutiny. He suggested that he put the question forward to them in respect of the co-commissioning arrangements.

The Chairman thanked Ms Dawson and Ms Illingworth for their presentation.

Resolved:
That the contents of the report are noted and the information provided be accepted.

8 County Durham Healthwatch Annual Report 2014/15

The Committee noted a report of the Assistant Chief Executive and presentation of the Chair of Healthwatch regarding the Healthwatch County Durham Annual Report for 2014-15 (for copy see file of Minutes).

Judith Mashiter, Chair of Healthwatch advised that they were in the process of nominating a replacement for Mr Paul Taylor. Referring to the Annual report she advised that Healthwatch County Durham provided regular reports to the Health and Wellbeing Board, provided statistics of the number of people they were engaged with, continued to listen, advise and speak up for people and continued to reach out to all corners of County Durham. The Health and Social Care agenda was covered and Ms Mashiter informed the Committee that all areas on the agenda had been covered by Healthwatch, demonstrating the commitment and importance of their role. For example, they had helped to facilitate meetings between the Dales Ambulance Group and NEAS/CCG, and gathered primary and secondary evidence prior to the inspection of the Tees, Esk and Wear Valley NHS Foundation Trust.
She concluded that Healthwatch County Durham continue to work below the line to influence local services for local people.

Councillor R Bell referred to the waiting times at the eye clinic and asked how Healthwatch would challenge as was not best practice for the patient. Ms Mashiter agreed that it was frustrating that best practice for clinicians was not always best practice for patients. She added that they had spoken to a whole cohort of patients and families that were waiting and that it was a matter that would be pursued.

Councillor P Brookes asked for a financial breakdown and Ms Mashiter said that this could be provided to him.

The Chairman thanked Judith Mashiter for her presentation and passed on his congratulations to Mrs Betty Carr for her involvement with the special inquiry into poor and unsafe discharge from hospital.

Resolved:
That the report and presentation be received and the information therein noted.

Adults Wellbeing and Health Overview and Scrutiny Committee

9th October 2015

County Durham and Darlington Urgent Care Strategy 2015-20

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

Purpose of the Report

1. This report informs members of the Health and Wellbeing Overview and Scrutiny Committee about the development of the County Durham and Darlington Urgent Care Strategy 2015-20.

2. Members of Overview and Scrutiny are asked to note that the:
   - strategy will be amended with any errors or omissions noted from the recent round of engagement;
   - final Urgent Care Strategy 2015-20 is scheduled to be approved by the System Resilience Group on 9th October 2015;
   - governance and implementation of the Urgent Care Strategy will be through the System Resilience Group;
   - Urgent Care Strategy 2015-20 is scheduled to go back to the Health and Wellbeing Board for endorsement on 3rd November 2015.

Background

3. The County Durham and Darlington System Resilience Group (SRG), which is a sub group of the Health and Wellbeing Board, has developed the County Durham and Darlington Urgent Care Strategy 2015-20.

4. The SRG has overall responsibility for the capacity planning and operational delivery across the health and social care system for urgent and emergency care. The SRG will be responsible for overseeing the implementation of the Urgent Care Strategy locally.

5. The SRG is chaired by the Chief Clinical Officer from Durham Dales, Easington and Sedgefield Clinical Commissioning Group with representation from North Durham Clinical Commissioning Group, Darlington Clinical Commissioning Group, both Local Authorities and all key stakeholders involved in the delivery of urgent and emergency are across County Durham and Darlington.

6. In Winter 2014/15 SRG members were asked to provide feedback from their organisations, consulting as appropriate, on the initial draft strategy. At this stage the initial draft strategy was also taken to the Health and Wellbeing Board

in January 2015 for consultation. The strategy has since been significantly revised and updated to:

- Incorporate feedback received, including that received from the Health and Wellbeing Board;
- Progress in local and regional urgent and emergency care Developments;
- Learning from Winter 2014/15;
- Recent guidance on implementing the National vision for urgent and emergency care, locally.

7. The strategy attached as Appendix 2 has been shaped by the standards encompassed within NHS England's Planning Guidance, Everyone Counts 2015/16 to 2019/20, key National and local reviews of urgent and emergency care services, NHS England's Five Year Forward View and the recently introduced Eight High Impact Interventions for urgent and emergency care attached at Appendix 3.

National Context

8. The Transforming Urgent and Emergency Care Review[1] proposed a new National vision urgent and emergency care which has now been adopted and is being heavily promoted by NHS England. The National vision has two key aims:

- People with urgent but non-life threatening needs must have a highly responsive, effective and personalised service outside of hospital – as close to home as possible, minimising disruption and inconvenience for patients and their families.
- People with serious or life-threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and minimise their chances of survival and recovery.

9. NHS England have recently published further guidance to help local commissioners and providers understand the practical elements of the vision and are providing support to facilitate local implementation. The main elements of the National approach underpinning the aims of the vision are:

- **Self-care** – through more easily accessible information about self-treatment option, pharmacy promotion and better access to NHS 111.
- **Right advice or treatment first time** – through an enhanced NHS 111. service which is easier to access and supported by a range of clinicians.
- **Faster, convenient, enhanced service** – to General Practice, primary and community care services aimed at providing care as close to home as possible and prevention unnecessary admissions to hospital.
- **Identify and designate available services in hospital based emergency centres** - aiming to ensure that urgent and emergency care services work cohesively together as an overall Urgent and

[1] Transforming urgent and emergency care services in England. Urgent and emergency care review end of phase one report *High quality care for all, now and for future generations.* Professor Sir Bruce Keogh, November 2013

Emergency Care Network so that the whole system becomes more than just a sum of its parts.

10. In addition to the above there has been a great deal of learning resulting from the challenges experienced throughout the urgent and emergency care system during Winter 2014/15. Some of the key messages from NHS England have included:
    - Higher patient acuity resulted in longer length of stay especially frail elderly.
    - The impact was earlier and lasted the whole winter and the system struggled with flow through the system including discharge.
    - It was a relatively mild winter with no major flu outbreak which leads to the question could the system have coped under a different scenario.
    - The NHS111 service faced similar unprecedented demand, dealing with 4.6 million calls this winter –which is an increase of one million calls or 27% on last winter. NHS111 call handlers and support reduced unnecessary pressures on A&E and emergency ambulance services by directing people to the right place for their care such as GPs, walk-in centres or pharmacists. Of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to Accident and Emergency (A&E).

11. With this learning from Winter 2014/15 NHS England developed eight High Impact Interventions for urgent and emergency care that are designed to provide focus for local commissioners and providers on elements of the system which are crucial to be in place to ensure effective patient flow and patient experience within urgent and emergency care services. These eight High Impact Interventions are **must do's**. Local System Resilience Groups are required to provide assurance to NHS England that these high impact interventions are fully met. Any gaps in full achievement will be challenged by NHS England.

12. To support the implementation of the National vision on a regional level the current Urgent Care Network is in the process of being replaced by a new Urgent and Emergency Care Network.

13. These new groups will work across several Clinical Commissioning Group geographical areas, and provide strategic oversight and improve the consistency and quality of urgent and emergency care by addressing together challenges in the urgent and emergency care system that are difficult for single System Resilience Group's to achieve in isolation.

Local Context

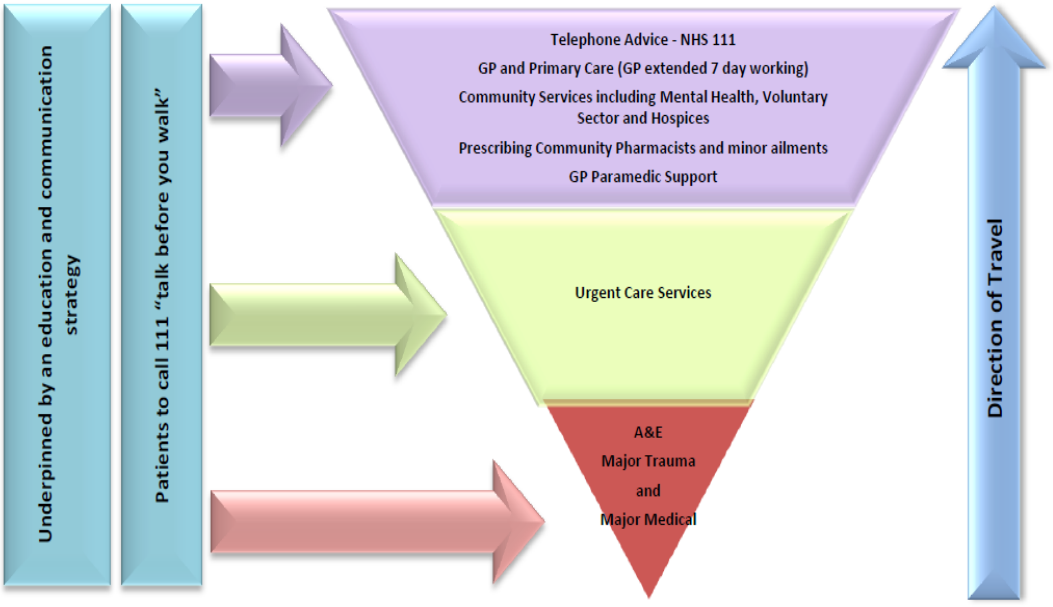
14. In line with the National vision, the local vision for urgent and emergency care that has been developed is:

'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

15. This vision incorporates the whole urgent and emergency care system from pharmacies, GP Practices and other primary care services, secondary care community services and acute hospital provision.

16. To implement the vision, the identified actions have been aligned to seven objectives:
    - People are central to designing the right systems and are at the heart of decisions being made.
    - Patients will experience a joined up and integrated approach regardless of the specific services they access.
    - The most vulnerable people will have an a plan to help them manage their condition effectively to avoid the need for urgent and emergency care
    - People will be supported to remain at their usual place of residence wherever possible
    - The public will have access to information and guidance in the event of them needing urgent or emergency care
    - The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs
    - The patient will not experience any unnecessary delay in receiving the most appropriate care

17. The County Durham and Darlington System Resilience Group would like to ultimately see the following model commissioned for patients requiring urgent and/or emergency care.



18. The main focus of the model is the availability of a range of community based services including pharmacy, promotion of self care, NHS 111, GP Paramedic Support, extended primary care joined up with secondary community care services providing a timely and effective service to patients who are quickly and safely directed to access the relevant service to meet their presenting health needs.

19. Those with urgent needs they will be quickly and safely directed to attend an urgent care service and those will serious or life threatening health conditions will be quickly, safely and effectively assessed and treated in an Accident and Emergency Department.

20. The County Durham and Darlington Urgent and Emergency Care Strategy 2015-20 is a high level strategy with each Clinical Commissioning Group responsible for developing implementation plans including appropriate local engagement to deliver on actions they have responsibility for leading on.

21. Implementation of the strategy is focused on a collaborative approach across commissioners and providers, developing an evidence based urgent and emergency care system, with equitable access to high quality, safe and effective urgent and emergency care services at the right time and in the right place, that comfortably achieves the constitutional standards for urgent and emergency care.

22. It is important to note that the urgent and emergency care system locally, is inextricably linked to wider regional provision as acute hospitals provide mutual aid to each other at times or pressure and the North East Ambulance Service being responsible for the co-ordination and response to both emergency and urgent healthcare needs through 999 services and NHS 111 across the region.

23. For this reason the action plan within the strategy identifies both local and regional actions with the regional actions. Local actions will be the responsibility of local commissioners and providers across County Durham and Darlington. SRG members will contribute to the development and delivery of regional actions but overall responsibility will sit with the Urgent and Emergency Care Network for the implementation of these actions across the region to ensure consistent service and effective use of resources.

24. North of England Commissioning Support Unit (NECS) Communications Team have proof read the document any spelling or grammatical errors have been addressed.

25. The final strategy will be agreed at the System Resilience Group meeting on 9th October 2015.

26. The strategy has been developed in conjunction with all relevant commissioners and providers involved in urgent and emergency care services. It incorporates urgent care engagement work that all three Clinical Commissioning Groups across County Durham and Darlington have undertaken.

27. All Clinical Commissioning Groups have shared the final draft with their Patient Reference Groups and other local engagement meetings who have been invited to advise on any errors/omissions and to make suggestions about how best to implement the strategy within each local area and who else needs to be involved.

28. Key feedback recently received include:
    - A keen interest from Patient Reference Groups to be involved in shaping the local implementation of the strategy;
    - A need to prioritise the action plan which is being taken forward by the System Resilience Group;
    - Some frustration from about the strong National steer and therefore 'given's which we must achieve;
    - The need for a patient voice on the System Resilience Group in addition to both County Durham and Darlington Healthwatch Groups – which is now being taken forward.

29. The final draft of the strategy has been approved by all three County Durham and Darlington Clinical Commissioning Group Management Executive and Governing Body's.

30. During the strategy implementation there will be need on occasion to undertake formal public consultation to ensure local involvement in shaping the local implementation of the strategy. In this event relevant System Resilience Group organisations including Clinical Commissioning Groups will be responsible for ensuring due process is followed to enable effective and meaningful engagement and consultation in relation to the implementation of specific strategy actions.

31. Work is being progressed between the System Resilience Group and NECS Communications Team to produce a fully polished version of the strategy which wil be uploaded onto partners websites. A summary version of the strategy will also be developed to accompany the full document to ensure the key messages of the strategy are accessible to all.

Recommendations

32. The Adults Wellbeing and Health Overview and Scrutiny Committee are asked to note that the:
    - strategy will be amended with any errors or omissions noted from the recent round of engagement;
    - final Urgent Care Strategy 2015-20 is scheduled to be approved by the System Resilience Group on 9th October 2015;
    - governance and implementation of the Urgent Care Strategy will be through the System Resilience Group;
    - Urgent Care Strategy 2015-20 is scheduled to go back to the Health and Wellbeing Board for endorsement on 3rd November 2015.

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Appendix 1: Implications

Finance Implementation of the strategy will in the main focus on re-configuration of existing resources to improve efficiency of resource including financial.

Staffing The strategy action plan will review the use of existing resources and seek to improve efficiency and productivity across the system overall.

Risk There are risks within the current urgent and emergency care system to the consistent and comfortable achievement of the key constitutional standards including breaches of the four hour 95% A&E target and ambulance response times.

This strategy will reduce the risk by implementing a more joined up approach which aims to ensure that patients are treated by the right professional, at the right place, first time.

Equality and Diversity / Public Sector Equality Duty Not applicable

Accommodation Not applicable

Crime and Disorder Not applicable

Human Rights Not applicable

Consultation The strategy has been developed in conjunction with all relevant commissioners and providers involved in urgent and emergency care services. It incorporates urgent care engagement work that all three Clinical Commissioning Groups across County Durham and Darlington have undertaken. During the strategy implementation there will be need on occasion to undertake formal public consultation. In this event relevant organisations will be responsible for ensuring due process is followed to enable effective and meaningful consultation.

Procurement Appropriate procurement advice will be sought in respect of any procurements that take place as part of this strategy implementation.

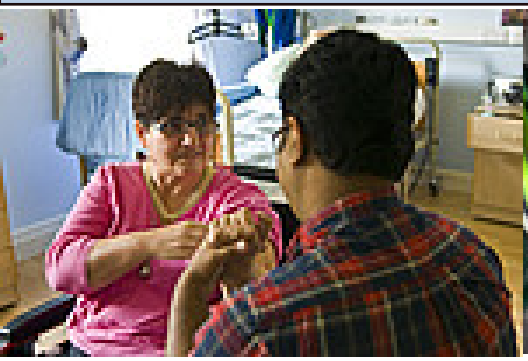
Disability Issues Not applicable

Legal Implication There may be some legal implications in relation to potential procurements or re-procurements during the life of this strategy. Where appropriate relevant legal or procurement advice will be sought.

APPENDIX 3– Eight High Impact Interventions for Urgent and Emergency Care

No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

County Durham and Darlington Urgent Care Strategy 2015 – 2020



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Key Contributors

This strategy has been written by Anita Porter, Senior Commissioning Support Officer, North of England Commissioning Support Unit with and on behalf of County Durham and Darlington System Resilience Group Members whose representation is comprised of:

- NHS North Durham Clinical Commissioning Group (ND CCG)
- NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG)
- NHS Darlington Clinical Commissioning Group (DCCG)
- Durham County Council (DCC)
- Darlington Borough Council (DBC)
- County Durham and Darlington NHS Foundation Trust (CDDFT)
- North Tees and Hartlepool NHS Foundation Trust (NFHFT)
- Local Pharmaceutical Committee (LPC)
- City Hospitals Sunderland NHS Foundation Trust (CHSFT)
- North East Ambulance Service NHS Foundation Trust (NEAS)
- County Durham Healthwatch
- Darlington Healthwatch
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)
- NHS 111
- North of England Commissioning Support Unit (NECS)
- NHS England
- Durham Police Authority
- Durham and Darlington Fire and Rescue Service

All organisations logos will be inserted here in final version.

Foreword

We are currently working within a landscape that is rapidly evolving, with the legislation that underpins the delivery of health and social care recently revised and the need to continue to strive to deliver high quality healthcare, maximising the benefit to patients from how scarce resources are used.

In recent times, there has been increasing pressure placed on urgent care systems as patients seek greater assurance regarding their condition and rapid response from services. We are keen that this highly responsive provision remains, but that wherever possible patients are treated in the right place, at the right time and by the right professional. Thus, urgent care should not be thought of as a stand-alone, discrete service but an integrated philosophy embedded within patient pathways to ensure that our patients receive a joined-up approach to their care, from all agencies involved, ideally in the community where they live.

The System Resilience Group for County Durham and Darlington has taken a whole systems approach in developing the strategy to ensure these principles are embedded from the beginning. Evidence suggests that attendances at emergency departments continue to rise, a significant proportion of which could more appropriately have been dealt with by primary and community services. Previous engagement has shown that this is also what patients would prefer. This also would result in better utilisation of specialist emergency department skills, and enable more effective relationships between the patient and their primary care clinician in managing their condition.

This Urgent Care Strategy aims to continue to improve urgent care provision from hospital emergency and ambulance services, but also strengthen patient access to urgent care from primary and community services.

There are a number of principles that underpin how all partners will work together and develop:

- a whole-system approach that has the patient journey and experience at the heart of the planning process;
- urgent care services are easier to navigate for patients as well as clinicians and those in social care or children's services, through the strengthening of the NHS 111 as a single point of access service;
- services that are streamlined to avoid duplication, utilising the options to co-locate services to drive efficiency and patient safety;
- close working relationships with all our stakeholders to develop an integrated approach, using shared records and information technology systems and ensuring communication between services is optimised and systems of monitoring are standardised;
- the concept of urgent care into the primary care strategy development, strengthening the role of community-based care, hospital avoidance schemes, and through the development of patient self-management programmes;
- partnership working with neighbouring boroughs, to ensure patient care is not compromised by boundary issues.

Contents

Version Control

Document History	Date	Amended by	Amendment
Document Version 0.5	10th October 2014	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Amendments to consultation draft.**
Document Version 0.6	22nd October 2014	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Revised format/layout for discussion.**
Document Version 0.7	14th November 2014	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Revised format/layout for discussion. Approval sought from SRG to proceed as consultation draft**
Document Version 0.8	18th December 2014	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Consultation draft for SRG and Health and Wellbeing Boards**
Document Version 0.9	22nd to 28th May 2015	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Updated with feedback received ahead of meeting with CCG's**
Document Version 0.10	29th May to 27th July 2015	Anita Porter, Senior Commissioning Support Officer, NECS on behalf of the System Resilience Group	**Updated with feedback received, new National guidance, feedback from SF/NB and local progress**

To be removed from final document.

1 Executive Summary

1.1 The Department of Health defines urgent and emergency care as the range of healthcare services available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly. This could include, for example, accident and emergency (A&E), walk-in and minor injury and illness services.

1.2 Nationally, statistics from NHS England Winter Health Check, March 2015, states that since the Winter of 2009/10 there has been a 14.1% increase in A&E attendances, and a leap of 26.3% since the winter of 2004/5. Emergency admissions have risen by 8.8% on the Winter of 2009/10 and by 25.7% on 2004/5.

1.3 Between November to February 2014/15 there was a total of 7,063,000 A&E attendances, 190,000 more than the same period last Winter. At it's peak the system managed 446,000 attendances within one week during December 2014, followed by 440,000 the following week. Both record figures recorded for a Winter period. Actual admissions showed a similar increase in demand, with a total of 1,821,000 during 2014/15, compared to 1,770,000 the previous Winter.

1.4 Two key factors are clearly identified as contributing to the growing pressures on A&E:

- An ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care.
- Many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E.

1.5 This strategy has been developed by the County Durham and Darlington System Resilience Group supported by NHS Improving Quality (NHS IQ). The strategy covers the period 2015 to 2020 and has been shaped by the standards encompassed within NHS England's Planning Guidance, Everyone Counts 2015/16 to 2019/20, key National and local reviews of urgent and emergency care services, NHS England's Five Year Forward View and the Eight High Impact Interventions.

1.6 The local vision for this strategy has been agreed by the Systems Resilience Group as:

'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

1.7 The vision is underpinned by seven objectives. All actions stated within the action plan help to achieve one or more of the seven objectives. Overall the strategy aims to ensure that all patients are seen by the right person, in the right setting at the right time as well as having a key focus on reducing demand overall for urgent and emergency care services to ensure resources can be appropriately targeted and effective.

1.8 To achieve the above, there are a number of agreed principles that underpin how all partners will work together and develop:

- a whole-system approach that has the patient journey and experience at the heart of the planning process.
- urgent care services are easier to navigate for patients as well as clinicians and those in social care or children's services, through the strengthening of the NHS 111 as a single point of access service.
- services that are streamlined to avoid duplication, utilising the options to co-locate services to drive efficiency and patient safety.
- close working relationships with all our stakeholders to develop an integrated approach, using shared records and information technology systems and ensuring communication between services is optimised and systems of monitoring are standardised.
- the concept of urgent care into the primary care strategy development, strengthening the role of community-based care, hospital avoidance schemes, and through the development of patient self-management programmes.
- partnership working with neighbouring boroughs, to ensure patient care is not compromised by boundary issues.

1.9 To achieve the local vision for urgent and emergency care several workstreams will provide a focused approach to the delivery of the strategy action plan and will be responsible for reporting progress into the System Resilience Group on a monthly basis.

1.10 In order to evidence that the implementation of the strategy is a success there are a number of critical success factors identified. These include the constitutional key performance measures but also that:

- Patients report that they are accessing the right service, at the right time, first time;
- Positive patient reports of their experience of all urgent and emergency care services within the system;
- Providers feel supported and have sufficient resources to meet patient need;
- Commissioners feel their investment is cost effective and resulting in positive patient outcomes.

1.11 **Appendix 1** provides a summary 'plan on a page' of the whole strategy.

1.12 The System Resilience Group will be responsible for the ownership, oversight and monitoring of the implementation of the strategy action plan.

2 Introduction

2.1 There is a national focus on urgent and emergency care services across England. In response to this, the County Durham and Darlington System Resilience Group have developed this Urgent Care Strategy specifically focusing on the standards in Everyone Counts 2015/16 to 2019/20. The strategy sets out a joint vision and patient centered principles, together with whole systems solutions to achieving them.

2.2 The strategic direction set out in this strategy will engage the public, key stakeholders, Overview and Scrutiny Committee and Health and Wellbeing Boards to make sure it is right for County Durham and Darlington.

2.3 Members of the System Resilience Group that have been involved in the development of this strategy include DDES CCG who Chair the System Resilience Group working in partnership with ND CCG, DCCG, Durham County Council, Darlington Borough Council, County Durham and Darlington NHS Foundation Trust, Durham Police Authority, County Durham and Darlington Fire and Rescue Service, Tees Esk and Wear Valleys NHS Foundation Trust, North East Ambulance Service, County Durham Healthwatch, Darlington Healthwatch, Local Pharmaceutical Committee, other local acute trusts and NHS England.

2.4 The Chair of each System Resilience Group meet together every month at the Urgent Care Network. This meeting supports System Resilience Group Chairs to have a regional focus, commission some services regionally, share good practice and information.

2.5 Local commissioners and providers are committed to the development of an evidence based service model that will provide local people with equitable access to high quality, safe and effective urgent care services at the right time and in the right place. The consolidation of urgent care provision across County Durham and Darlington, will deliver on our commitment to provide urgent care services that are geographically located to provide equity and consistency of service.

2.6 To ensure that the public and key stakeholders are appropriately involved in the local development of urgent and emergency care in line with this strategy, across County Durham and Darlington, engagement work in relation to specific actions included within the strategy action plan will be undertaken by individual Clinical Commissioning Groups as the strategy action plan is realised over the next five years.

2.7 To support local health care provision in England, the NHS Constitution sets out the principles and values under which all health care services should operate. First developed in 2009 as part of the NHS Next Stage Review led by Lord Darzi it also sets out the rights and responsibilities of the public, patients and staff delivering and benefitting from healthcare services provided by the NHS. The current version was updated in April 2013.

2.8 Underpinning the NHS Constitution are a number of rights that clearly specify maximum waiting times and emergency care response times that all patients should be able to expect. These standards are regularly monitored locally through the System Resilience Group as well as by NHS England and will be used to help

measure success in the delivery of this strategy. For urgent and emergency care these include:

- A maximum four-hour wait in A&E from arrival to admission, transfer or discharge;
- All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within 8 minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

(Handbook to the NHS Constitution, March 2013)

2.9 In addition to the above constitutional rights for general urgent and emergency care the System Resilience Group will also be responsible for monitoring the 62 day cancer waits and diagnostic waiting times. The constitutional rights for patients in relation to these are:

- a maximum two month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers;
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer;
- a maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers);
- start your consultant-led treatment within a maximum of 18 weeks from referral for non urgent conditions; and
- be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

(Handbook to the NHS Constitution, March 2013)

2.10 The support structure to implement the National urgent care vision within each region and locally within each Clinical Commissioning Group area will include an Urgent and Emergency Care Network, replacing the current Urgent Care Networks, working across several Clinical Commissioning Group geographical areas enabling strategic oversight of urgent and emergency care on a regional footprint and that patients with more serious or life threatening conditions receive treatment in centres with the right facilities. The urgent and emergency care networks will improve the consistency and quality of urgent and emergency care by addressing together challenges in the urgent and emergency care system that are difficult for single System Resilience Group's to achieve in isolation.

2.11 People with urgent needs with have them met locally by services as close to home as possible with System Resilience Groups leading on the co-ordination and delivery of a range of urgent services including clinical support hubs and, early intervention for mental health needs, accurate data capture and performance monitoring and ensuring the effective development and configuration of primary and community care to underpin the provision of urgent care outside hospital settings 24/7.

2.12 Improving the urgent and emergency care pathway across County Durham and Darlington is included in all three Clinical Commissioning Group's current Commissioning Intentions. In January 2015 the County Durham Health and Wellbeing Board referred to the Better Care Fund Strategy target to reduce emergency admissions and overall activity across the urgent and emergency care system by 3.5%.

Vision, Outcomes and Objectives

2.12 The local vision for this strategy has been agreed by the System Resilience Group as:

'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

Outcome

2.13 The overall outcome for the whole strategy is an urgent and emergency care system that is able to meet the needs of the County Durham and Darlington population, both adults and children, within the resources available, delivering improved quality and patient experience.

Strategy Objectives

2.14 The implementation of the strategy will be overseen by the System Resilience Group, with the establishment of specific sub-groups, as required, to explore, design, plan and implement the projects to meet stated objectives and outcomes.

2.15 Seven objectives have been developed together by all partners during a series of workshops held to facilitate the strategy development. The objectives have been based on the key national messages and local strategic direction for urgent and emergency care services. The seven local objectives are:

Seven Local Objectives	
1	People are central to designing the right systems and are at the heart of decisions being made.
2	Patients will experience a joined up and integrated approach regardless of the specific services they access
3	The most vulnerable people will have an a plan to help them manage their condition effectively to avoid the need for urgent and emergency care
4	People will be supported to remain at their usual place of residence wherever possible
5	The public will have access to information and guidance in the event of them needing urgent or emergency care
6	The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs
7	The patient will not experience any unnecessary delay in receiving the most appropriate care

3 What should Good Urgent and Emergency Care Services look like?

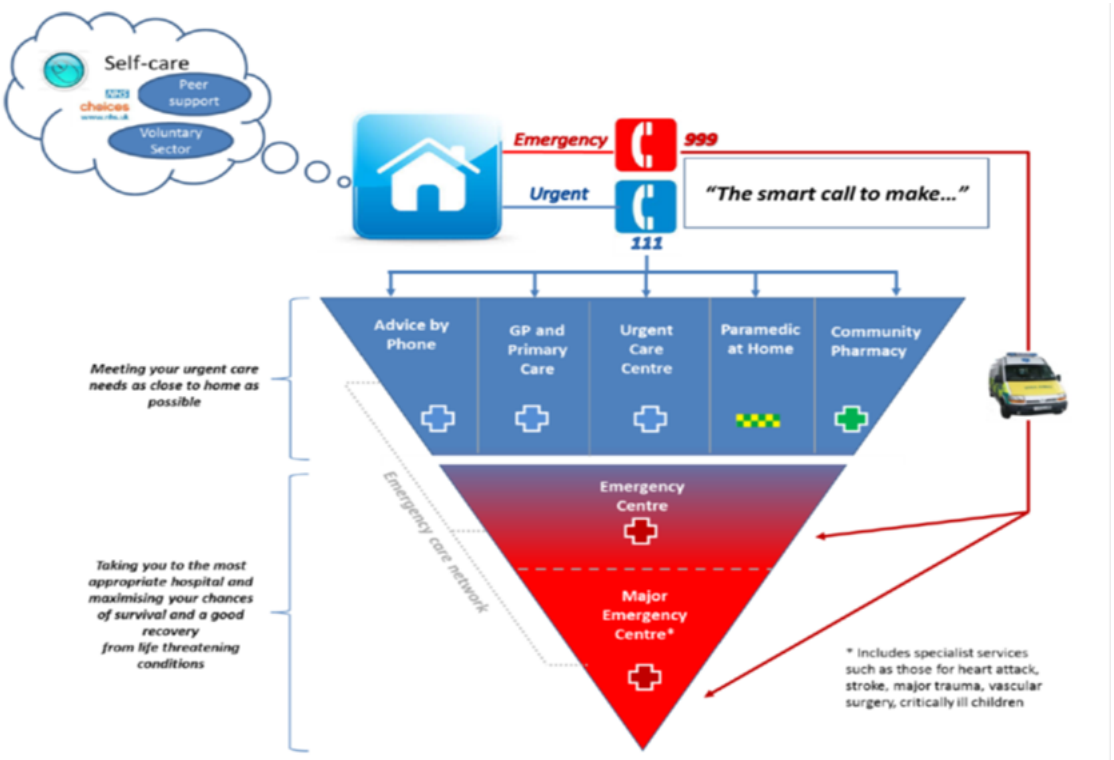
National Approach

3.1 The National vision for urgent and emergency care is captured within **Transforming urgent and emergency care services in England. Urgent and emergency care review end of phase one report *High quality care for all, now and for future generations.* Professor Sir Bruce Keogh, November 2013** with two aims:

1 People with urgent but non-life threatening needs must have a highly responsive, effective and personalized service outside of hospital – as close to home as possible, minimizing disruption and inconvenience for patients and their families.

2 People with serious or life-threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and recovery.

3.2 The diagram below represents the look and design of the new system proposed by Sir Bruce Keogh.



(Transforming urgent and emergency care services in England, Nov 2013, Page 23)

3.3 As well as the Keogh review, a number of other National reviews of urgent and emergency care and subsequent guidance have been produced in recent years:

- The walk in centre review: final report and recommendations, Monitor, February 2014
- Emergency admissions to hospital: managing the demand, Comptroller and Auditor General Health, October 2013
- A promise to learn– a commitment to act: improving the safety of patients in England, National Advisory Group on the Safety of Patients in England, August 2013
- Review into the quality of care and treatment provided by fourteen hospital trusts in England: Professor Sir Bruce Keogh, July 2013
- Report of the Mid Staffordshire NHS Foundation Trust public inquiry executive summary, Robert Francis QC, Feb 2013
- Emergency care and emergency services: view from the frontline, Foundation Trust Network,2013

3.4 Together these reviews provide a clear agenda for improving urgent and emergency care systems across the Country with a view to achieving the National vision:

- Help people to manage their own health through **self-care** and management for urgent but non-life threatening needs;
- Help people with urgent care needs to get **the right advice in the right place at the right time**, including enhancing the current NHS 111 service to facilitate this;
- Provide **responsive urgent care services** outside of hospital so that people with non-emergency needs no longer choose to seek treatment at A&E departments;
- Introduce **two levels of emergency departments**, Emergency Centres and Major Emergency Centres, to ensure that people with serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximize chances of survival and a good recovery;
- Connect urgent and emergency care services together in **emergency care networks** so the overall system becomes more than just a sum of it's parts.

3.5 Underpinning the National vision and work being progressed to put it in place, some of the National reviews focused on improving hospital standards, patient safety and performance, underpinning the fundamental need to deliver high quality care. These reviews called for cultural change enabling transparency, accountability, clear standards that services were measured by that patients understood with evidence based compliance.

3.6 Captured by Sir Bruce Keogh in his review of fourteen trusts reporting high mortality rates (July 2013), but key to all the reviews into hospital practices and performance, five key areas were identified as safety, workforce, clinical and operational effectiveness, governance and leadership. With these in mind Keogh identified eight ambitions for hospitals in England to deliver.

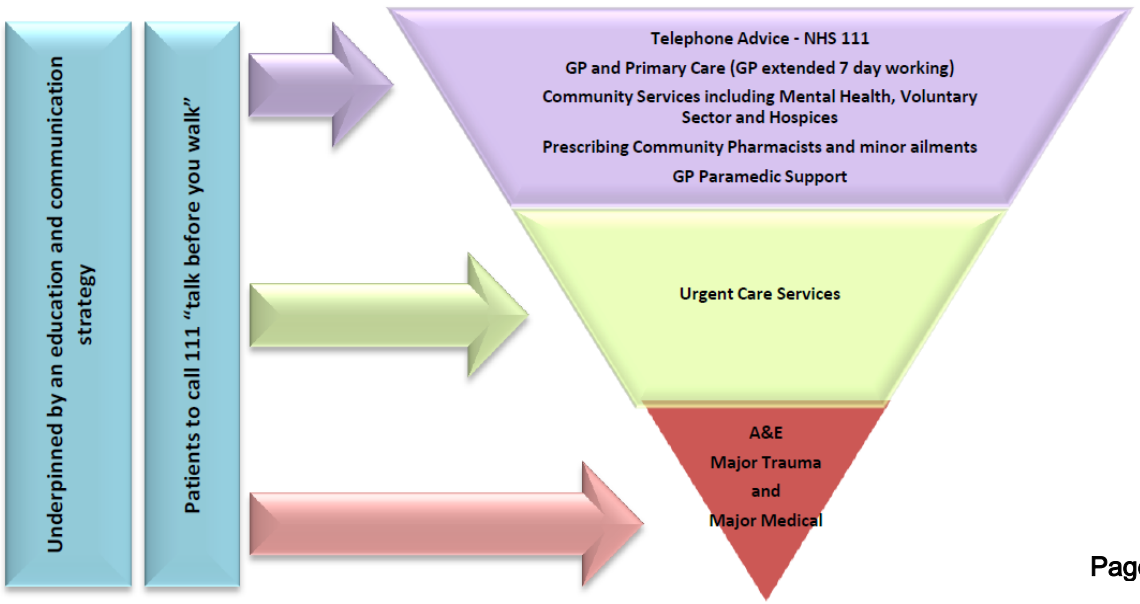
Keogh Review Ambitions	
1	…demonstrable progress towards reducing avoidable deaths in our hospitals
2	confident and competent use of data and other intelligence for the forensic pursuit of quality improvement by leaders of provider and commissioners
3	Patients, carers and members of the public will increasingly feel treated as vital and equal partners in the design and assessment of their local NHS
4	Patients and clinicians will be involved in and have confidence in the quality assessments made by the Care Quality Commission
5	Professional, academic and managerial isolation for hospitals will be a thing of the past.
6	Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients
7	Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today
8	All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy

3.7 With exceptional A&E, emergency ambulance and NHS 111 pressures, and learning experienced during Winter 2014/15, NHS England developed Eight High Level Interventions, detailed in **Appendix 2**, that all have key benefits to improving urgent and emergency care services for patients. As such the Eight High Impact Interventions are non-negotiable and therefore now underpin this strategy implementation and local actions stated within the action plan have been aligned where possible.

Local Approach

3.8 Using the National approach and applying it's principles locally in County Durham and Darlington, Clinical Commissioning Groups need to ensure effective use of existing services such as primary care, community nursing, NHS 111 services and other rapid response services as part of their strategies for urgent and emergency care. The National approach support people being assessed and treated as close to home as possible, reducing the pressure on acute resources and ensuring patients are supported in the right place at the right time.

3.9 The County Durham and Darlington System Resilience Group would like to ultimately see the following model commissioned for patients requiring urgent and/or emergency care.



Securing Quality in Health Services (SeQIHS)

3.10 The Securing Quality in Health Services (SeQIHS) Programme was established in 2012 by the former Primary Care Trusts across County Durham Darlington and Tees and has been continued by the five Clinical Commissioning Groups across this geographical area, working also in association with Hambleton, Richmondshire and Whitby Clinical Commissioning Group. The programme is focused on continuing to improve and sustain high quality hospital services in the Durham, Darlington and Tees area.

3.11 The Programme is looking at delivering agreed clinical quality standards in the following clinical areas: A&E, acute medicine, acute surgery, critical care, acute children's care, maternity and neonatology and interventional radiology in the context of the financial and workforce resources available to support implementation of the standards.

3.12 In the latest phase of the Programme, clinicians from secondary and primary care have been working together to describe a model of care that will maximise our ability to deliver the standards.

3.13 During the lifetime of this urgent and emergency care strategy, it is anticipated that the SeQIHS Programme will make recommendations on the model of care and configuration of services and opportunities to commission services differently, based on the principle of keeping services local wherever possible and centralise services where necessary.

3.14 The model will aim to describe different levels of care and the number of sites where this care will be available. It is essential that these recommendations dovetail with the urgent and emergency care services in primary care and in the community to ensure that patients receive the right care in the right place in a timely manner.

3.15 There is a substantial amount of work to be carried out to deliver the next phase of planning, including expanding the public and stakeholder engagement and involvement, developing a long list of scenarios and reducing it to a short list of options, modelling and evaluating the options and ensuring that any proposals that emerge on a County Durham and Tees footprint are consistent with local plans and developments.

4 National and Local Context

National Statistics

4.1 Nationally, statistics from NHS England Winter Health Check (March 2015) states that since the Winter of 2009/10 there has been a 14.1% increase in A&E attendances, and a leap of 26.3% since the winter of 2004/5. Emergency admissions have risen by 8.8% on the winter of 2009/10 and by 25.7% on 2004/5.

4.2 Between November to February 2014/15 there was a total of 7,063,000 A&E attendances, 190,000 more than the same period last Winter. At it's peak the system managed 446,000 attendances within one week during December 2014, followed by 440,000 the following week. Both record figures recorded for a Winter period. Actual admissions showed a similar increase in demand, with a total of 1,821,000 during 2014/15, compared to 1,770,000 the previous Winter.

4.3 NHS 111 faced similar unprecedented levels of demand, managing 4.6 million calls during Winter 2014/15. This represents an increase of one million calls, or 27% on the same period the previous year. Nationally of all the calls triaged, just 11% had ambulances dispatched and 7% were recommended to A&E.

4.4 It is recognised that these figures demonstrate the increased patient needs that staff had to cope with this winter, during which time the NHS in England continued to provide a robust service, admitting, treating and discharging more than nine out of ten people across the course of the winter.

4.5 The current urgent and emergency care system has complex supply and demand flows and some National recruitment challenges, particularly for GP's, Paramedics and key Acute and Emergency Medicine staff.

4.6 Two of the key factors contributing to the increased levels of demand on Accident and Emergency Departments are:

- An ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care.
- Many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E.

National Guidance

4.7 The current National direction and guidance has evolved in recent years. Since 2010, policy objectives have evolved with commissioning responsibilities transferring to Clinical Commissioning Groups, a focus on offering patients greater choice, high quality care and the challenges of both financial and increasing demand pressures on the urgent and emergency care system resulting in several instrumental National reviews bringing together some fundamental questions to be addressed and offering a new vision, proposed design of urgent and emergency care for the future and a blueprint for achieving it.

4.8 The Everyone Counts Planning for Patients Guidance 2014/15 to 2018/19 set out a five year strategic plan for Clinical Commissioners. With a focus on quality, convenient access to services for all, driving change through innovation and value for the public purse, the guidance set a challenging agenda of transformational change for Clinical Commissioning Groups around the County.

4.9 The NHS Five Year Forward View (October 2014) sets out the key focus for how the NHS will be sustained and improved for everyone over the next five years with an emphasis on prevention, health promotion and greater patient control of their own care. Enabling people to be responsible for their own health will result in people living healthier lives and help ensure that urgent and emergency care resources are available for those who really need them.

4.10 The Five Year Forward View includes integration of A&E departments, GP Out of Hours services, Urgent Care Services, NHS 111 and ambulance services. The guidance sets out opportunities for new models of care, such as a Multi-specialty Community Provider – where GP's are enabled to combine with nurses, other community health and social care to create integrated out-of-hospital care.

4.11 In August 2014, NHS England published 'Transforming urgent and emergency care services in England. Update on the urgent and emergency care review, urgent and emergency care review team' update on progress in addressing the system changes highlighted by Sir Bruce Keogh. The update acknowledged that the vision set out in the original report would take three to five years to put in place and set out work progressed to date including:

- Working closely with local commissioners in developing five year strategic and two year operational plans;
- Undertaking trials for new models of delivery for urgent and emergency care and seven day services;
- Developing new ways for paying for urgent and emergency care services, in partnership with Monitor;
- Completing and introducing a new service description for NHS 111;
- Provision of commissioning guidance to support new ways of delivering urgent and emergency care.

4.12 NHS England are developing a suite of guidance documents and tools to facilitate the achievement of the National vision including the 8 High Impact Interventions, supporting a fundamental shift towards new ways of working and models of urgent and emergency care.

4.13 With regard to supporting Mental Wellbeing, HM Government published the Mental Health Crisis Care Concordat, February 2014, which is a joint statement committing a range of key partners to '…work together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.' The Mental Health Concordat also has a key focus on supporting the recovery of people with mental health problems.

Local Statistics

4.14 **Appendix 3** details local performance for 2013/14 and 2014/15 against the National constitutional performance measures for urgent and emergency care. Reflecting the National trends, locally there has been increasing demands on the whole urgent and emergency care system from GP Practices, Urgent Care Services and A&E Departments. All local Acute Trusts have seen an increase in both attendances at A&E and actual admissions during Winter 2014/15. Alongside this, all services are experiencing increasing complex and multiple health needs as people grow older and their frailty increases.

4.15 Nationally the expectation is that all Acute Trusts assess and treat a minimum of 95% of people within both urgent (Type 3) and emergency (Type 1) care within four hours. Locally this has fluctuated, with performance by City Hospitals of Sunderland and sometimes County Durham and Darlington NHS Foundation Trust particularly struggling to meet the target consistently. In Sunderland the introduction of the 'Perfect Week' in March 2015 has yielded some improved results. North Tees and Hartlepool NHS Foundation Trust have faired better overall and have recovered their performance much quicker.

4.16 Emergency ambulances should be able to handover the patient to the A&E department safely and be able to get back on the road within 15 minutes. At peak times this target is much more difficult to achieve and handover times can increase. Locally there are stark differences between the ambulance handover times achieved between the North East Ambulance Service and each Acute Trust with North Tees and Hartlepool achieving the best performance.

4.17 The number of people having to wait to be discharged from hospital due to a hold up in one or more elements of their discharge plan being put into place vary significantly between Acute Trusts. Fundamentally, City Hospitals of Sunderland have seen a significant decline in the numbers of delayed discharges experienced over the last two years, County Durham and Darlington have also experienced a recent decline and North Tees and Hartlepool are experiencing an increasing trend. There is still a significant amount of work to do locally to ensure that discharge processes are working more effectively to prevent delays in transfers of care.

Local Demographics and Health Inequalities – County Durham

4.18 The health of people living in County Durham has improved significantly over recent years, but remains worse than average for England. Health inequalities remain persistent and pervasive. Levels of deprivation are higher and life expectancy is lower than average for England. Local priorities for tackling these inequalities include reducing smoking, tackling childhood and adult unhealthy weight, promoting breastfeeding, reducing alcohol misuse, reducing teenage conceptions (and promoting good sexual health), promoting positive mental health and reducing early deaths from heart disease and cancer.

4.19 Much of the population in County Durham suffer from avoidable ill-health or die prematurely from conditions that are preventable. Lifestyle choices remain a key driver to reducing premature deaths but it is clear that social, economic and environmental factors also have a direct impact on health status and can exacerbate existing ill health.

4.20 The vision for the County Durham Joint Health and Wellbeing Strategy is to:

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

Central to this vision is the belief that decisions about the services provided for service users, carers and patients, should be made as locally as possible and involve the people who use them. The vision is supported by the following Strategic Objectives that outline the areas of priority for the Board:

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

4.21 In County Durham some of the demographic trends are:

- The current population
- The 65+ age group was projected to increase from almost one in five people in 2013 (19.2%) to nearly one in four people (24.7%) by 2030, which equates to an increase of 39.8% from 99,000 to 138,400 people.
- The proportion of the County's population aged 85+ is predicted to almost double (+ 95.2%) by 2030.
- Life expectancy is improving for both males (77.9) and females (81.5), but is still below the England average (79.2 for males), (83 for females).

(Joint Strategic Needs Assessment 2014 statistics)

4.22 Social isolation and loneliness is a significant and growing public health challenge for County Durham's population. It affects many people living in County Durham and has a significant negative effect on health and wellbeing across the life course. Anybody can be affected by social isolation or loneliness and it can 'affect any person, living in any community'. It is costly to local health and care services and can increase the chances of premature death.

(Adapted from County Durham Joint Health and Wellbeing Strategy 2015-2018)

4.23 The County Durham Joint Health and Wellbeing Strategy states that 'A Wellbeing for Life Service has been implemented to help people achieve a positive physical, social and mental state. The wellbeing approach goes beyond looking at single-issue healthy lifestyle services and a focus on illness, and aims to influence the circumstances that help people to live well, and build their capacity to be independent, resilient and maintain good health for themselves and those around

them'. This is in addition to a range of other services to support people to remain health and as independent as possible, including short term rehabilitation.

Local Demographics and Health Inequalities – Darlington

4.24 In Darlington some of the demographic trends are:

- The current population is estimated to stand at 105,564
- By 2020 the over 50 population is projected to be 44,220 (40% of the total population) and the over 65s projected to rise to 22,306 (20% of the total population).
- Darlington has some of the most deprived areas in England, and is ranked 75th most deprived local authority out of 326 in England (IMD 2010)
- People in Darlington are living longer. However, life expectancy remains slightly less than the average for England. On average males are living to 78 years (England average 78.9 years) and women 82.4 (England average 82.9 years).

(Adapted from Strategic (Single) Needs Assessment Refresh 2013, Darlington Borough Council)

4.25 The health of people in Darlington is generally worse than the rest of England with some specific local health inequalities to be addressed. These include: 18% of children in year being classified as obese; long-term health prospects are undermined by above average number of children living in poverty and below-average breastfeeding rates; alcohol-related hospital admissions remain high; the health effects of individual lifestyle choices, particularly smoking, drinking, lack of exercise and poor sexual health are significant and there is growing concern about the emergence of mental health issues, linked to poverty as both a cause and effect.

4.26 Darlington's Sustainable Community Strategy[1] contains two specific objectives focussed on helping to improve the health and wellbeing of people living in Darlington: 'more people heathy and independent' and 'more people active and involved' both aimed at addressing the above health inequalities.

4.27 The 'Healthy Darlington' approach is now supporting people to eat well, move more and live longer and together with a range of wider initiatives is encouraging people take care of themselves, with more people using the support and facilities available to make lifestyle choices that support active, healthy living. This is combined with a growing culture of volunteering and active citizenship, in which more and more people are choosing to take care of others or of their neighbourhood as a lifestyle choice, through the growing 'social capital' of volunteering programmes. Darlington is an active, engaged community of citizens first and foremost, rather than service users.

(Adapted from One Darlington, Perfectly Placed, May 2014 Refresh)

4.28 The increasing aging population across both County Durham and Darlington coupled with the challenges of addressing poor personal health choices and health inequalities are significant and impact on the demand for our local urgent and emergency care services.

[1] 'One Darlington Perfectly Placed' 2008-2026 Revised May 2014

Local Plans

4.29 The whole system needs to be robust enough to support people to become healthy, stay healthy and react quickly and effectively when someone needs support. There a range of local plans developed by all organisations who are members of the County Durham System Resilience Group to support these aims with a wide variety of innovative local approaches and actions. **Appendix 4** details a list of current local plans and strategies. The table below contains some broad themes of what all the plans aim to achieve across the County, together with how this whole systems approach supports the urgent and emergency care system:

Broad Theme	What does this mean?	How does this support the urgent and emergency care system?
Helping people to look after themselves better	Local information and initiatives to encourage people to eat healthily, take regular exercise, reduce or stopping smoking, reduce alcohol intake, reduce stress levels and development of social networks and support.	Reducing unnecessary demand on urgent and emergency care services by helping people to remain fit and healthy wherever possible.
Helping people to take responsibility for their health and wellbeing	Providing clear and easy to access information and advice about where to go for help, providing health checks and guidance and support to enable self-care.	People feel supported to be confident and informed about when and where to go for help with their health needs, using pharmacies, GP Practices and Urgent Care Services appropriately depending on their level of health need.
Helping people to maintain their independence	Information and advice, social care, planned and reactive, intensive, health and social care services such as intermediate care, for people with complex health and social care needs.	These services are crucial to help people remain at home when it is safe for them to do so, avoiding unnecessary hospital admission, admissions to long term care and supporting appropriate, safe hospital discharges.
Making sure that people have rapid access to appropriate health and social care service when they need them	Ensuring that local health and social care services are appropriately resourced and joined up to provide rapid interventions when people need them.	Urgent and emergency care resources can be targeted appropriately to make sure people who have urgent or life-threatening health needs receive help in a timely manner.

5 Where are we now?

5.1 This section explains the urgent and emergency care services that currently operate across County Durham and Darlington. The tables detail how these services are currently spread across the County.

5.2 **Appendix 5a and 5b** details the locations of the main urgent and emergency care services across County Durham and Darlington.

Accident and Emergency Departments

5.3 Located on acute hospital sites, Accident and Emergency Departments provide round the clock, Consultant led care for life-threatening situations such as:

- Loss of consciousness;
- Acute confusion and fits that are not stopping;
- Continuing, severe chest pain;
- Breathing difficulties;
- Severe bleeding that cannot be stopped.

5.4 County Durham and Darlington NHS Foundation Trust provide Accident and Emergency Departments located Darlington Memorial Hospital and University Hospital North Durham. Both Hospitals in County Durham and Darlington provide 24 hour Consultant led Accident and Emergency care. This includes critical care, ambulatory care, acute medicine and surgery. Stroke and vascular surgery is also provided at University Hospital of North Durham.

5.5 Hospitals that have Accident and Emergency Departments that provide this level of emergency care are referred to as being able to provide a Type 1 Accident and Emergency response. A Type 1 response means 'A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients'.[2]

5.6 A lot of work was undertaken at both hospital sites during 2014 including improving the Ambulatory and Rapid Assessment and Treatment routes for patients to ensure that each patient is seen by the right clinician in the Accident and Emergency Department, first time, every time. Beginning with an initial decision by a Nurse Navigator (senior nurse/doctor), patients are guided to the most appropriate practitioner for their needs. Successful pilots of this initiative across both hospital sites resulted in full implementation from 1st April 2014.

5.7 Recent expansion of the Medical Assessment Unit and medical bed capacity has also taken place within the University Hospital of North Durham enabling patients to be directed to the Medical Assessment Unit, where appropriate, without the need for them to first be assessed within the Accident and Emergency Department.

[2] Emergency Care Weekly Situation Report Definitions, NHS England, April 2014

5.8 Some people living in County Durham and Darlington may also use one of the acute hospitals located outside County Durham and Darlington. For example Sunderland Royal Hospital provided by City Hospitals Sunderland NHS Foundation Trust, the Queen Elizabeth Hospital located in Gateshead or the University Hospitals of North Tees or Hartlepool that are provided by North Tees and Hartlepool NHS Foundation Trust.

Urgent Care Services

5.9 Urgent Care Services are split into different types but they all provide assessment and treatment for non life-threatening situations. The different services are:

- Urgent Care Centres
- Minor Injury Units
- GP Out of Hours
- Walk in Centres

5.10 In County Durham an Urgent Care Service is currently provided by County Durham and Darlington NHS Foundation Trust across six Urgent Care Centres located around the County. There is also a separate Walk-in service in Easington provided by Intrahealth.

5.11 Some of the common injuries and ailments that can be treated by these services include: chest infections, urine infections, minor burns and scalds, wound infections, suspected eye infections, fevers, cuts, sprains and strains, hand, foot and wrist fractures, insect and animal bites and minor head injuries. Minor Injury Units usually just assess and treat minor injuries whereas Urgent Care Services, including Walk-in Centres, may also treat minor illnesses depending on the local service arrangements.

5.12 There are differences in the Urgent Care Services currently available in different locations. **Table 3.1a** shows some differences in how these services are currently provided.

5.13 One of the main differences is when Urgent Care Services are open. Some are only open during the day (In Hours), some are only open overnight, weekends and on Bank Holidays (Out of Hours). Some are open all the time (In Hours and Out of Hours).

5.14 As part of the range of Urgent Care Services currently available, a GP Out of Hours Service operates across the County with GP's based overnight, at weekends and Bank Holidays in some of the Urgent Care Centres.

Primary Care and Community Services

GP Practices

5.15 General Practitioner's (GP's) look after the health and wellbeing of people in their local community. They support people with a wide range of health needs and also provide health education, offer advice on smoking cessation, diet and fitness, run clinics, give vaccinations and carry out simple surgical procedures. GP Practices

include a range of staff, for example, Nurses, Healthcare Assistants, Practice Managers, Receptionists and other staff. They work as a team and closely with other community health and social care services including Health Visitors and Midwives to make sure people receive the best support and advice for their individual needs.

5.16 Some GP Practices have additional 'branch' locations so they can deliver services closer to their population. The location of GP Practices and their 'branch' locations can be seen in **Appendix 5a.**

5.17 All three Clinical Commissioning Groups currently have extended GP Practice working arrangements in place to facilitate increased capacity, flexibility and availability of GP appointments. These vary locally and are detailed in **Table 5.1b.** This type of service is important in supporting the move towards seven days services available within Primary Care.

Community Pharmacies

5.18 Community Pharmacies provide a wide range of NHS services summarised in the table below. Overall they offer free and confidential health advice without the need for an appointment.

	Service Provided
All Pharmacies	Dispensing of Drugs / Drug Tariff Appliances / Elastic Hosiery Repeat Dispensing Disposal of Unwanted Medicines Health Advice, Travel Health Advice Promotion of Healthy Lifestyles Signposting to other Healthcare Providers
Most Pharmacies	Medication Use Reviews and Prescription Interventions Support for people starting to take New Medicines Advice on Minor Ailments Sexual health services Support for Smoking Cessation
Some Pharmacies	NHS Health Checks Anticoagulant (Warfarin) Monitoring Clinic Substance Misuse Services Needle and syringe exchange services Alcohol Interventions Pandemic and Seasonal 'Flu vaccination services Palliative care services Medication support to Care Homes Out of hours services – Sunday and Bank Holidays on a rota basis and 100 hour pharmacies

(Summarised from 'Services available through our Community Pharmacies' County Durham and Darlington Local Pharmaceutical Committee July 2012[3])

5.19 The majority of pharmacies support with minor ailments providing advice and where appropriate prescribing medication. Examples of minor ailments include sore throats, headaches, earache, temperature, allergic contact dermatitis, hay fever, head lice and infant teething.

5.20 **Appendix 5b** details the location of all Community Pharmacies in County Durham

[3] http://www.durhamlpc.org.uk/Assets/Contractors_PDFs/0E_AF_75_EE_40_OE/CD_D_Pharmaceutical_Services.pdf

and Darlington.

Telephone Advice – NHS 111

5.21 NHS 111 is the NHS non-emergency number. Across the North East region, the North East Ambulance Service provide the NHS 111 service. This includes a telephone triage service staffed by trained advisors, supported by healthcare professionals. This service will ask a range of questions to assess a person's symptoms, enabling them to be directed to the right medical care for their needs. The service is for a wide range of situations where urgent medical support is required but the situation is not life threatening. The service is free to access and available 24 hours a day, 365 days a years.

Other Community Services

5.22 A wide range of local community health and social care services exist across County Durham and Darlington providing support to the current urgent and emergency care pathway. These include Community Mental Health Teams, Statutory Social Care Assessment and Support, Voluntary Sector Services for example British Red Cross, Home from Hospital Services and Hospices.

5.23 It should be noted that some work areas for improving the current local urgent and emergency care pathways link directly to work already being progressed within other pathway areas such as intermediate care and end of life. As such this strategy will not duplicate work being progressed elsewhere but will work collaboratively to ensure that actions being progressed within other workstreams are delivered in line with the requirements for urgent and emergency care pathway improvements. The key cross cutting areas are:

5.24 Across County Durham only, an Intermediate Care Plus service, funded through the Better Care Fund, includes a range of intensive short term health and social care services to help people get back on their feet has been running through a Single Point of Access from April 2014. The service expands the existing integrated health and social care services by:

- bringing together existing community based short-term intervention services
- adding significant capacity to the existing intermediate care pathway, and;
- providing new, additional community based short-term health and social care services;
- all under one umbrella, for people who need rehabilitation and recovery support, either within the community and for people returning home from hospital;
- providing a Single Point of Access for health and social care professionals through 24 hours a day, 7 days a week, including Bank Holidays.

5.25 In Darlington, the Responsive Integrated Assessment Care Team (RIACT) is the intermediate care and re-ablement service that supports older people through a range of health and social care professionals and support from the voluntary sector to provide a comprehensive community based assessment and support service. The service supports older people to stay out of hospital where they can be supported safely and appropriately at home and helps people with their recovery and rehabilitation following a stay in hospital.
The service is central to the Multi-disciplinary Team work that is taking place as part

of the Better Care Fund projects.

5.26 Improving Palliative and End of Life Care is being led by all three County Durham and Darlington Clinical Commissioning Groups with a Strategic Commissioning Plan in place between 2013 and 2018. The strategy focuses on the establishment of a *new social system* for palliative and end of life care, which operates for the best interest of the patient and works together to deliver the best care possible, will improve collaborative working, strengthen joint ownership and reposition patients and their carers at the centre of the work. Key Palliative and End of Life Strategy deliverables that also facilitate improvements in the Urgent Care Systems include:

- development of single point of access making it easier for palliative patients to know where to go for support;
- development of the multi-disciplinary approach to advanced care planning and emergency care planning;
- Standard application of the Deciding Right *(A North-East initiative for making care decisions in advance)*;
- Keeping people at home through, rapid response, palliative care at home, carer services, implementation of the Deciding Right with regard to care homes.

Table 5.1a Urgent and Emergency Care Services in County Durham and Darlington

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham		Durham Dales, Easington and Sedgefield				Darlington	
					University Hospital of North Durham	Shotley Bridge Community Hospital	Seaham Primary Care Centre	Easington Health-works	Peterlee Community Hospital	Bishop Auckland General Hospital	Darlington Memorial Hospital	Dr Piper House
Accident and Emergency	Life-threatening conditions	Emergency	• Emergency Ambulance Transfer • GP referral • Walk-in	24/7, 365 days of the year	✓						✓	
In-hours Urgent Care	Minor illness and injury	Urgent	• Booked appointments • Walk-in • Telephone appointments • Home visits	8am to 6pm Monday to Friday		✓	✓		✓	✓		✓
Out of Hours Urgent Care	Minor illness and injury	Urgent	• Walk-in • Telephone appointments • Home visits	6pm to 8am Monday to Friday, Weekends and Bank Holidays	✓	✓			✓	✓	✓	
Walk-in Centre	Minor illness and injury	Urgent	• Walk-in only • No need to book appointments	8am to 8pm Monday to Sunday				✓				
GP Out of Hours Service	Minor illness and injury	Urgent	• Telephone appointments • Home visits	6pm to 8am Monday to Friday, Weekends and Bank Holidays	✓	✓			✓	✓	✓	
Minor Injury Service	Minor injury only*	Urgent	• Walk-in • Telephone appointments • Home visits									

Table 5.1b Urgent and Emergency Care Services in County Durham and Darlington

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham	Durham Dales, Easington and Sedgefield	Darlington
GP Practices	Minor illness and injury	Urgent and Non Urgent/ Routine	• Booked appointments • Telephone appointments • Home visits	8am to 6pm Monday to Friday	31	40	11
Extended GP Practices Opening	Minor illness and injury	Urgent and Non Urgent/ Routine	• Booked appointments • Telephone appointments • Home visits	Hour of extended GP Practice opening vary	Extended opening times vary between local GP Practices including appointments on Saturday mornings.	South Durham Health: 10 x practices open Saturday 8.00 – 12.00 noon Durham Dales Health: 5 x practices open Saturday 8.00am – 1.00pm Intrahealth: 1 practice open Saturday and Sunday 8.00am – 8.00 pm 1 practice open Saturday 8.00am – 1.00pm 1 practice open Saturday 9am – 12pm	Most GP practices offer extended opening hours b but these vary between practices
Pharmacies	Minor illness and injury	Urgent and Non Urgent/ Routine Advice and Information	• Walk-in • Telephone advice and information	Pharmaceutical Needs Assessment	52	73	23
NHS 111	Minor illness and injury	Urgent Advice and Information	• Telephone	24/7, 365 days of the year	Regional Service		
Intermediate Care Plus	Prevention of hospital admission and	Non urgent Intensive community based interventions	• Single point of access for health and social care professionals	24/7, 365 days of the year	✓	✓	
Responsive Integrated Assessment Care Team (RIACT)	Prevention of hospital admission and	Non urgent Intensive community based interventions	• Single point of access for health and social care professionals	24/7, 365 days of the year			✓

Urgent and Emergency Care Transport

Life Threatening Situations

5.25 The North East Ambulance Service provide emergency ambulances staffed with Paramedics and Emergency Care Assistants, responding to a wide variety of serious or life-threatening calls. Working alongside ambulance crews, a Rapid Responders Team also provide paramedic rapid response to commence emergency treatment before the ambulance arrives on scene.

5.26 In some serious emergencies, you could also be treated by a medical team from the Great North Air Ambulance. The medical team on the helicopter includes an acute Consultant (for example, Anesthetists, Emergency Department Consultant) and a Paramedic who are skilled in treating patients who have serious traumatic injuries.

Urgent Situations

5.27 At present transport is provided for doctors to visit patients at home and for patients who are unable to travel to the GP Practice or Urgent Care Service on their own.

Non Urgent Situations

5.28 Non urgent transport is currently provided by the North East Ambulance Service's Patient Transport Service. This planned service takes members of the public to and from their homes to outpatients' appointments, dialysis, chemotherapy, clinics, physiotherapy or non-urgent transfers between different hospitals.

5.29 This service covers Teeside, South Tyneside, North Tyneside and Northumberland as well as County Durham and Darlington and undertakes over a million journeys every year. Crews are trained as ambulance care assistants with specialist knowledge of comprehensive first aid, driving skills and patient moving and handling techniques. Some GP Practices organise their own non urgent patient transport directly outwith this service.

Table 5.2 Emergency and Urgent Care Transport

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	Coverage
999 Emergency Ambulance Great North Air Ambulance	Life-threatening conditions	Emergency	• Telephone	24/7, 365 days of the year	Regional
Urgent Care Transport	Minor illness or injury	Urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	County Durham and Darlington
Patient Transport Service	Minor illness or injury Routine appointments Hospital Discharge	Non urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	Regional

Mental Health Services

5.30 Urgent and emergency services specifically for people with acute mental health needs are detailed in **table 5.3**. There are two Crisis Teams that cover the whole of County Durham and Darlington; one is based at West Park Hospital and provides services across South Durham and Darlington and one is based at Lanchester Road Hospital and provides services for North Durham and Easington.

5.31 For those individuals who would ordinarily benefit from intensive home treatment but are unable to receive this in their own home, each locality provides a nine bedded crisis recovery house to support short-term interventions and prevent hospital admissions. This service has recently been rated as outstanding against the Care Quality Commission's standards for 'caring' for its person centred approach.

5.32 The mental health liaison service is based at University Hospital of North Durham and Darlington Memorial Hospital and provides mental health support to all acute and community hospitals. The service provides three main roles – multi disciplinary assessment of individuals attending A&E departments, ward based support for acute hospital staff and disciplinary assessment of those presenting with medically unexplained physical symptoms. The service ensures that people with mental health needs or presenting symptoms receive the specialist assessment and support they need.

5.33 All mental health services are provided across County Durham and Darlington with the exception of the Children and Adolescent Mental Health Service (CAMHS) - Crisis and Liaison Service that is currently running across County Durham only with non re-current funding. The CAMHS Crisis Team is co-located with the Adults Mental Health Crisis Team at Lanchester Road Hospital.

Table 5.3 Urgent and Emergency Mental Health Services

Type of Service	What is it for?	Level of need	How is it accessed?	Hours of Operation	North Durham	Durham Dales, Easington and Sedgefield	Darlington
Adult Mental Health Crisis Teams	Potential Life-threatening conditions	Emergency	• Telephone • Self-referral by people known to mental health	24/7, 365 days of the year	✓	✓	✓
Children and Adolescent Mental Health Crisis Teams	Potential Life-threatening conditions and Urgent Mental Health Needs	Emergency	• Telephone • Self-referral by people known to mental health services or professional	Not 24/7	✓	✓	

Crisis Recovery Beds	Urgent Mental Health Needs and Potential Life-threatening conditions	Urgent	• By professionals who need to arrange urgent transport for their patients	24/7, 365 days of the year	✓	✓	✓
Mental Health Inpatient Beds				24/7, 365 days of the year	✓	✓	✓
Acute Liaison	Mental health assessment and Potential Life-threatening conditions	Urgent	• Health professionals based at acute hospital sites	Not 24/7 (8am – 10pm, 7 days/week)	✓	✓	✓

Children and Young People's Services

5.34 The Poorly Child Pathway aims to integrate all aspects of Child Health and includes pathways which support specialist referral / intervention. Children who attend an Emergency Department with two episodes of asthma in twelve months are referred to a Consultant Paediatrician. There is also additional support from the paediatric respiratory nurse.

5.35 Clinical pathways for managing common children's illnesses have been developed within the Poorly Child Pathway. Within these pathways there are 3 categories of severity of illness:

Well enough to go home		**Requires further management/ supervision / assessment**		**Requires hospital admission**

5.36 In Darlington Memorial Hospital limited support is available from an Advanced Paediatric Nurse Practitioner within the emergency department. This is not currently available at University Hospital of North Durham. Both sites benefit from a Consultant Paediatrician up to 10pm weekdays and 6 hours in Paediatric Wards at weekends.

5.37 Paediatrics services provided by County Durham and Darlington NHS Foundation Trust currently do not currently support Urgent Care Centres.

Alcohol Harm Reduction Services

5.38 Durham 2012/13 there were 2063 alcohol related ambulance call outs for in County Durham reducing slightly in 2011 in 2013/14. Saturday and Sunday see consistently higher alcohol related ambulance callouts with peak times of 10pm. Males generally have more alcohol related ambulance callouts then females. The age group 20-29 category accounted for the highest numbers of alcohol related ambulance callouts. A high proportion of alcohol related ambulance callouts are from the most deprived wards. In Darlington, despite a reduction from 2,417 to 2,336 alcohol related

admissions during 2012, the current rate for alcohol related admissions still remains high.

5.39 Despite these statistics there is a limited understanding of the demand on accident and emergency services in relation to alcohol since the primary presenting condition and diagnosis in relation to alcohol is injury rather than the alcohol itself.

5. 40 The 2015 Local Alcohol Profile for England shows that the rate of alcohol specific hospital admissions in County Durham is 468 per 100,000 and remains higher than the England average. The rate of alcohol specific hospital admissions for men is 606 per 100,000 and has increased by 2% over time. Alcohol specific hospital admissions for women is 340 per 100,000 and has increased by 18% over time.

5.41 There are a number of individuals who have alcohol issues, chronic, mental and behavioural who are likely to frequently attend Urgent Care and Emergency Departments and more needs to be done to ensure comprehensive recovery support services are available in the community to provide appropriate support and help reduce the number of frequent attenders.

5.42 In 2013/14 there were 186 alcohol related ambulance call outs for young people under the age of 18 across County Durham. A number Emergency Department staff in both University Hospital of North Durham and Darlington Memorial Hospital have been trained in identification and brief advice for young people.

5.43 In County Durham, Lifeline provides alcohol and drugs treatment and recovery support for both young people and adults. In Darlington, the North East Council on Alcoholism (NECA) provides alcohol and drugs treatment and recovery support for both young people and adults. The police and Druglink also run an Alcohol Diversion Scheme for low level/first time offenders who pay to attend an awareness course in lieu of further criminal action and/or fines. We are also in early stages of looking at lessons learned from a Local Alcohol Action Area pilot undertaken recently in Middlesbrough, with a view to adopt partnership good practice across the Tees Valley.

How is the Urgent and Emergency Care System Managed?

5.44 A robust planning and assurance process is in place, managed by Nationally by NHS England and locally through each System Resilience Group, to make sure that all organisations contributing to the urgent and emergency care system are appropriately prepared to effectively manage anticipated peak times of demand. This includes the Winter period but also other times such as Bank Holidays.

5.45 The process is supported National guidance and local experience about where the system needs additional capacity at peak times and good practice with a focus on continuously improving key areas such as patient flow, ambulance handover management and discharge planning.

5.46 A sub group of the System Resilience Group focuses specifically on improving hospital discharge processes reducing the number of Delayed Transfers of Care

(DTOC). Smooth and effective discharge processes help reduce the time spent in an acute hospital bed, therefore improving overall patient flow through the hospital as well as making sure that people returning home from hospital have timely access to the right health and care support to meet their needs.

5.47 Part of the process is the appropriate allocation and management of resilience funding through the Systems Resilience Group. For the last two years the County Durham & Darlington System Resilience Group have taken a fair shares approach to the distribution of this funding across all major providers in the system to help them put additional capacity in place during peak demand periods.

5.48 Spend of allocated funding and delivery of agreed capacity and resilience projects agreed are then monitored both locally and Nationally with providers required to evaluate their projects at the end of the Winter period. Through this process the System Resilience Group partners can continuously refine what initiatives are yielding the most benefits on the system and inform where any future funding would be most effectively targeted.

5.49 The System Resilience Group monitors performance on a monthly basis against the NHS Constitutional Standards for Urgent and Emergency Care, 62 day cancer wait timescales, referral to treatment timescales and diagnostics.

5.50 Throughout the Winter North of England Commissioning Support Unit provide a Surge Management Service on behalf of the North East and Cumbria Clinical Commissioning Groups. The Surge Management Team provide an essential co-ordination and communication point for all Foundation Trusts and the North East Ambulance Service.

5.51 The team co-ordinate daily conference calls and provide up to the minute information to help manage capacity across the emergency care system. A Winter Web specifically dedicated to the sharing of information and management of capacity management across the regional urgent and emergency care system is in place to support communication across the region.

6 What do we want?

6.1 Local analysis of our urgent and emergency care system and supporting National evidence has identified the main challenges that we need to address in County Durham and Darlington to achieve our local vision:

- Increased demand across the system for both urgent and emergency care;
- An ageing population and increasing numbers of people with long-term conditions and complex needs;
- An urgent and emergency care system difficult for both patients and professionals to find their way around;
- Urgent and emergency care services that appear unrelated or fragmented;
- Current systems that are unable to meet future expectations and demand;
- A lack of up to date 'real-time' understanding of how demand flows around the system, particularly surge activity;
- Current potential for duplication and inefficient use of staff resource and skills;
- Historical poor performance in consistent achievement of the A&E 95% constitutional target and achievement of timely ambulance handover times;
- Reducing the average length of time people need to spend in an acute hospital bed;
- Improving discharge processes to increase patient flow and patient experience;
- Poor public perception of timely GP appointment availability within Primary Care.

6.2 This section identifies the current urgent and emergency care Clinical Commissioning Group priorities for urgent and emergency care in their local area and the gaps in the current urgent and emergency care pathway.

6.3 **Section 7 – 'How are we going to get there?'** details the actions that will be implemented both locally and regionally to address the challenges, meet the gaps and deliver both the local vision for County Durham and Darlington and the National vision for urgent and emergency care.

Current Clinical Commissioning Group Priorities

6.4 North Durham Clinical Commissioning Group

North Durham Clinical Commissioning Group is working closely with County Durham and Darlington NHS Foundation Trust to support their redevelopment of the emergency care department at University Hospital of North Durham and also works in collaboration with neighbouring Durham Dales, Easington and Sedgefield Clinical Commissioning Group in the development of urgent and emergency care services.

Their approach to urgent and emergency care dovetails with their Primary Care Strategy which supports the development of responsive GP practice based services over 7 days.

6.4.1 Gaps in Current Provision

Two of the key gaps currently identified in North Durham are the need to ensure the physical urgent and emergency care needs of children and young people are met and that there is a comprehensive and effective minor injury/illness pathway available in-hours within the Emergency Department.

6.4.1 Immediate Priorities

North Durham Clinical Commissioning Group have engaged with the public to develop their local urgent and emergency care strategy. Their strategy includes a range of actions that recognises GP Practices supported by health and social care community services as being central to providing an accessible and responsive service 7 day service that is able to swiftly and effectively meet local urgent care needs. Some of the current priorities over the next 12 months include:

- Working with County Durham and Darlington NHS Foundation Trust to develop plans for the provision of a new emergency care centre on the University Hospital Durham North Durham site;
- Monitor the impact of the recently implemented Local Divert Policy to help manage emergency care activity more effectively;
- Following a successful pilot, roll out direct booking of GP practice appointments NHS 111 service;
- Review GP Out of Hours Service and consider future fit with integrated service;
- Expand community primary care support vulnerable patients during week end by providing a GP led service supported by Community Matrons and District Nursing;
- Support the implementation of the Local Mental Health Crisis Care Concordat action plan;
- Evaluate Paediatrics Urgent Appointments pilot within Cedars Medical Practice, currently facilitating priority urgent GP appointments after school for children and teenagers.

6.4.3 Patient Engagement

During the Summer of 2014 North Durham Clinical Commissioning Group engaged the public and key stakeholders on their views about how urgent care is provided. The engagement exercise included range of engagement methods were used which included online information and feedback forms, wide distribution of information about the proposals across health and social care acute community facilities such as hospital waiting areas, GP Practices, libraries and leisure centres, focus groups and drop-in sessions.

The feedback received has helped shape the Clinical Commissioning Groups local urgent care strategy. The engagement exercise also identified a general need for the public to have a better understanding of difference between urgent care and emergency care and that patients value their GP practice and in some areas would like to see improvements in access to appointments.

6.5 Durham Dales, Easington and Sedgefield Clinical Commissioning Group

6.5.1 Gaps in Current Provision

Durham Dales, Easington and Sedgefield Clinical Commissioning Group are currently reviewing their local urgent care services and are exploring the potential for GP Practices to provide more urgent care capacity through better access during the day and extended opening. As part of this work an audit of the type of health care needs currently supported through the existing urgent care services during April to September 2014 was undertaken to help the Clinical Commissioning Group develop a better understanding of the patient needs within urgent care and identify any gaps or duplication in existing service provision.

6.5.2 Immediate Priorities

The Clinical Commissioning Group has considered National guidance in developing it's local approach to urgent care. Building on feedback from engagement work undertaken during 2014 with patients using the existing urgent care services, the proposed approach is to place GP Practices at the heart of the urgent care system providing access to responsive primary and community care services 7 days a week.

Work is continuing to understand the activity, trends, patient flows and resource distribution within current urgent care services and further engagement and consultation with primary and acute care clinicians, patients and the public will take place.

6.5.3 Patient Engagement

During 2014, DDES CCG undertook an Experience Led Commissioning approach to ask the public and key stakeholders how best to support people with urgent care needs in community settings. The engagement exercise included mapping both patient and front line staff experiences in particular of Primary Care (especially General Practice and Community Pharmacy), Out of Hours GP's, Accident and Emergency, Urgent Care Centres, self-management of long-term conditions and unexpected health issues, maintaining mental and emotional wellbeing and community based support.

The key message from patients was that Urgent Care Centres are their second choice or last resort, with their first choice being their own GP Practice.

There were also some suggestions around better communication to help people feel informed, confident and supported when they become ill and are deciding what to do and educated and helped to understand their health issues when they are with urgent care professionals.

6.6 Darlington Clinical Commissioning Group

6.6.1 Gaps in Current Provision

The main gap in the urgent and emergency care pathway currently identified by Darlington Clinical Commissioning Group is the need for integration between emergency and urgent care services, particularly within the Accident and Emergency Department within Darlington Memorial Hospital.

6.6.2 Immediate Priorities

Supported by National evidence about what works well Darlington Clinical Commissioning Group are working with County Durham and Darlington NHS Foundation Trust to reconfigure the existing Accident and Emergency Department within Darlington Memorial Hospital to enable an integrated emergency and urgent care service to be delivered 24/7. The aim is to provide local people with equitable access to sustainable, high quality, safe and effective urgent and emergency care services at the right time and in the right place.

6.6.3 Patient Engagement

Healthwatch Darlington hosted two engagement events on behalf of Darlington Clinical Commissioning Group in February 2015. The events attracted over 100 people and focused *on exploring better future models of care with the public. The events were informed by* NHS England's Five Year Forward View, explaining why change is needed and what services could look like in Darlington for a range of health care services including urgent care, primary care and pharmacy.

Resulting from these initial events Darlington Clinical Commissioning Group are planning a further series of events focusing on specific area of healthcare over the coming months, including primary and urgent care.

Urgent and Emergency Care Pathway Gaps

6.7 The current gaps in the urgent and emergency care pathway across County Durham and Darlington that need to be addressed to deliver the local vision have been aligned to the seven objectives of the strategy.

6.8 **Objective 1:** People are central to designing the right systems and are at the heart of decisions being made.

Over the years urgent and emergency care systems in County Durham and Darlington have evolved as a result of changes in both National and local policy, time limited funding streams and available resources. Although public and patient engagement has taken place, this strategy provides an opportunity to engage on a local vision across the whole of County Durham and Darlington.

During the life of this strategy, Clinical Commissioning Groups and other key stakeholders within the System Resilience Group will continue to engage with their partners, the public, patients and clinicians to shape and deliver the local vision within their geographical area. This may mean requesting feedback on experience of current services, helping to shape local services and consultation on proposed solutions. The exact nature of engagement and consultation work will vary depending on the nature of the issue the Clinical Commissioning Group is trying to resolve within the overall urgent and emergency care pathway.

6.9 **Objective 2:** Patients will experience a joined up and integrated approach regardless of the specific services they access

Recent National guidance is supporting the development of an 'integrated service' approach between NHS 111 and both in and out of hours primary and urgent care services across each Urgent and Emergency Care Network area. The key elements of this new model have been consulted on across the Country by NHS England and this approach guidance will be provided to support implementation.

In County Durham and Darlington aspects of this model are already in place with NHS 111 being able to book some direct GP Practice and urgent care appointments directly into clinical systems and NHS 111 having some clinical support to help ensure ambulances are appropriately dispatched to those who really need them.

Locally, there is a need to integrate the falls and frail elderly pathway to ensure an integrated approach to falls prevention for older people and all Clinical Commissioning Groups have been considering their current make up of primary and urgent care services in their local community and how these can be developed to provide a truly integrated and responsive primary and urgent care approach for local patients.

There is a need to continue this work as part of the delivery of this strategy to help achieve the overall local vision. This will include progressive work to develop an integrated primary care and secondary care offer within each Clinical Commissioning Group area with local clinical hubs that can provide comprehensive assessment and treatment in the community. There is a challenge within each Clinical Commissioning Group area to ensure that the future local arrangements dovetail with the National 'integrated service' for both in and out of hours so that they patient receives a smooth services from accessing NHS 111 for assistance to being assessed and treated locally or all primary care and urgent care needs, 7 days a week, 365 days of the year.

To achieve the above, current work to review and understand current services, research and develop best practice local models will continue, with options being considered that may include extended hours services, stronger integration between primary and secondary care and expanding direct booking of GP appointments by NHS 111 and development of local minor illness and injuries pathways.

To achieve and integrated approach that works effectively for both clinicians and patients the System Resilience Group partners will need to support the development of appropriate clinical access to patient records to facilitate clinicians to provide the safest outcome for the presenting patient needs.

6.10 **Objective 3:** The most vulnerable people will have a plan to help them manage their condition effectively to avoid the need for urgent and emergency care

Across all Clinical Commissioning Groups work has been progressed within primary care to identify the most vulnerable patients, at risk of a hospital admission and to make sure they have a joined up health and social care plan in place providing them with both a proactive and reactive multi-disciplinary team approach to their care needs. The purpose of this it to provide a proactive approach to helping people maintain their health, respond quickly to prevent a deterioration in patient's health, provide proactive and appropriate clinical support in line with their individual needs and help prevent an unnecessary hospital or long-term care admission and support people with safe discharge where a stay in an acute hospital bed has been necessary.

In addition, some work has been undertaken to identify and understand the needs of people who are the most frequent attenders at Accident and Emergency Departments within County Durham and Darlington NHS Foundation Trust and begin developing proactive care management plans to help better support their needs and prevent their need to regularly attend A&E at an emergency.

However, there is still work to be done to help people take responsibility for their own welfare and support the self-management of long term conditions. Current gaps that need to be addressed include:

- The need to embed the role of peer support, voluntary sector and community networks to help and support people to self-care;
- The development of a strategy to help people self-care through individual focused agreed anticipatory care plans;
- The need to review and develop local falls prevention arrangements, particularly comprehensive management plans within care homes, to prevent falls and reduce unnecessary ambulance conveyances and acute admissions;
- Continue the current work to develop comprehensive care management plans across primary, secondary and emergency care to proactively support the people who are the most regular attenders at Accident and Emergency Departments.

6.11 **Objective 4:** People will be supported to remain at their usual place of residence wherever possible

Across all Clinical Commissioning Group's gaps have been identified in how current primary, urgent and emergency care services work together to make sure that vulnerable people receive timely and appropriate healthcare and/or social care support so that their health needs can be safely managed at home wherever possible.

This approach helps prevent unnecessary hospital admissions and re-admissions, ensuring acute hospital resources are targeted at those who need acute care, minimises disruption and inconvenience for patients and their families and helps achieve the best outcome for the patient. These services also support patients with timely, safe hospital discharge.

Some work has already been progressed, including extended opening hours for GP Practices, significant expansion of intermediate care arrangements in County Durham, a Vulnerable Adults Wraparound Service in Durham Dales, Easington and Sedgefield and aligning Community Matrons or Advanced Nurse Practitioners and GP Practices to care homes. However, this work needs to continue as part of this strategy implementation to make sure that as everyone whose health could be supported at home, has access to the right support for them, when they need it.

Remaining work to achieve this objective includes:

- Making sure that the deciding rights of palliative care patients who have chosen not to be transported to hospital are implemented to respect people's preferred place of death and reduce the number of people dying within 48 hours of a hospital admission;
- Review and evaluate the effectiveness of a range of local additional clinical support to care homes and understand the impact on reducing acute hospital admissions and re-admissions;
- Further development of primary and secondary care clinical hub arrangements supporting care homes and people within their own homes to make sure everyone has responsive, timely and effective health and social care interventions to avoid a hospital admission where appropriate and support people with timely safe hospital discharge 7 days a week;
- Clarification of the scope of the Emergency Medication Service following evaluation and training and education of health and social care staff in the proper use of inhalers as a preventative measure;
- Clarification of scope of the Minor Ailments service in light of availability of real time data;
- There is need to improve the skills of health and social care staff to ensure the consistent application of medication reviews for frail elderly people;
- Developing responsive children's community services that are integrated with urgent and emergency care services. This includes increasing specialist community paediatric capacity to help further support children and their families at home with acute and chronic disease management;
- Ensuring special patient notes are up to date and available for paramedics to contact local clinical support for vulnerable patients;
- Developing intermediate care services in line with the outcome of local reviews.

6.12 **Objective 5:** The public will have access to information and guidance in the event of them needing urgent or emergency care

One of the key challenges locally is to create an urgent and emergency care system that proactively supports people to use primary and urgent care services as a first port of call for urgent needs, as opposed to going straight to A&E.

Over Winter 2014/15 a comprehensive Keep Calm campaign used a wide variety of media to encourage people to go to the right service to meet their health needs, and only going to Accident and Emergency Departments for emergency health needs.

Ensuring patient education and public health messages continue to be a high priority focus and work is progressing with NHS England and local System Resilience Groups through the Urgent and Emergency Care Networks to make sure that National and local messages are dovetailed to provide a consistent message to the public, particularly during Winter.

More work to be done to address patient perception that a GP appointment may not be available in a timely manner, or that is convenient by asking people who attend Accident and Emergency Departments whether and how they have tried to access primary and urgent care services before attending A&E and if so what barriers they faced so that any perceived or actual barriers to accessing primary and urgent care services locally can be addressed.

There is also a need make sure the current community pharmacy services are fully utilised and that key services such as advice on new medications and medicine use reviews are undertaken consistently by all pharmacies.

6.13 **Objective 6:** The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs

Achieve of objective six within the delivery of this strategy is fundamental to ensure that people receive timely support with all their healthcare needs, and are not passed between services. This wastes time, creates unnecessary expensive duplication, is demoralising for staff and means that scarce resources are not being effectively used.

A great of work is already being undertaken to work towards providing an urgent and emergency care system that makes sure that people access the pathway at the right place to ensure their health needs are assessed and met first time, every time. However, with such a complex system there is a great deal of work still to do before the right systems are in place to meet this objective.

Current gaps and issues that still need to be addressed include:

- Completing the full relocation of the urgent care service in Darlington within the Accident and Emergency Department in Darlington Memorial Hospital;
- Reducing inappropriate emergency ambulance dispatches to Accident and Emergency Departments by reviewing the clinical triage arrangements with NHS 111 to make sure they are sufficient and working effectively;
- Reducing inappropriate emergency ambulance dispatches to Accident and Emergency Departments by ensuring effective clinical support is in place for paramedics including timely response from local primary and urgent care services;
- Reduce inappropriate referrals to ambulatory care and increase appropriate referrals from Accident and Emergency Department's;
- Monitor progress in the two year reduction trajectory for See, Treat and Convey activity and associated increases in Hear and Treat and See and Treat activity;
- There is a need to make sure Crisis and Liaison support for children and adolescents with mental health needs are sufficient and effective across County Durham and Darlington;

- There is a need to make sure that clinical and referral pathways into recovery services for both adults and young people with an alcohol dependency are sufficiently robust and effective across County Durham and Darlington;
- Reviewing and expanding Community Mental Health Services across County Durham and Darlington to support people in mental health crisis including people with dementia, and providing a patient centred response;
- All System Resilience Group members need to work proactively work with the Directory of Service Team to continuously improve access to the NHS Pathways Directory of Service for County Durham and Darlington to promote easier and faster access to appropriate services across health and social care.

6.14 **Objective 7:** The patient will not experience any unnecessary delay in receiving the most appropriate care

This objective is linked closely to objective 6, in making sure that people do not receive any delays in their assessment or treatment of their healthcare needs. If people are able to access the right service, first time, every time, it should significantly reduce any delays patients experience in accessing the clinical support they need to address their health care needs.

However, this objective specifically focuses on ensuring there is no waste in the process or shortage of resources once people arrive at the right service, to make sure their needs can be addressed quickly.

One of the key areas that urgent and emergency care systems across the Country struggle with is patient flow from entering Accident and Emergency Departments, right through to being discharged from an acute hospital bed, in a timely manner, with the right health and social care support in place, where appropriate. This is particularly important for people with multiple health needs who often need multi-disciplinary support when they return home.

There is a significant focus from both NHS England and locally within the System Resilience Group by all partners to help improve all aspects of patient flow through acute hospital. The key areas that need to be addressed include:

- Ensuring that Rapid Assessment and Treat is in place to support patients in Accident and Emergency and Medical Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on;
- Making sure that Consultant led morning ward rounds take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend;
- Making sure that there is sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance;
- Complete the redevelopment of University Hospital of North Durham's Accident and Emergency Department to significant increase capacity, improve patient flow and patient experience;

- Improving ambulance handover times at Accident and Emergency Departments supporting County Durham and Darlington patients;
- Making sure that the Ambulatory Care Service provided by County Durham and Darlington NHS Foundation Trust has sufficient capacity to manage demand;
- Ongoing work to reduce unnecessary breaches of the 95% four hour wait target;
- Use collated primary, urgent and emergency care demand levels to help understand fluctuations in overall levels of demand across the whole system, particularly surge activity;
- Continue to develop and improve initiatives that reduce acute bed length of stay, particularly for people aged 75 and over;
- The regional management of demand for emergency ambulances through the Regional Flight Deck and local arrangements in North Durham will need to be reviewed and evaluated to determine their effectiveness;
- There is a need to undertake a full review of the Patient Transport Service and discharge transport services to make sure that these services are able to meet demand, are robust and cost effective;
- Work to better understand bottlenecks and pressures throughout the urgent and emergency care pathway and the most effective approach to alleviate these pressures will need to be further explored, possibly through the use of NHS England's Data Intelligence Tool;
- Ensuring that the mental health acute care pathway processes are as efficient as possible to make sure patients receive a timely response and improve patient experience;
- Expand the current Mental Health Acute Liaison Service in A&E to 24/7 coverage;
- Ensure that the re-configurations of Accident and Emergency Departments in both Darlington Memorial Hospital and University Hospital of North Durham include the integration of children's care that is also sufficiently resourced;
- County Durham and Darlington NHS Foundation Trust need to make sure that their Consultant Ward rounds are timely, efficient and effective in facilitating morning and weekend discharges to improve patient flow;
- Although pockets of work has been progressed there is an overall need to develop 7 day service access to a range of key clinical services to support effective discharge management. These include diagnostics, access to diagnostic scanners, cardio-pulmonary tests and pharmacy;
- Timely access to care packages, particularly at times of pressure, during weekends and Bank Holidays needs to improve;
- The process for people accessing prescribed medication from community pharmacies following discharge from hospital could be streamlined;
- There is a need to put in place an effective Discharge to Assess[4] model reducing delays in hospital discharge.

[4] Safe, compassionate care for frail older people using and integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders; NHS England, February 2014

NHS 111 Regional Workplan

6.15 There are number of gaps and issues to be addressed in the urgent and emergency care pathway across County Durham and Darlington that are similar or the same as gaps and issues experienced in other parts of the Region. The remit of the Urgent and Emergency Care Network is to look at those challenges that are too big for one System Resilience Group to resolve on their own or to make sure there is a consistent solution in place across a region to prevent duplication of resources.

6.16 A regional workplan has been developed which includes the gaps and issues highlighted in bold under each of the above objectives that will be addressed regionally with input from our local System Resilience Group.

7 How are we going to get there?

7.1 To address the current challenges The County Durham and Darlington System Resilience Group have agreed to work collaboratively to provide:

- Integrated urgent care services will be embedded into patient pathways;
- Joined up pathways ideally in the community where patients live;
- Simpler, safer and more effective services;
- Improved patient experience and outcomes;
- Better quality and value for the tax payer; and
- Overall the right care, in the right setting, at the right time.

7.2 In essence the future of emergency and urgent care services across County Durham and Darlington will seek to meet the seven strategy objectives all partners will need to work jointly, proactively and effectively to review existing resources and pathways, explore alternative options for provision and consider joint commissioning opportunities to make best use of the resources available and ensure a joined up approach for patients.

7.3 Whilst this strategy intends to deliver a shared vision over the next five years, it is acknowledged that health and social care is continually developing and changing and this strategy will need to be reviewed annually to ensure it continues to meet the needs of the population.

7.4 The Urgent Care Strategy actions will be implemented through three workstream areas with specific actions aligned to each workstream. Project Leads will be identified for each action. The System Resilience Group will oversee the implementation of the whole action plan, receiving updates and monitoring progress on a monthly basis.

7.5 Each project lead is responsible for ensuring that each project area is supported by the key enablers, Communication, Workforce, Information Management and Technology and Engagement during the implementation process.

Links to other care pathways

7.6 It should be noted that some of the actions identified within this strategy link directly to work being undertaken within other care pathways, such as the Frail Elderly and End of Life Pathways. A joined up approach to prevent duplication will be implemented where appropriate.

High Level Action Plan

This Action Plan will be reviewed monthly by the System Resilience Group to monitor progress and updated annually during the life of the strategy. The implementation of the actions identified below will in the main be the overall responsibility of the County Durham and Darlington System Resilience Group. However, those that are the overall responsibility of the regional Urgent and Emergency Care Network have been highlighted.

Those actions that are also aligned to the delivery of NHS England's 8 High Impact Interventions have also been clearly identified.

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
Objective 1: People are central to designing the right systems and are at the heart of decisions being made					
1.1	All System Resilience Group commissioners and providers will ensure that appropriate public, patient and clinical engagement and consultation takes place in the delivery of strategy actions to make sure people are able to input their views into the development of local urgent and emergency services in line with the strategy vision	Clinical Commissioning Groups Local Authorities	All SRG Providers	System Resilience Group	
Objective 2: Patients will experience a joined up and integrated approach regardless of the specific services they access					
2.1	Review current provision where appropriate and develop an 'integrated service' for NHS 111 and in and out of hours primary care across the Urgent and Emergency Care Network	All Regional System Resilience Groups	All relevant providers	Urgent and Emergency Care Network	✓
2.2	Review and develop local arrangements for enabling GP Practices to provide extended hours/additional capacity and increased access opportunities providing a responsive service to both primary and urgent needs 7 days a week	Clinical Commissioning Groups	GP Federations	System Resilience Group	✓
2.3	Review, research and develop community based urgent care clinical hub arrangements within primary and urgent care, ensuring appropriate fit with the Urgent and Emergency Care Network 'integrated service'	Clinical Commissioning Groups	All relevant providers	System Resilience Group	✓
2.4	Develop robust links with the Frail Elderly pathway to ensure each care home has effective arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate	Clinical Commissioning Groups Local	All relevant providers	System Resilience Group	✓

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
		Authorities			
2.5	Support the development of appropriate clinical access to patient records to facilitate clinicians to provide the safest outcome for the presenting patient needs	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
2.6	Expand NHS 111's ability to directly book appointments with GP Practices	Clinical Commissioning Groups	GP Federations	Urgent and Emergency Care Network	
Objective 3: The most vulnerable people will have a plan to help them manage their condition effectively to avoid the need for urgent and emergency care					
3.1	Embed the role of peer support, voluntary sector and community networks to help and support people to self-care	Local authorities	All relevant providers	System Resilience Group	
3.2	Develop a clear strategy to help people self-care through individual focused agreed anticipatory care plans	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
3.3	Review existing arrangements and make sure a robust falls prevention approach is in place including comprehensive care management plans for all care homes with primary care, pharmacy and falls services for prevention and response training, to support management of falls without conveyance to hospital where appropriate	Clinical Commissioning Groups Local Authorities	All Care Home Providers	System Resilience Group	✓
3.4	Continue to develop comprehensive care management plans across primary, secondary and emergency care to proactively support the people who are the most regular attenders at Accident and Emergency Departments	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
Objective 4: People will be supported to remain at their usual place of residence wherever possible					
4.1	Ensure that the deciding rights of palliative care patients who have chosen not to be transported to hospital are robustly implemented in all circumstances to respect people's preferred place of death and reduce the number of people dying within 48 hours of a hospital admission	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
4.2	Review and evaluate the effectiveness of a range of local additional clinical support to care homes and understand the	Clinical Commissioning	All relevant providers	System Resilience	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
	impact on reducing acute hospital admissions and re-admissions	Groups		Group	
4.3	Further develop the range of primary and secondary care clinical support to care homes and people within their own homes to make sure everyone has responsive, timely and effective health and social care interventions to avoid a hospital admission where appropriate and support people with timely safe hospital discharge 7 days a week	Clinical Commissioning Groups	All relevant providers	System Resilience Group	
4.4	Clarify the scope of the Emergency Medication Service following evaluation and training and education of health and social care staff in the proper use of inhalers as a preventative measure	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
4.5	Clarify the scope of the Minor Ailments service in light of availability of real time data	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
4.6	Improve the skills of health and social care staff to ensure the consistent application of medication reviews for frail elderly people	Clinical Commissioning Groups Local Authorities	All relevant providers	System Resilience Group	
4.7	Develop responsive children's community services that are integrated with urgent and emergency care services. This includes increasing specialist community paediatric capacity to help further support children and their families at home with acute and chronic disease management	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
4.8	Ensure special patient notes are up to date and available for paramedics to contact local clinical support for vulnerable patients	Clinical Commissioning Groups	North East Ambulance Service	System Resilience Group	
4.9	Develop intermediate care services in line with the outcome of local reviews	Local Authorities	County Durham and Darlington NHS	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
			Foundation Trust		
Objective 5: The public will have access to information and guidance in the event of them needing urgent or emergency care					
5.1	Develop and implement patient education and public health messages, particularly throughout Winter for urgent and emergency care services, that are appropriately aligned to key National messages	Clinical Commissioning Groups	NECS Comms Team	Urgent and Emergency Care Network	
5.2	Strengthen patient feedback mechanisms to include feedback from patients attending Accident and Emergency about any perceived or actual barriers they have encountered in trying to first access a GP or urgent care appointment within a timely manner	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
5.3	Ensure public and patient education about the breadth and accessibility of community pharmacy services is comprehensive and effective to make sure community pharmacy services are fully utilised	Clinical Commissioning Groups	NECS Comms Team	System Resilience Group	
5.4	Ensure that community pharmacies provide consistent delivery of key services such as advice on new medications and medicine use reviews	Clinical Commissioning Groups	Community Pharmacies	System Resilience Group	
Objective 6: The patient will be seen at the right time, in the right place, by a person with the appropriate skills to manage their needs					
6.1	Complete the full relocation of the urgent care service in Darlington within the Accident and Emergency Department in Darlington Memorial Hospital	Darlington Clinical Commissioning Group	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
6.2	Reduce inappropriate emergency ambulance dispatches to Accident and Emergency Departments by reviewing the clinical triage arrangements	Clinical Commissioning	North East Ambulance	Urgent and Emergency	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
	with NHS 111 to make sure they are sufficient and working effectively	Groups	Service	Care Network	
6.3	Reduce inappropriate emergency ambulance dispatches to Accident and Emergency Departments by ensuring effective clinical support is in place for paramedics including timely response from local primary and urgent care services	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	✓
6.4	Monitor progress in the two year reduction trajectory for See, Treat and Convey activity and associated increases in Hear and Treat and See and Treat activity;	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	✓
6.5	Reduce inappropriate and increase appropriate referrals to ambulatory care within County Durham and Darlington hospitals	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
6.6	Make sure Crisis and Liaison support for children and adolescents with mental health needs is sufficient and effective across County Durham and Darlington	Clinical Commissioning Groups	Tees Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
6.7	Make sure that clinical and referral pathways into recovery services for both adults and young people with an alcohol dependency are sufficiently robust and effective across County Durham and Darlington	Local Authorities	Relevant community support services	System Resilience Group	
6.8	Review and expand Community Mental Health Services across County Durham and Darlington to support people in mental health crisis including people with dementia, and providing a patient centred response	Clinical Commissioning Groups	Tees Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
6.9	Make sure that the NHS Pathways Directory of Service for County Durham and Darlington is comprehensively populated with up to date and accurate information to promote easier and faster access to appropriate	Clinical Commissioning Groups	All SRG Providers	System Resilience Group	✓

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
	services across health and social care				
Objective 7: The patient will not experience any unnecessary delay in receiving the most appropriate care					
7.1	Ensure that Rapid Assessment and Treat is in place to support patients in Accident and Emergency and Medical Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.2	Make sure that Consultant led morning ward rounds take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.3	Make sure that there is sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓
7.4	Complete the redevelopment of University Hospital of North Durham's Accident and Emergency Department to significant increase capacity, improve patient flow and patient experience	North Durham Clinical Commissioning Group	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.5	Significantly improve ambulance handover times in line with contractually agreed targets at Accident and Emergency Departments supporting County Durham and Darlington patients	Clinical Commissioning Groups	County Durham and Darlington	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
			NHS Foundation Trust North East Ambulance Service		
7.6	Make sure that the Ambulatory Care Service provided by County Durham and Darlington NHS Foundation Trust has sufficient capacity to manage appropriate demand	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.7	Ensure consistent achievement of maximum four-hour wait in Accident and Emergency from arrival to admission, transfer and discharge at 95% as a minimum	Clinical Commissioning Groups	All Acute Trusts reporting to the System Resilience Group	System Resilience Group	✓
7.8	Use collated primary, urgent and emergency care demand levels to help understand fluctuations in overall levels of demand across the whole system, particularly surge activity	Clinical Commissioning Groups	GP Federations Urgent Care Service Providers Acute Trusts	Urgent and Emergency Care Network	
7.9	Continue to develop and improve initiatives that reduce acute bed length of stay, particularly for people aged 75 and over	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	✓

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
7.10	Review and evaluate the implementation, management and effectiveness of the Regional Flight Deck	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.11	Review and evaluate the implementation, management and effectiveness of the Regional Divert Policy	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.12	Review and evaluate the implementation, management and effectiveness of the North Durham Local Divert Policy	North Durham Clinical Commissioning Group	North East Ambulance Service	System Resilience Group	
7.13	Complete a full review of the Patient Transport Service and discharge transport services and implement any agreed recommendations to make sure that these services are able to meet demand, are robust and cost effective	Clinical Commissioning Groups	North East Ambulance Service	Urgent and Emergency Care Network	
7.14	Work to better understand the bottlenecks and pressures throughout the urgent and emergency care pathway and the most effective approach to alleviate these pressures, possibly through the use of NHS England's Data Intelligence Tool	Clinical Commissioning Groups	All SRG Providers	System Resilience Group	
7.15	Ensure that the mental health acute care pathway processes are as efficient as possible to make sure patients receive a timely response and improve patient experience	Clinical Commissioning Groups	Tees Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
7.16	Expand the current Mental Health Acute Liaison Service in A&E to 24/7 coverage	Clinical Commissioning Groups	Tees Esk and Wear Valleys NHS Foundation Trust	System Resilience Group	
7.17	Ensure that the re-configuration of Accident and Emergency Departments in both Darlington Memorial Hospital and University Hospital of North Durham include the integration of children's care that is also sufficiently	Clinical Commissioning Groups	County Durham and	System Resilience Group	

Reference	Action	Lead Commissioner	Lead Provider/s	Governance Lead	Fit with 8 High Impact Interventions
	resourced		Darlington NHS Foundation Trust		
7.18	County Durham and Darlington NHS Foundation Trust need to make sure that their Consultant Ward rounds are timely, efficient and effective in facilitating morning and weekend discharges to improve patient flow	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.19	Develop 7 day service access to a range of key clinical services to support effective discharge management including diagnostics, access to diagnostic scanners, cardio-pulmonary tests and pharmacy	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	
7.20	Ensure timely access to care packages, particularly at times of pressure, during weekends and Bank Holidays across both County Durham and Darlington	Local Authorities	Local Authorities	System Resilience Group	
7.21	Streamline the process for people accessing prescribed medication from community pharmacies following discharge from hospital	Clinical Commissioning Groups	County Durham and Darlington NHS Foundation Trust	System Resilience Group	

8 How will we measure success?

8.1 There are a number of critical success factors which are essential in order to deliver the plan outlined in this strategy which is outlined below.

Firstly there should be an improvement across all Clinical Commissioning Groups in terms of the constitutional standards as mentioned in Section 2.8 and 2.9 but most specifically in relation to the two relating directly to urgent care:

- A maximum of a four-hour wait in A&E from arrival to admission, transfer or discharge;
- All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within 8 minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

8.2 In addition there will be other indicators of success, including

- Patients report that they are accessing the right service, at the right time, first time, these reports may come via patient feedback channels such as patient surveys or the Friends and Family Test
- Positive patient reported experience of all urgent and emergency care services within the system, again this would come via surveys or general feedback
- Providers feel supported and have sufficient resources to meet patient need;
- Commissioners feel their investment is cost effective and resulting in positive patient outcomes;
- Completion of actions stated within the Strategy Action Plan;
- Minimum 3.5% reduction in overall demand for urgent and emergency care across the whole system;
- Consistent achievement and over-achievement of the National 95% A&E 4 hour wait target;
- An improvement in handover times for ambulances at CDDFT in line with contractual targets;
- A sustained reduction in Delayed Transfers of Care with consultant led morning ward rounds 7 days a week so that discharges at the weekend are at least 80% of weekday and at least 35% of discharges are achieved by midday throughout the week;
- An increase in the number of patients who use Primary Care as their first stop for Urgent Care;
- Able to evidence a reduction in:
    - Acute length of stay
    - In appropriate re-admissions
    - Admissions for people aged 75 and over
    - Reduction in unavoidable deaths in acute settings
- Services feel they have been enabled to work in a joined up or integrated way.

8.3 There are a number of key behaviors that will be required from all commissioners and providers contributing to the implementation of this strategy to achieve the critical success factors set out above. These include:

- Strong leadership that empowers individual staff to take responsibility and make appropriate decisions;
- An ability to lead and drive forward cultural change in a positive way;
- The commitment of all stakeholders from front line staff to executive teams to implementing the strategy;
- A commitment to work collaboratively;
- A determination and mature approach to working through difficult issues collaboratively;
- A resolve to ensure that positive patient experience is at the heart of all system changes undertaken.

9 Governance Structures

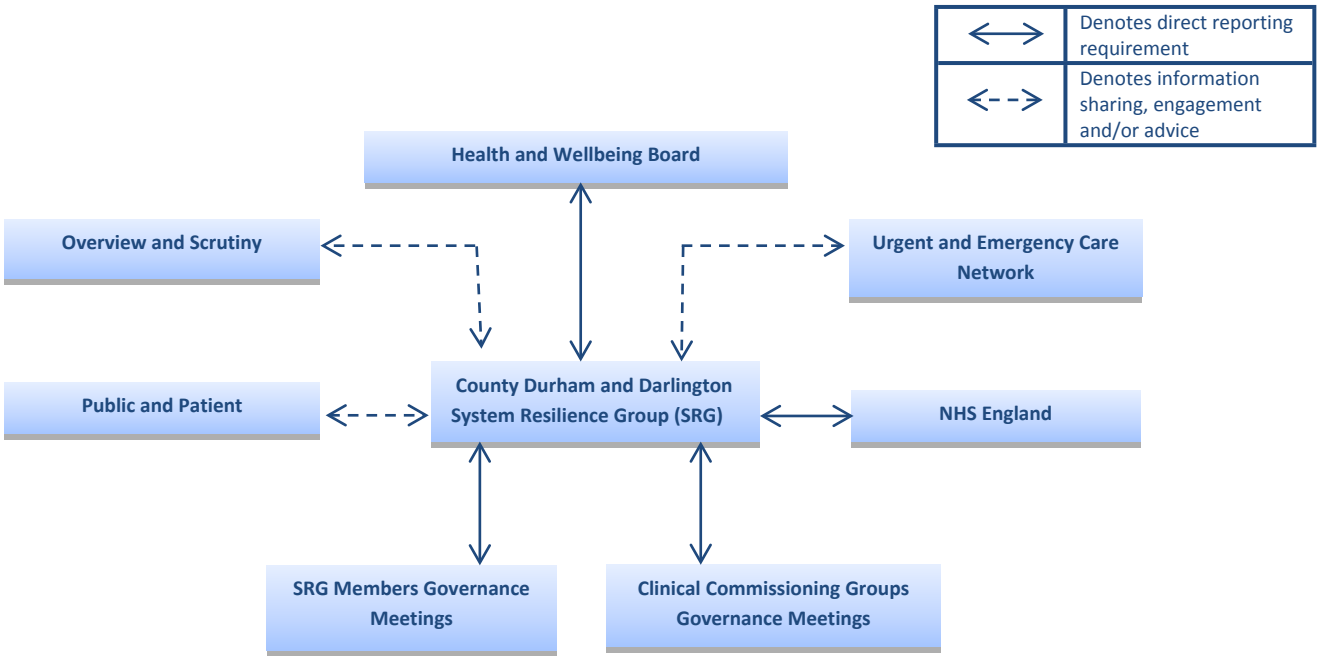
9.1 The System Resilience Group will be responsible for the ownership, oversight and monitoring of the implementation of the strategy action plan.

9.2 Each lead for the actions currently being progressed by the System Resilience Group will be required to provide an update on risks and action taken to mitigate risks on a monthly basis.

9.3 The groups will use the NHS Change Model and its key components to develop the projects, and identify the key enablers and levers that need to be implemented such as funding streams or outcome measures, to enable transformational change.

9.4 The System Resilience Group is supported by local decision making within partner organisations own Management Meetings and Boards. NHS England's Durham, Darlington and Tees Area Team has a close working relationship with the SRG, attending the meetings and providing an overall assurance role.

System Resilience Group – Governance Structure July 2015



9.5 More detail on what each of these bodies does is below:

- Health and Wellbeing Board - legal body, responsible for Health and Wellbeing Strategy and ensuring joined up local approach to health and wellbeing Overall the County Durham and Darlington System Resilience Group reports into both local Health and Wellbeing Boards to ensure appropriate engagement and ratification of key areas of work, for example, the Urgent Care Strategy.
- Urgent and Emergency Care Network - based on the geographies required to give strategic oversight of urgent and emergency care on a regional footprint

- NHS England - National assurance of local SRG plans and delivery
- Clinical Commissioning Groups Governance Meetings - local decision making
- SRG Members Governance Meetings - Local decision making
- Public and Patient - Public and patient engagement to support the work of the System Resilience Group is a crucial aspect to ensure the system changes implemented over the life of the strategy are in line with the needs of the public and patients. Appropriate targeted engagement will be undertaken by lead organisations for specific strategy actions as opposed to be being led by the System Resilience Group itself. However the learning will inform the overall strategic direction as well as help shape local service delivery models.
- Overview and Scrutiny- provides public scrutiny to strategy and system development The SRG ensures involvement of local Overview and Scrutiny Committees in proposed service changes and the strategy development
- County Durham and Darlington System Resilience Group (SRG) - drives delivery, quality, performance, operational resilience, key system improvements, and ensures financial balance

APPENDIX 1 — Urgent Care Strategy 2014 – 2019 Plan on a Page

To be inserted. Summary of vision, objectives, actions, outcomes

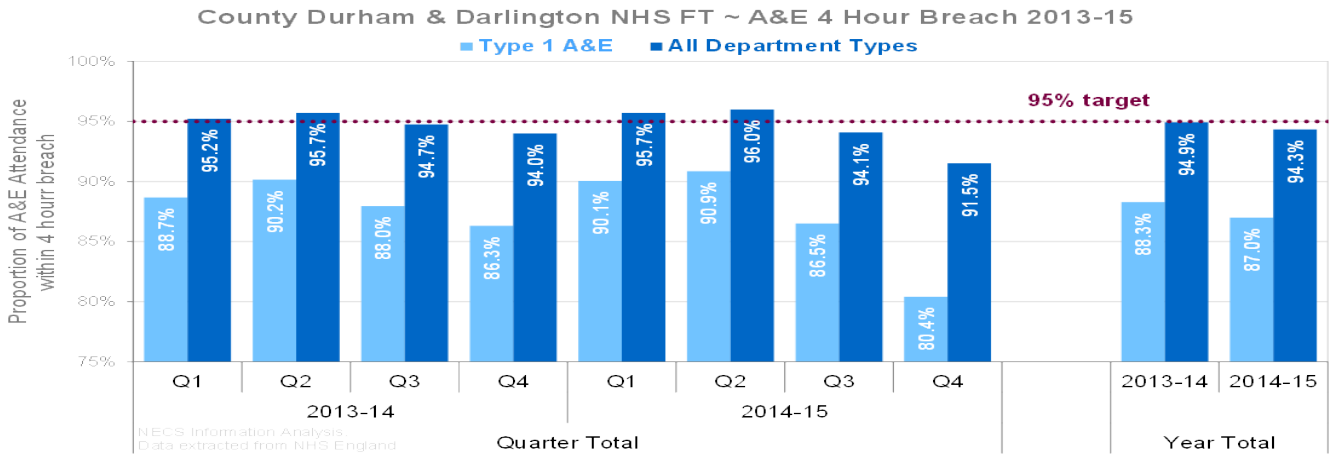
APPENDIX 2 – Eight High Impact Interventions for Urgent and Emergency Care

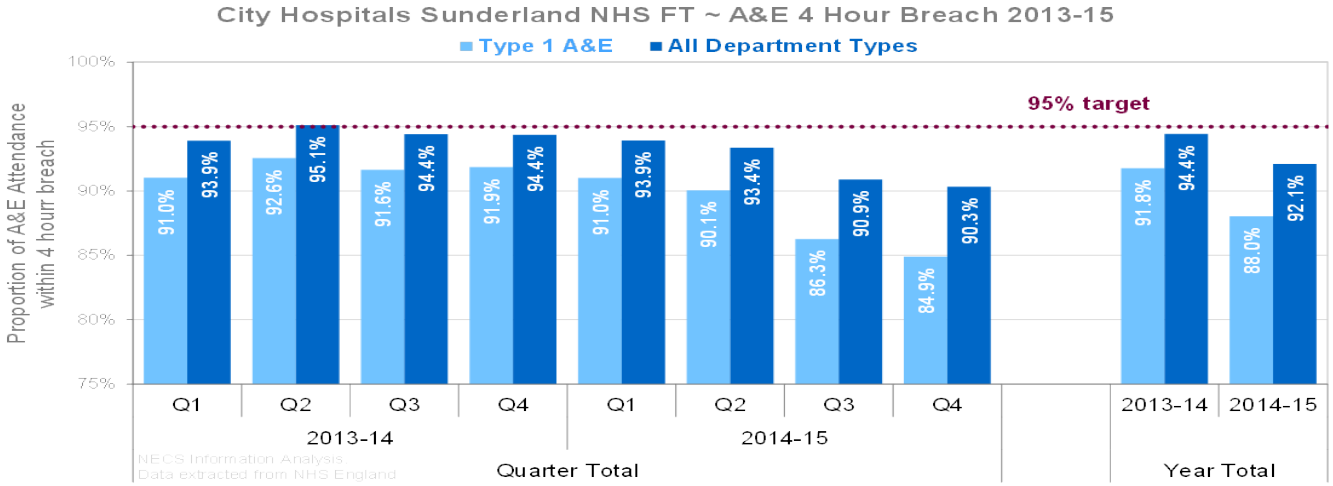
No.	High Impact Interventions
1	No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
2	Calls to the ambulance 999 service and NHS 111 should undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.
3	The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
4	SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
5	Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
6	Rapid Assessment and Treat should be in place, to support patients in A&E and Assessment Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
7	Consultant led morning ward rounds should take place 7 days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
8	Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

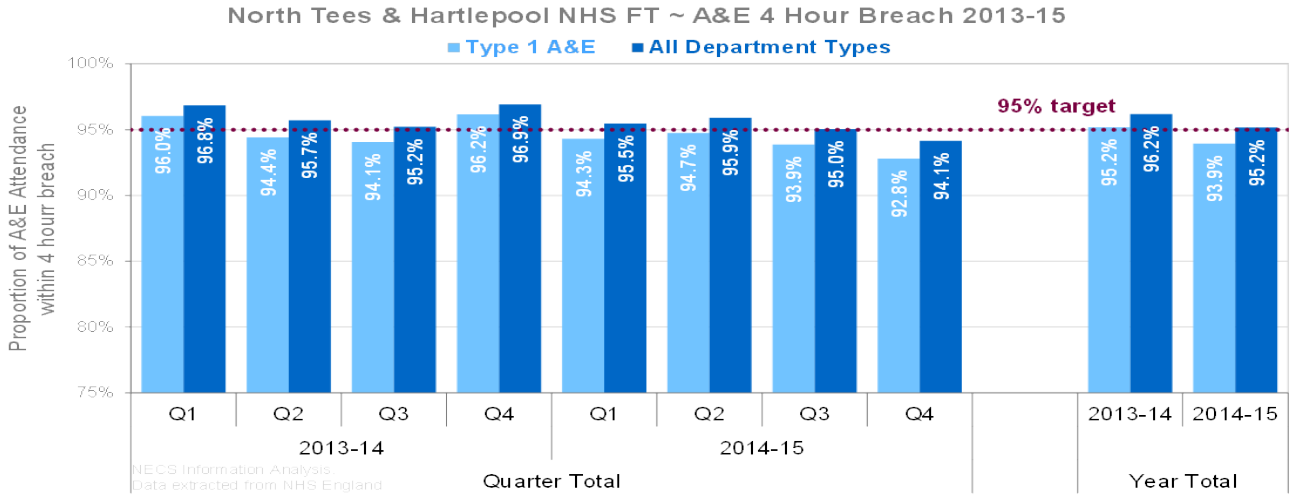
APPENDIX 3 – Local Performance and Activity Information 2013-15

Maximum four-hour wait in A&E from arrival to admission, transfer or discharge at 95%

The ability of each individual trust to achieve the minimum 95% target each quarter and over the year as a whole varies.



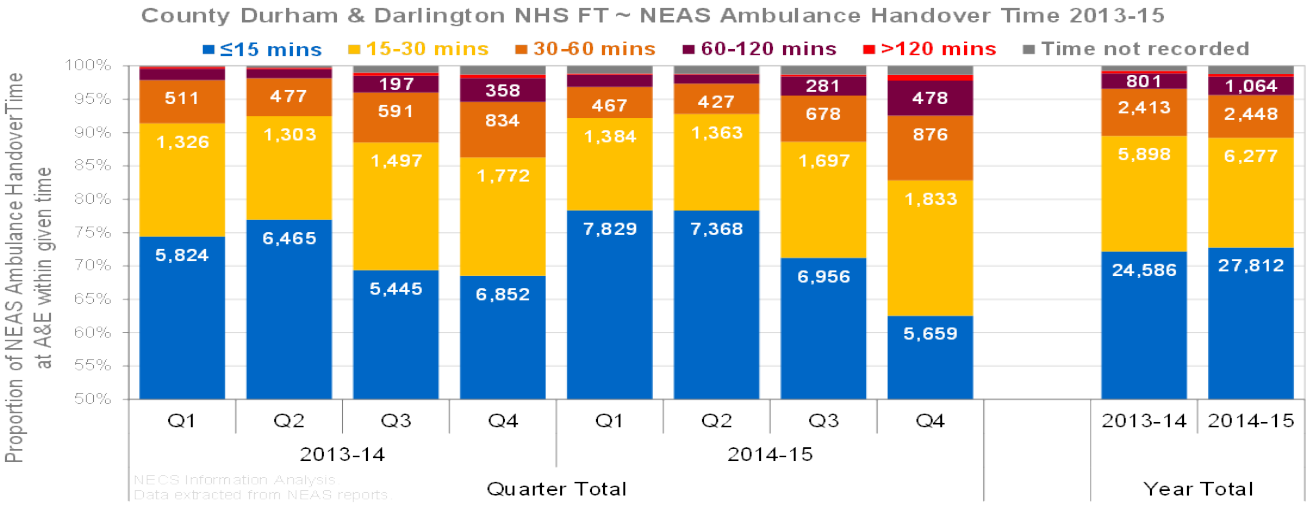


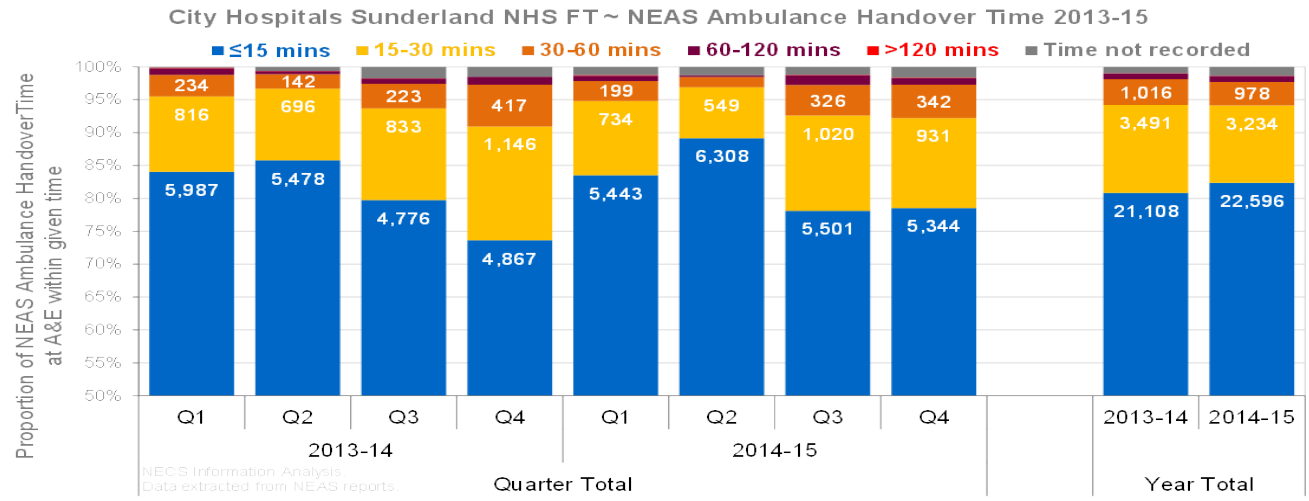


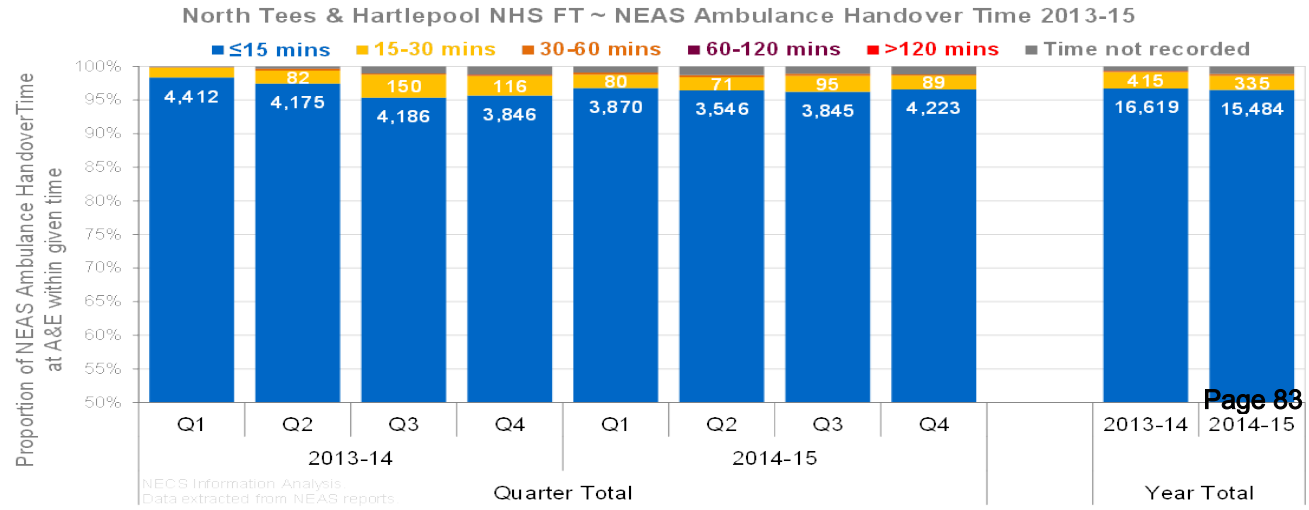
Ambulance Handovers

All ambulance trusts to respond to 75 per cent of Category A (the most urgent) calls within 8 minutes and to respond to 95 per cent of Category A calls within 19 minutes of a request being made for a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner.

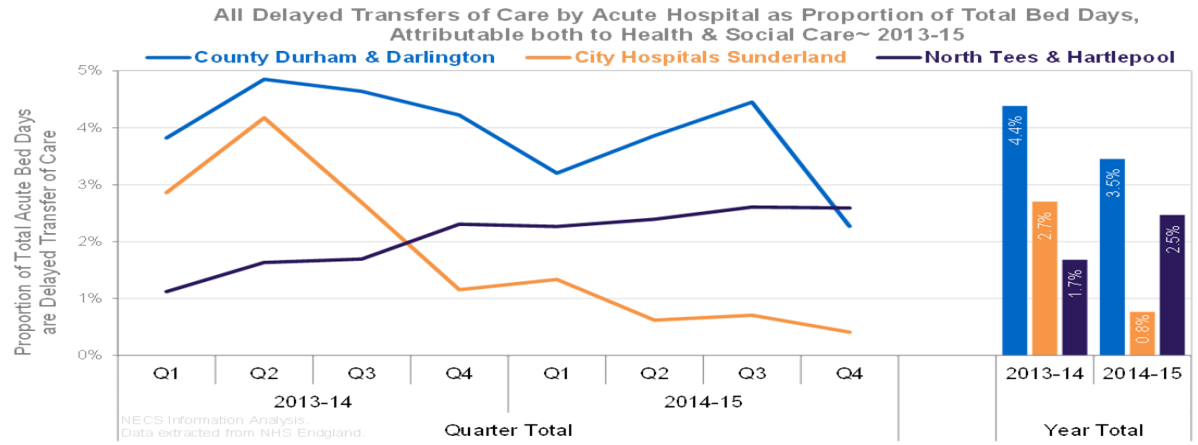
The ability of each individual acute trust to 'clear' an ambulance that arrives at A&E within 15 minutes varies considerably.





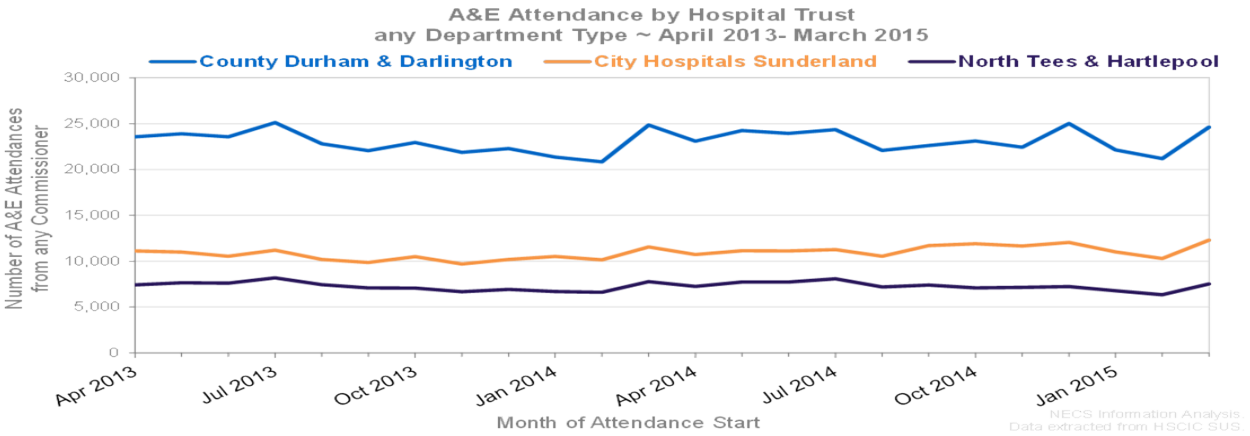


Delayed Transfers of Care

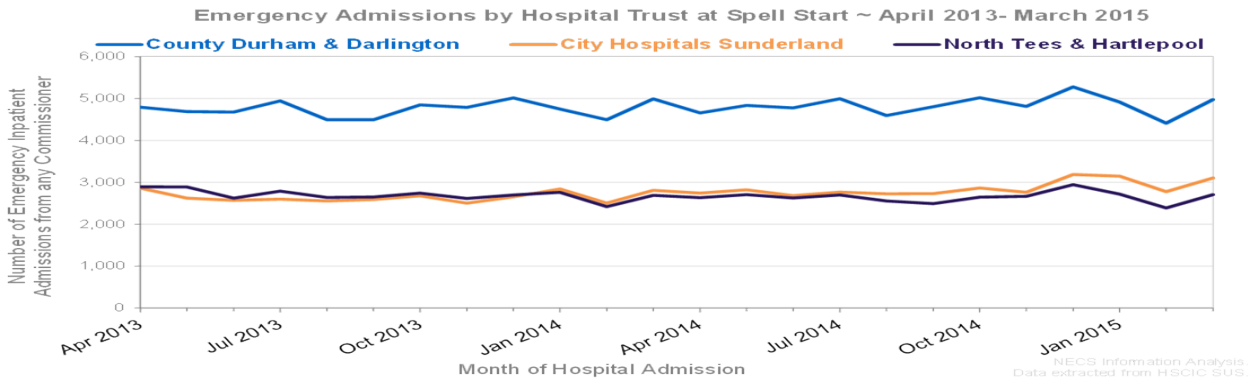


There is a strong focus from NHS England in reducing all delayed transfers of care whether the initial causal factor is health or social care related.

Emergency Attendances



Locally all three acute hospital trusts experienced an increase in the overall number of emergency attendances during Winter 2014/15.



Both Nationally and locally the number of admissions has seen an increase during Winter 2014/15.

APPENDIX 4 – Key National and Local Policy and Best Practice Documents

National Policy and Guidance

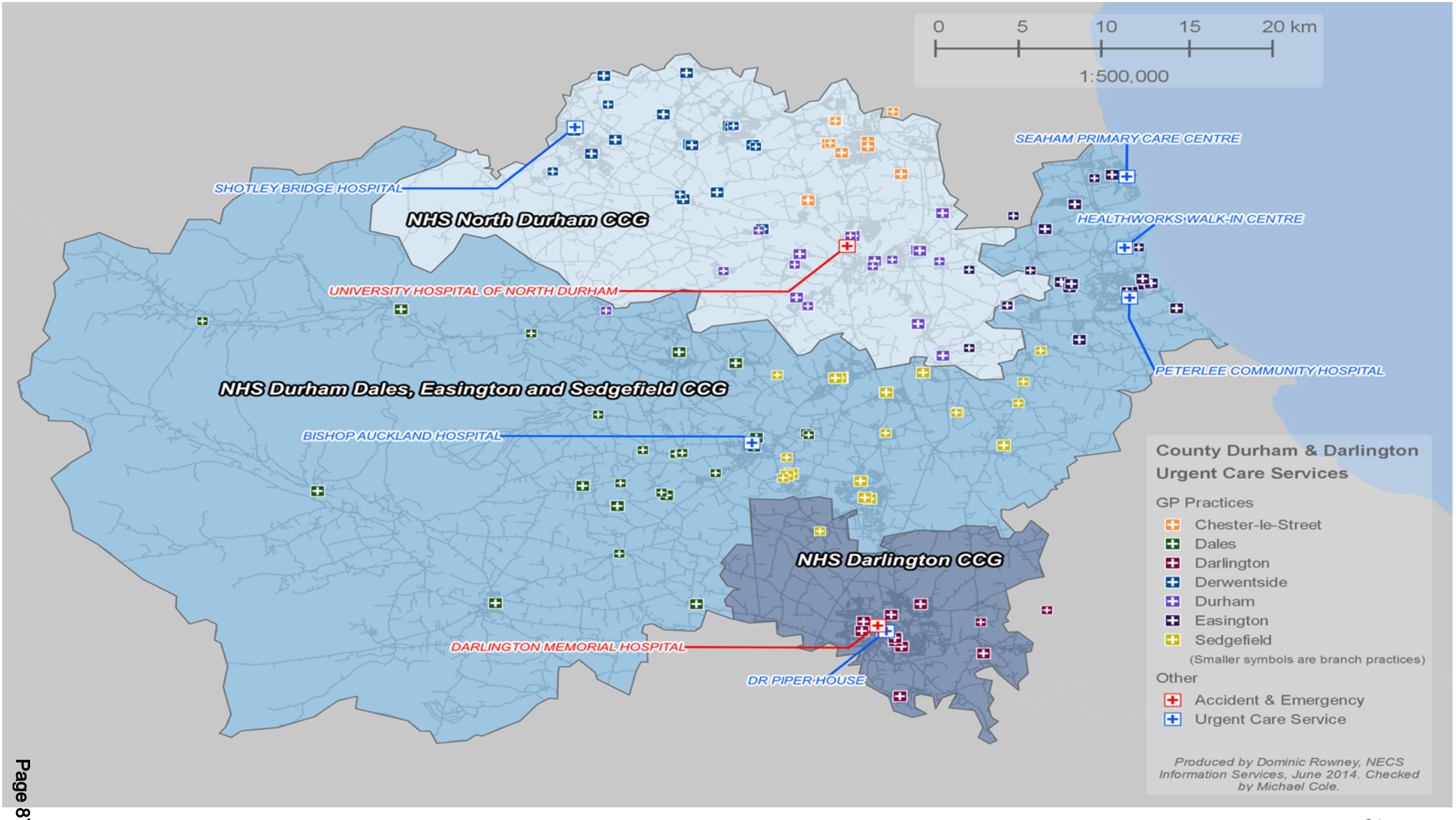
- NHS Five Year Forward View, October 2014
- NHS Operating Framework 2014/15
- NHS England Winter Health Check, March 2015
- Transforming urgent and emergency care services in England, November 2013
- NHS England: Improving A&E Performance Gateway Reference: 00062
- NHS England: Improving and sustaining cancer performance Gateway Reference: 03614
- Royal College of General Practitioners Guidance for Commissioning integrated Urgent and Emergency Care – A Whole System Approach (2011)
- Primary Care Foundation – Breaking the mould without breaking the system (2011)
- National Ambulance Commissioners Group Achieving Integrated Unscheduled Care - the view from the National Ambulance Commissioners Group (2010)
- Department of Health Equity and Excellence: Liberating the NHS (2010)
- Department of Health A Vision for Adult Social Care (2010)
- The King's Fund: Avoiding Hospital Admissions (2010)
- Department of Health Equity and Excellence: Liberating the NHS (2010)
- Health and Social Care Act 2012
- The Francis Report (2013) http://www.midstaffspublicinquiry.com/report (accessed 8 April 2013)
- Urgent Care Strategy 2013 – 2018, Hartlepool and Stockton on Tees CCG
- Safe, compassionate care for frail older people using and integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders; NHS England, February 2014
- Handbook to the NHS Constitution, March 2013
- Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, HM Government, February 2014

Local Policy and Guidance

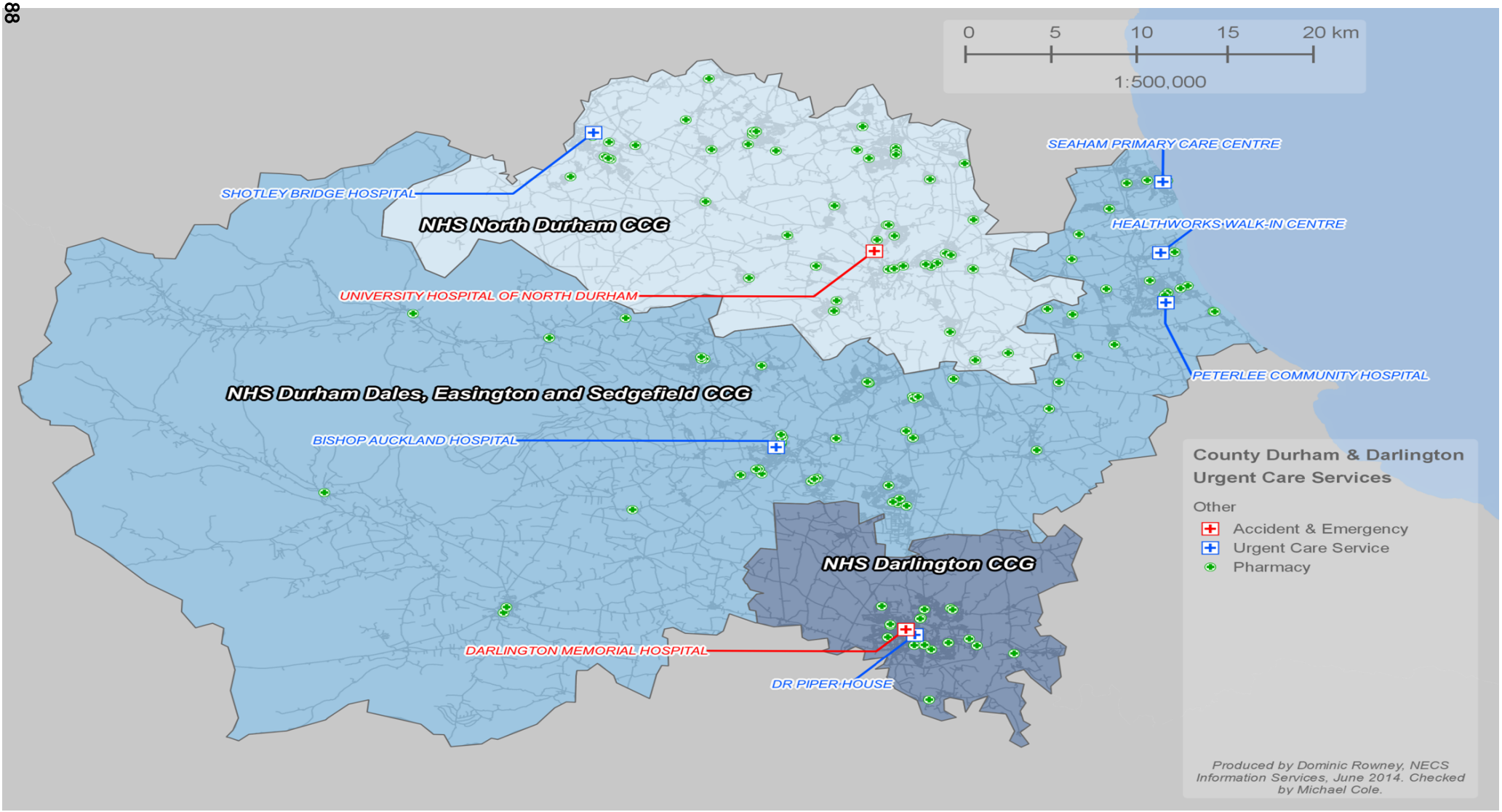
- County Durham and Darlington NHS Foundation Trust Clinical and Quality Strategy: Right First Time 24/7 2014, http://www.cddft.nhs.uk/about-the-trust/quality-matters-our-clinical-and-quality-strategy/right-first-time-247,-our-evolving-clinical-strategy.aspx
- North Durham, Durham Dales Easington and Sedgefield, and Darlington Clinical Commissioning Groups: Improving Palliative and End of Life Care: Strategic Commissioning Plan 2013 – 18, http://democracy.durham.gov.uk/documents/s42228/Item%208%20-%20Appendix%202%20%20Improving%20Palliative%20and%20End%20of%20Life%20Care%20Strategic%20Commissioning%20Plan%202013-20.pdf
- County Durham and Darlington Fire and Rescue Service: Three Year Strategic Plan 2015-18 Consultation Document https://www.ddfire.gov.uk/service-plans
- County Durham and Darlington Local Resilience Forum: Annual Report 2013-14 https://www.durham.police.uk/Information-and-advice/Pages/Local-Resilience-Forum.aspx

- Tees Esk and Wear Valleys NHS Foundation Trust: Business Plan 2014/16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340252/TEWVALLEYS_Operational_Plan_April_2014_-_March_2016_1_.pdf
- County Durham Partnership: The Sustainable Community Strategy for County Durham 2014-30 http://www.countydurhampartnership.co.uk/Pages/CDP-SustainableCommunityStrategy.aspx
- County Durham Health and Wellbeing Strategy http://www.durham.gov.uk/jhws
- North Tees and Hartlepool NHS Foundation Trust: http://www.nth.nhs.uk/our-vision
- North East Ambulance Service: Strategic Plan Summary for 2014-19 North East Ambulance Service NHS Foundation Trust
- City Hospitals Sunderland NHS Foundation Trust: Operational Plan 2014-16
- *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338071/SUNDERLAND_Operational_Plan_14-16_1_.pdf*
- Durham County Council: Council Plan 2015-18 http://www.durham.gov.uk/media/4847/Council-Plan-2015-2018/pdf/CouncilPlan2015-2018.pdf
- Darlington Partnership: One Darlington Perfectly Placed 2008 – 2026 revised May 2014 http://www.darlington.gov.uk/media/362819/one-darlington-perfectly-placed.pdf
- Sunderland Clinical Commissioning Group: Sunderland Health & Care System Strategic Plan 2014-19: *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/392969/SUNDERLAND_Publishable_Summary_Strategic_Plan_1415.pdf*
- Hartlepool and Stockton-on-Tees Clinical Commissioning Group: Clear and Credible Plan Refresh2014/15 – 2018/19 *http://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2013/11/HAST_CCG_5_YEAR_PLAN_FINAL_INTERNAL_WEB-15-August.pdf*

Appendix 5a - Map of Current Services: Hospital Sites, Urgent Care Centres and GP Practices



Appendix 5b – Map of Current Services: Community Pharmacies



Appendix 6 - Glossary

Acute Medicine	Medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies.
Acute Care	A type of secondary care where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.
Ambulatory Care	The treatment of a condition that is urgent but that does not need to be assessed and treated within an Accident and Emergency Department. Ambulatory care services may provide assessment and treatment services but the service itself may be provided outside the hospital itself.
Acute Liaison (mental health)	This service aims to increase the detection, recognition and early treatment of mental health problems, for people within an acute hospital setting.
Clinical	The assessment and treatment of actual patients in relation to their healthcare needs.
Clinician	A person, such as a doctor or a nurse, who is trained and qualified in the assessment and treatment of medical needs for actual patients, as opposed to a person studying medical research in a laboratory.
Critical Care	The specialised care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units. This type of care is also known as intensive care.
Consultant	Medical staff who mainly deliver expert clinical care usually within a team, including the ability to recognise and manage the more complex health care needs.
Clinical Commissioning Groups	NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England
Chronic Care	A type of care that treats pre-existing or long term illness. Without effective treatment chronic conditions may lead to disability.
Emergency Care	A type of care that provides assessment and treatment for people with serious or life-threatening conditions.

Emergency Department	Emergency Department (ED): also known as Accident and Emergency (A&E), or casualty department, is a medical facility specialising in acute care for patients who present without prior appointment, either by their own means or by ambulance.
Experience Led Commissioning	An approach to planning and buying healthcare services. It is built around the idea that if commissioners listen to and deeply understand people's experiences, they will design better, more person-centred services that deliver better care.
Interventional Radiology	An independent medical specialty that uses minimal invasive procedures to diagnose and treat diseases.
General Practitioner	A medical practitioner who treats acute and chronic illnesses and provides preventative care and health education to patients within a primary care setting.
Medical Assessment Unit	Usually receives acutely ill medical patients from primary care via GP referral and referrals from the Emergency Department.
Multi-disciplinary	Group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.
Monitor	Sector regulator for health services in England, Monitor's job is to make the health sector work better for patients.
Multi-speciality community provider	Under this new care model outlined in the NHS five year forward view, GP group practices would expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift the majority of outpatient consultations and ambulatory care to out-of-hospital settings.
Neonatology	Subspecialty of paediatrics that consists of the medical care of newborn infants, especially the ill or premature newborn infant. It is a hospital-based specialty, and is usually practiced in neonatal intensive care units (NICUs).
NHS 111	A three digit telephone service introduced to improve access to NHS urgent care services.
NHS Constitution	The NHS document that sets out rights for patients, public and staff, and outlines the NHS commitments and responsibilities to make sure the NHS operates fairly and effectively.

NHS Commissioning Assembly	The community of leaders for NHS commissioning – the 'one team' which will deliver better outcomes for patients.
Paediatrics	The branch of medicine that deals with the medical care of infants, children and adolescents.
Primary Care	The health care given by a health provider who typically acts as the first point of consultation for patients within the healthcare system and co-ordinates other specialists that the patient may need, for example, GP's.
Secondary Care	Secondary care means the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients. This may include medical staff who work in an acute hospital environment and those who work within community healthcare teams.
See and Treat	A system developed with the aim of reducing waiting times between patients, thereby reducing the overall maximum wait that some patients experience.
Self-care	Personal health maintenance. Any activity of an individual, family or community with the intention of improving or restoring health, or treating or preventing disease.
Urgent Care	The delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of the hospital emergency department.
Unscheduled care	A term used to describe any unplanned health or social care. Also known as urgent and emergency.
Urgent Care Centre	A centre where urgent but non-life threatening conditions can be treated.

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Adults Wellbeing and Health Overview and Scrutiny Committee

9 October 2015

Review of Care Connect

Joint Report of the Lorraine O'Donnell, Assistant Chief Executive and Ian Thompson, Corporate Director, Regeneration & Economic Development

Purpose of the Report

1 To inform the Adults Wellbeing and Health Overview and Scrutiny Committee of the proposed Medium Term Financial Plan (MTFP) savings associated with the Care Connect Service and to advise upon proposals agreed by Cabinet for consultation on the said proposals.

Background

2 At its meeting on 16 September 2015 the Cabinet considered a report setting out proposals to generate MTFP savings associated with the Care Connect service and agreed to commence a consultation on the proposals before reporting back to Cabinet for final consideration.

3 A copy of the Cabinet report is attached to this report at Appendix 2.

Overview and Scrutiny Considerations

4 As part of the stakeholder consultation and engagement associated with policy changes of this nature, Overview and Scrutiny Committees are often invited to consider proposals and comment on them as part of this process.

5 Key considerations that Overview and Scrutiny may wish to consider include:-

- Medium Term Financial Plan implications arising from the proposals including details of potential savings realised from the proposed changes;

- Consultation and Engagement proposals including what is being consulted upon, who is to be consulted and the consultation dates;

  The council agreed at its 16 September 2015 Cabinet meeting to consult on a proposed change to its Care Connect Service. This will focus on the proposal to introduce a contributory charge of £2.80(excluding VAT) per week for those customers currently receiving a free service. The consultation will also include those customers who currently pay for the service and the proposal is that this charge be increased from £4.60 per week (excluding VAT) to £4.80 per week (excluding VAT)

Please note that the majority of current Care Connect customers do not pay VAT as they complete a self-declaration that they are exempt from VAT due to a medical condition or disability. These declarations are monitored and managed by Care Connect

The consultation will seek to identify the effects of the proposals on customers and stakeholders as well as to seek views on this approach and seek to identify any possible alternatives.

We will ask customers, their carers or family members how the proposed change may affect them as well as talk to other organisations such emergency services and the NHS to gather views on the approach and any possible alternatives.

Consultation methods will include:

- A targeted letter sent to 9,750 households with attached paper survey and SAE
- An online survey for customers and families (this will allow family and advocates to respond but they need to be identified in the survey)
- Home visits will be made available but will be limited to those in most need
- A contact number and generic email address will be provided for those wishing to respond in this way or to ask for a visit
- Letter to stakeholder organisations (Police, Ambulance, Fire service and NHS
- Elected Members to be advised of the consultation document

To ensure consistent messages, staff will be provided with scripts.

The outcome will be published on the website after the cabinet decision and those directly affected will be notified by letter.

- Equality Impact Assessment issues identified in respect of the proposals.

6 Representatives from the Regeneration and Economic Development service grouping and the Partnerships and Community Engagement team, ACE will be in attendance to provide the Committee with this information.

Recommendations and reasons

7 The Adults Wellbeing and Health Overview and Scrutiny Committee is invited to consider the information presented in this report and to comment on the proposals as part of the ongoing consultation in respect of the Care Connect service.

Background papers

Cabinet Report – Review of Care Connect – 16 September 2015

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer
Tel: 03000 268140

Appendix 1: Implications

Finance – See attached Cabinet report

Staffing - See attached Cabinet report

Risk - See attached Cabinet report

Equality and Diversity / Public Sector Equality Duty - See attached Cabinet report

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation - See attached Cabinet report

Procurement - None

Disability Issues - See attached Cabinet report

Legal Implications - See attached Cabinet report

Cabinet

16 September 2015

Review of Care Connect

Report of Corporate Management Team
Ian Thompson, Corporate Director, Regeneration & Economic Development
Councillor Eddie Tomlinson, Cabinet Portfolio Member for Assets, Strategic Housing and Rural Issues

Purpose of the report

1. The purpose of this report is to inform Cabinet of the proposed Medium Term Financial Plan (MTFP) savings associated with the Care Connect service.

2. The report requests approval to consult on the proposals before reporting back to Cabinet for final consideration.

Background

3. The Council continues to be impacted by the Government's ongoing austerity programme, where Government funding to the Council is forecast to have reduced by 60% by 2018/19 when compared to the funding levels in 2010/11. This is despite the Council facing demographic and inflationary budget pressures that need to be financed across this period also.

4. Overall, it is forecast that the Council will need to save £250 million over the 2011 to 2018 period, based on the forecast public sector funding reductions outlined in the Government's March 2015 and July 2015 Budget statements.

5. A sum of £153.2 million of savings will have been delivered by the end of 2015/16, with forecasted savings over the MTFP (6) period 2016/17 to 2018/19 of £115.8 million being required to achieve a balanced budget.

6. Care Connect is the council's community alarm and telecare/telehealth provider. It provides a range of additional preventative services to a variety of people many of whom are older people and some who also receive a social care service. The community alarm service is non-statutory but the service assists users to live independently in their own home, safe in the knowledge that if there is an accident or they have a fall, they can get help quickly 24 hours a day, seven days a week, 365 days a year through our alarm monitoring and response service.

7. The total annual cost of delivering the Care Connect service (excluding CCTV provision) is £4.942m. This is funded through a combination of a financial contribution from CAS of £2.376m, income from self-funding customers of £1.175m, Service Level Agreements (mainly with housing providers) of £0.562m and income from Public Health of £0.822m.

8. In December 2013 Cabinet agreed a report detailing a £1m MTFP reduction in funding support from CAS for the delivery of Care Connect. This saving was achieved through a combination of service efficiencies, the reduction in support planning visits from quarterly to annual and additional income generation from those who pay for the service. Cabinet agreed to transitional protection for those customers receiving a free community alarm service for a period of at least two years. This was based on trying to protect those customers on lower incomes from the impact of funding reductions.

9. In order to address ongoing reductions in government funding support for local authorities, MTFP proposals include a further reduction in CAS expenditure on Care Connect services of £750k for 2016/17 financial year.

Existing provision of community alarms

10. Historically, customers in receipt of Guaranteed Pension Credit, Council Tax Benefit or Housing Benefit qualified for a free community alarm service. This qualification was removed for new customers from April 2014, as part of the previous MTFP savings measures. However, Cabinet agreed to protect those customers already receiving a free service for a period of at least two years. The two year period would end on 31 March 2016.

11. There are currently around 16,300 households (around 20,000 customers) receiving the community alarm monitoring and response service. This comprises approximately:

    - 9,750 households who receive the service free due to being in receipt of means tested benefits;
    - 4,750 'self-funding' households (who currently pay £4.60 per week)
    - 1,800 households in receipt of Telecare equipment and monitoring (which includes the community alarm service as part of an assessed care package)

12. A graph showing the existing customer base and projected changes over coming years (see appendix 2) together with an analysis of unit costs has been used to develop a business model to identify savings options.

13. In terms of the customer base for Care Connect, it is likely to grow in line with the demographic change in the county. The 65+ age group is projected to increase from almost one in five in 2012 to nearly one in four people (24.5%) by 2030. The proportion of the county's population aged

85+ is predicted to increase more acutely, from 2.2% in 2012 to 3.9% in 2030, almost doubling in terms of numbers from 11,300 to 22,000.

Savings proposals

14. The longer term viability of the service depends on being able to cover the costs of providing community alarms through charging its customers. The cost to the council of continuing to deliver the community alarm service in 2016/17 is currently estimated to be around £4.80 per week. To develop our savings proposals against the £750k target, we have made some assumptions about usage and likely impact.

15. It is therefore proposed to increase the charge for the self-funding customers from £4.60 to £4.80 per week to cover the cost. It is anticipated that the number of users will increase in line with demographic changes highlighted in paragraph 13. For modelling purposes it has been assumed that there will be 370 additional users in 2016/17 generating additional income of £93k. The extra income from the existing customers by increasing the charge by 20 pence a week will be £49k. This will increase the total income to the service in 2016/17 by £142k.

16. In order to realise the full £750k MTFP saving for 2016/17, it is also proposed to introduce a contributory charge for those customers currently receiving the service for free.

17. The introduction of charges where none previously existed, may lead to people withdrawing from the service. For example, Sunderland City Council introduced community alarm charges in 2013 and saw a reduction of around 40% of their customer base.

18. Through natural reductions, the number of customers receiving the service free of charge is projected to reduce from 9,750 customers currently to an average of 7,520 during the 2016/17 financial year.

19. It should also be noted that there are around 4,200 smoke alarms linked to the community alarm system in registered housing provider properties. We currently receive 60p per week for each monitored smoke alarm, equating to £131k a year under Service Level Agreements with the housing providers. If this customer base also falls by 40% there will be a loss of 1,680 customers equating to an annual income loss of £52k a year. Should individual customers decide not to stay on the Care Connect service, we would need to renegotiate our SLA or adjust the budget for loss of this income.

20. If we assume a similar elasticity as Sunderland and make an adjustment for the loss of SLA income, then the required level of income will be £660k (£750k minus £142k additional income from increasing the charge by 20 pence a week plus £52k from 40% loss of smoke alarm income).

21. The £660k of income to meet the savings target will need to be generated from the 4,500 remaining customers (7,500 x 60%) who currently don't pay anything. This would require a charge of £2.80 per week (around £145 per year) and would therefore still represent a considerable subsidy from the Council for these customers.

22. Should the customer base fall by a greater amount than 40%, then the reduced level of income would need to be offset by a further reduction in the costs of staffing and resources required to deliver the service. Any shortfall in the anticipated income would be met from cash limits until exact numbers, costs and savings levels have been established.

Comparison with other Local Authorities

23. Many authorities already charge for some or all of the similar services provided by Care Connect.

24. A sample of comparator authorities is included in appendix 3, showing charges ranging from £2.88 to £16.70 per week. It is difficult to make detailed comparisons as the service offered varies from one location to the next. However, the proposed charges in County Durham appear to compare favourably with other local authorities.

Implications for users and partner organisations

25. The customers who currently receive a free service are amongst the highest users of the service. Over the last 12 months we have answered and responded to around 40,000 calls from these customers which equates to an average of 5 calls a year.

26. An Equality Impact screening has been undertaken and is included at appendix 4. Many of these calls relate to low level incidents. However, any withdrawal from the service will inevitably place additional burdens on the Police, Fire and Ambulance services.

27. The consultation plan will identify key stakeholders and seek to assess the level of impact of potential changes.

Next Steps

28. Should the recommendations of this report be approved the next steps would be to initiate a period of consultation with service users and key stakeholders.

29. The consultation would assist in understanding any issues that may arise through the introduction of charging. This information would be used in completing the full Equalities Impact Assessment.

30. It is anticipated that a report setting out the consultation feedback, details of the equality impact assessment and any mitigation measures, together

with a proposed implementation plan will be presented to Cabinet in January 2016, on which a final decision could be made. This would allow the introduction of charges to begin from April 2016.

Recommendations

31. Cabinet is recommended to:

(i) Agree to begin consultation on proposals to:

(a) Introduce a contributory charge of £2.80 per week for customers currently receiving a free community alarm service to deliver a forecasted saving of £608k in 2016/17.

(b) Increase the current charge of £4.60 to £4.80 for self-pay customers to deliver a forecasted saving of £142k in 2016/17.

(ii) Receive a further report in January 2016 following consultation.

Contact: Adrian White, Head of Transport and Contract Services
Tel: 03000 267455

Appendix 1: Implications

Finance
The recommended proposals will allow the service to remain viable whilst delivering a saving of £750k in line with the council's MTFP requirements.

Staffing
The introduction of additional charging will require a review of the administration staff within Care Connect. It is not anticipated that wider staffing levels will be affected by this proposal. However, should there be a significant withdrawal of customers, then a review of staffing levels would be undertaken in consultation with staff and trades unions.

Risk
This is a front line service utilised by many of County Durham's most vulnerable residents. There is a potential reputational risk to the council in changing this service. A communication plan is being developed to ensure sensitivity in the consultation and informing service users and their support networks of the proposed changes.

Equality and Diversity
An initial Equality Impact Assessment screening has been carried out (see appendix 4). A full EIA will be undertaken and presented to Cabinet alongside the results of consultation.

Accommodation
None

Crime and Disorder
None.

Human Rights
None.

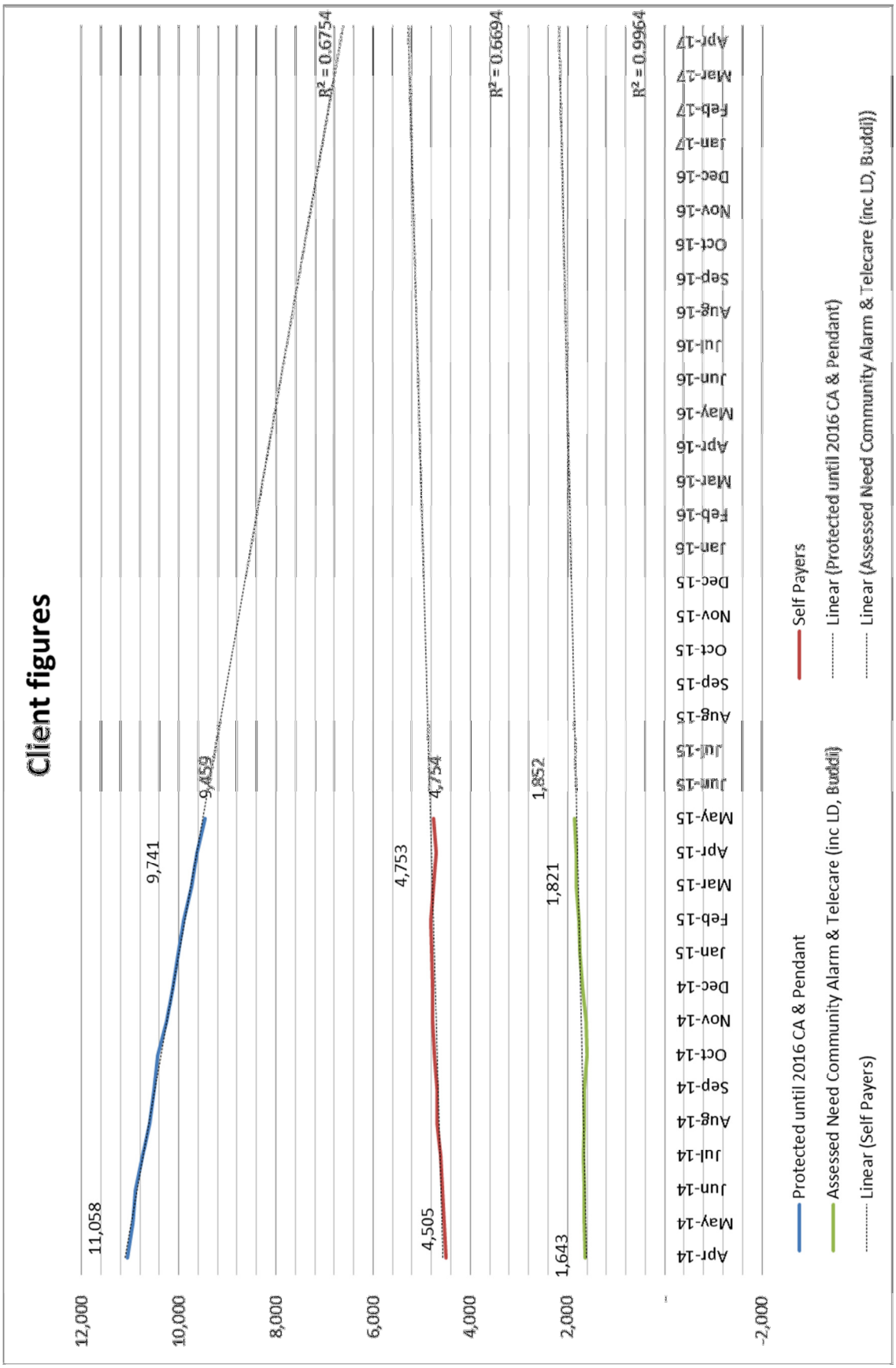
Consultation
A full consultation with service users and key stakeholders will be undertaken to help understand any issues that may arise as a result of introducing charges to those customers currently receiving a free service.

Procurement
None.

Disability Discrimination Act
Disability issues to be addressed thorough Equality Impact Assessment.

Legal Implications
Council has the power to charge for discretionary services under s 93 of the Local Government Act 2003. The aim of the legislation is to allow local authorities to recover the costs of providing the services that are not obligatory and not to generate a surplus. The authority must ensure that the income it derives from the

service equates to the cost and guidance on this matter gives advice on how to assess the costs. The guidance also states, however that the local authority does not have to recover the full cost if there are policy reasons for limiting charges, thus enabling different charging arrangements provided it can justify its reasons for doing so, but if the charge imposes is less than the full cost of the service, it should be reviewed annually.


Client figures
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Protected until 2016 CA & Pendant
Assessed Need Community Alarm & Telecare (inc LD, Buddi)
Linear (Self Payers)
Self Payers
Linear (Protected until 2016 CA & Pendant)
Linear (Assessed Need Community Alarm & Telecare (inc LD, Buddi))

Appendix 3

Community Alarm Service Benchmarking of Costs (June 2015)

Local Authority	Community Alarm monitoring charge	24/7 call centre	Mobile Response	Comments
Durham	£4.60	Y	Y	
Broadacres	£4.35	Y	N	Monitoring only
Broadacres	£6.26	Y	Y	With mobile response
Broadacres	£12.54	Y	Y	As above with weekly visit / daily tel call
Middlesbrough	£3.99-£4.57	Y	Y	Free to people in receipt of pension credit
Middlesbrough - Erimus	£16.70	Y	Y	Response Mon - Fri, 9am - 5pm only
Darlington	£5.21	Y	Y	
Stockton	£3.77	Y	Y	
Sunderland	£2.88	Y	Y	
Gateshead	£4.20	Y	Y	Subsidy for council tenants in receipt of HB
Newcastle	£3.36-£8.55	Y	N/Y	Basic package is monitoring only
North Yorkshire	£6.20-£12.30pw	Y	Y	Installation, maintenance, monitoring and response
East Ridding of Yorkshire	£14-£22/month	Y	N/Y	Response only where contacts are not available
Doncaster	£3.20pw	Y	Y	Free for low income benefits
Barnsley	£3.24-£4.29	Y	N/Y	Basic package is monitoring only

Durham County Council – Altogether Better equality impact assessment form

NB: Equality impact assessment is a legal requirement for all strategies plans, functions, policies, procedures and services. We are also legally required to publish our assessments.
You can find help and prompts on completing the assessment in the guidance from page 7 onwards.

Section one: Description and initial screening

Section overview: this section provides an audit trail.	
Service/team or section: Care Connect	
Lead Officer: Linda Ogilvie	Start date: 6th July 2015
Subject of the Impact Assessment: (please also include a brief description of the aims, outcomes, operational issues as appropriate) Care Connect is the council's community alarm and telecare/telehealth provider. It provides a range of additional preventative services to a variety of people many of whom are older people and some who also receive a social care service. The community alarm service is non-statutory provision which assists users to live independently in their own home, safe in the knowledge that if there is an accident or they have a fall, they can get help quickly 24 hours a day, seven days a week, 365 days a year through our alarm monitoring and response service. In order to address ongoing reductions in government funding support for local authorities, MTFP proposals include a further reduction in Children and Adult Services (CAS) expenditure on Care Connect services of £750k from April 2016. The long term need for community alarm type services is likely to grow as the demographics of the county change. The longer term viability of the service depends on being able to cover the costs of providing community alarms through charging its customers. The cost to the council of delivering the community alarm service is currently estimated at £4.80 per week per client.	

Historically, customers in receipt of Guaranteed Pension Credit, Council Tax Benefit or Housing Benefit qualified for a free community alarm service. This qualification was removed for new customers from April 2014, as part of the previous MTFP savings measures. However, Cabinet agreed to protect those customers already receiving a free service for a period of at least two years.

It is proposed to increase the charge for the self-funding customers from £4.60 to £4.80 per week. This increase is carried out on an annual basis and will increase the income to the service by £142k. In order to realise the full MTFP saving it is also proposed to introduce a contributory charge for those customers currently receiving the service for free.

The introduction of charges where none previously existed may lead to people withdrawing from the service. For example, Sunderland City Council introduced community alarm charges in 2013 and saw a reduction of around 40% of their customers.

It should also be noted that there are around 4,200 smoke alarms linked to the community alarm system in registered housing provider properties. We currently receive 60p per week for each monitored smoke alarm under Service Level Agreements with the housing providers. Should individual customers decide not to stay on the Care Connect service, we would need to renegotiate our SLA or adjust the budget for loss of this income.

If we assume a similar elasticity as Sunderland and make an adjustment for the loss of SLA income, then in order to make the appropriate level of savings it would be necessary to introduce a charge of £2.80 per week (around £145 per year) for those currently receiving a free service. This would still represent a considerable subsidy from the Council for these customers.

Should the customer base fall by a greater amount than 40%, then the reduced level of income would need to be offset by a further reduction in the costs of staffing and resources required to deliver the service. Any shortfall in the anticipated income would be met from cash limits until exact numbers, costs and savings levels have been established.

Who are the main stakeholders: General public / Employees / Elected Members / Partners/ Specific audiences/Other (please specify) –
Care Connect service users, staff, potential users,NHS,Emergency Services,Public Health

Is a copy of the subject attached? Yes

If not, where could it be viewed?

Initial screening

Prompts to help you:
Who is affected by it? Who is intended to benefit and how? Could there be a different impact or outcome for some groups? Is it likely to affect relations between different communities or groups, for example if it is thought to favour one particular group or deny opportunities for others? Is there any specific targeted action to promote equality?

Is there an actual/potential negative or positive impact on specific groups within these headings?
Indicate :Y = Yes, N = No, ?=Unsure

Gender	Y	Disability	Y	Age	Y	Race/ethnicity	N	Religion or belief	N	Sexual orientation	N

How will this support our commitment to promote equality and meet our legal responsibilities?
Reminder of our legal duties:

- Eliminating unlawful discrimination & harassment
- Promoting equality of opportunity
- Promoting good relations between people from different groups
- Promoting positive attitudes towards disabled people and taking account of someone's disability, even where that involves treating them more favourably than other people
- Involving people, particularly disabled people, in public life and decision making

The service is generally provided to older people and those who are vulnerable, for example as a result of a disability. There are more older women in the county's population so the likelihood is that more women will be affected by changes to this service than men. The gender profile of current service users shows that just under 65% are female. 58% of users are aged over 75.
There is no direct evidence that changes to the service will have a specific impact in relation to transgender status, race, religion or

sexual orientation.

The potential impacts relate to health and wellbeing as well as financial impacts. The increase in weekly payments for self funders and the proposed introduction of charges for those who currently do not currently pay will have a financial impact which may mean that some cancel, this could leave them at risk and would potentially increase reliance on other emergency response services such as ambulance or fire and rescue services.

The customers who currently receive a free service are amongst the highest users of the service. Over the last 12 months we have answered and responded to around 40,000 calls from these customers. Many of these calls relate to low level incidents. However, any withdrawal from the service will inevitably place additional burdens on the Police, Fire and Ambulance services. The consultation plan will identify key stakeholders and seek to assess the level of impact of potential changes.

If proposals are implemented and the customer base falls this may affect staffing with a potentially greater impact on women as more women are employed within the service. Corporate HR procedures would be followed to ensure fair treatment.

What evidence do you have to support your findings?

There are currently around 16,300 households (20,000 customers) receiving the community alarm monitoring and response service. This comprises approximately:

- 9,750 households who receive the service free (through historical funding arrangements)
- 4,750 self-funding households (who currently pay £4.60 per week)
- 1,800 households in receipt of Telecare equipment and monitoring (which includes the community alarm service as part of an assessed care package)

Data for current users who receive the service for free (9,750 households = 11584 customers)

Gender breakdown: 7510 (65%) female, 4074 (35%) Male

Age breakdown:

Age Range	Customers
Birth to 64 yrs	2370
65 to 69 yrs	1091
70 to 74 yrs	1400
75 to 79 yrs	1959
80 to 84 yrs	2054
85 yrs +	2710
Total	11584

This assessment will proceed to full assessment if agreed to proceed with consultation.

Decision: Proceed to full impact assessment – Yes Date: 6th July 2015

If you have answered 'No' you need to pass the completed form for approval & sign off.

Adults Wellbeing and Health Overview and Scrutiny Committee

9th October 2015

Health and Wellbeing Board Annual Report 2014-15

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

Anna Lynch, Director of Public Health County Durham

Purpose of Report

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

Background

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

3. The first Health and Wellbeing Board Annual Report was agreed by the Health and Wellbeing Board in July 2014 and was received by Durham County Council's Cabinet for information in October 2014, and Adults Wellbeing and Health Overview and Scrutiny Committee in November 2014.

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

5. The functions of the Health and Wellbeing Board remain as:

- Develop a Joint Strategic Needs Assessment
- Develop a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health services, public health and social care services.

6. Adults Wellbeing and Health Overview and Scrutiny Committee has continued to develop a relationship with the Health and Wellbeing Board and has been kept up to date on the work of the Board, which includes sharing regular updates on performance with the Committee.

7. Adults Wellbeing and Health Overview and Scrutiny Committee continues to have a “critical friend” approach with the Health and Wellbeing Board in relation to sharing information during the production and refresh of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Achievements during 2014/15

8. Central to achieving the vision of the Health and Wellbeing Board to “Improve the health and wellbeing of the people of County Durham and reduce health inequalities” is the belief that decisions about the services provided, should be made as locally as possible and involve the people who use them.

9. A number of achievements have been made during 2014/15 which include:

- The Health and Wellbeing Board agreed the first Joint Health and Wellbeing Strategy and Delivery Plan in 2013/14, and have undertaken subsequent reviews, which have been informed by the Joint Strategic Needs Assessment, the Annual Report of the Director of Public Health County Durham, and feedback from engagement and consultation.

- The Health and Wellbeing Board hosted a ‘Big Tent’ engagement event in October 2014 as part of the consultation process for the refresh of the Joint Health and Wellbeing Strategy. The event was attended by over 240 people and included a number of themed workshops relating to health, social care and the wider wellbeing approach.

- The Health and Wellbeing Board agreed the County Durham Better Care Fund plan which supports the following seven work programmes to integrate health and social care initiatives locally:

    - **Intermediate Care+ Short term intervention services** which includes intermediate care community services, reablement, falls and occupational therapy services
    - **Equipment and adaptations for independence** which includes Telecare, Disability adaptations and the Home Equipment Loans Service
    - **Supporting independent living** which includes mental health prevention services, floating support, supported living and community alarms and wardens
    - **Supporting Carers** which includes carers breaks, carer’s emergency support and support for young carers
    - **Social inclusion** which includes local coordination of an asset based approach to increase community capacity and resilience to provide low level services
    - **Care home support** which includes care home and acute and dementia liaison services
    - **Transforming care** which includes maintaining the current level of eligibility criteria, the development of IT systems to support joint working and Implementing the Care Act

The Better Care Fund is aligned to the strategic objectives in the Joint Health and Wellbeing Strategy and supports the aim to provide people with the right care, in the right place at the right time.

- The County Durham Mental Health Implementation Plan was developed by the Mental Health Partnership Board, and agreed by the Health and Wellbeing Board, and is the overarching mental health strategy for children and adults in County Durham. It is the local implementation plan of the national 'No Health without Mental Health' strategy and aims to improve mental health and wellbeing across all ages within County Durham. The Plan is supported by a range of strategies, with work taking place in a number of areas and local priorities, which are aligned to the Joint Health and Wellbeing Strategy, identified as follows:

    - Improving outcomes for people experiencing mental health crisis
    - Supporting people who are socially isolated
    - Reducing the number of people developing mental health problems through promotion of mental health, prevention of mental ill-health and improving the quality of life for those with poor mental health through early identification and recovery
    - Developing a specific Mental Health, Emotional Wellbeing and Resilience Plan to take forward work relating to children and young people, incorporate Children and Adolescent Mental Health Services (CAMHS)
    - Reducing the rate of people who self-harm or attempt suicide in County Durham

- The Health and Wellbeing Board agreed the Dementia Strategy for County Durham and Darlington 2014-17, which has been developed to identify areas of need and priority actions over the next three years, to meet challenges of the national dementia policy and to enable people to live well with dementia. The strategy emphasises the role of appropriate, high quality services in the community, which will help to avoid inappropriate hospital admissions and facilitate timely discharge. It identifies housing initiatives for people with dementia, and specific services such as dementia advisors, and highlights the need to establish 'Dementia Friendly Communities' in Durham, which has been highlighted as an area of good practice.

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

- Health Express in Shildon, which aims to increase knowledge and awareness of health issues in the local community and help people access health services and get support in better managing long term health conditions.
- The roll out of dementia friendly communities, focusing on improving inclusion and quality of life for people living with dementia.

Commitments of the Health and Wellbeing Board

11. The Health and Wellbeing Board has made a number of commitments since it was established in April 2013, which include:

- Signing up to the Disabled Children's Charter to ensure the needs of disabled children are fully understood and services are commissioned appropriately
- The Chair of the Health and Wellbeing Board and the Director of Public Health County Durham are mental health champions, whose role includes promoting wellbeing, and initiating and supporting action on public mental health
- Signing up to the National Dementia Declaration and Dementia Care and Support Compact to support the delivery of the National Dementia Strategy and improving care and support for people with dementia, their carers and families.
- In addition the Health and Wellbeing Board have signed up to the Carers' Call to Action to ensure that the vision for carers of people with dementia is achieved
- Signing the NHS Statement of Support for Tobacco Control to actively support local work to reduce smoking prevalence and health inequalities

Local Government Association Peer Challenge

12. The Annual Report includes a section on the Local Government Association Peer Challenge, which took place between 24th and 27th February 2015, and provides an overview of areas which are strong, as well as the following four areas of best practice which the Local Government Association would like to share with other Health and Wellbeing Boards. These are in relation to:

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

Future work of the Health and Wellbeing Board

13. There are a number of initiatives that the Health and Wellbeing Board will continue to take forward during the coming year, which include:

- Agreeing the approach to further develop health and social care integration.
- Agreeing the Cardiovascular Disease (CVD) Prevention Strategic Framework to prevent the disease, which is the second largest cause of death in County Durham.

Details of further initiatives are included in the Annual Report.

Recommendations

14. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Committee:

- Note the work that has taken place in 2014/15 by the Health and Wellbeing Board and receive the Health and Wellbeing Board Annual Report 2014/15 for information.

Contact: Peter Appleton, Head of Planning and Service Strategy, Children and Adults Services Tel: 03000 267 381
Andrea Petty, Strategic Manager, Policy, Planning and Partnerships, Children and Adults Services Tel: 03000 267 312

Appendix 1: Implications

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

The Better Care Fund will be used to deliver integrated services between health and social care in County Durham in 2015/16.

Staffing – Not Applicable

Risk – A risk sharing agreement is in place for the Better Care Fund, which has been developed between the Clinical Commissioning Groups and the Local Authority.

Equality and Diversity / Public Sector Equality Duty – Equality Impact Assessments have been completed for the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).

Accommodation - No direct implications.

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

Human Rights - No direct implications.

Consultation – Consultation has taken place as part of the development of the JSNA and JHWS. This includes consultation through the Big Tent engagement event to gather the views of a wide range of stakeholders including service users, patients GPs, carers, members of the voluntary and community sector as well as partner agencies and elected members.

Consultation has also taken place through service user and carers forums, Investing in Children agenda days, The Bridge (Family Action) young carers group, and Making Changes Together (parents of disabled children).

Carers are involved in consultation, to ensure their needs and the needs of the people they care for are considered.

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

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

Legal Implications – The Health and Social Care Act 2012 established the requirement for all upper tier local authorities to establish Health and Wellbeing Boards.

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Support

Wellbeing

Health

Independence

Our vision:-

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

County Durham Health and Wellbeing Board Annual Report 2014-2015

Contents

1. Foreword

Welcome to the Health and Wellbeing Board Annual Report 2014/15. As Chair and Vice Chair of County Durham's Health and Wellbeing Board we are privileged to have been supported by a group of partners who have continued to work together with the shared vision of improving the health and wellbeing of the people of County Durham and reducing health inequalities.

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

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

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

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

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

Councillor Lucy Hovvels
Chair of the Health and Wellbeing Board

Cabinet Portfolio Holder for Adult and Health Services

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

Dr Stewart Findlay
Vice Chair of the Health and Wellbeing Board

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

2. The Health and Wellbeing Board

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

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

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

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

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

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

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

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

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

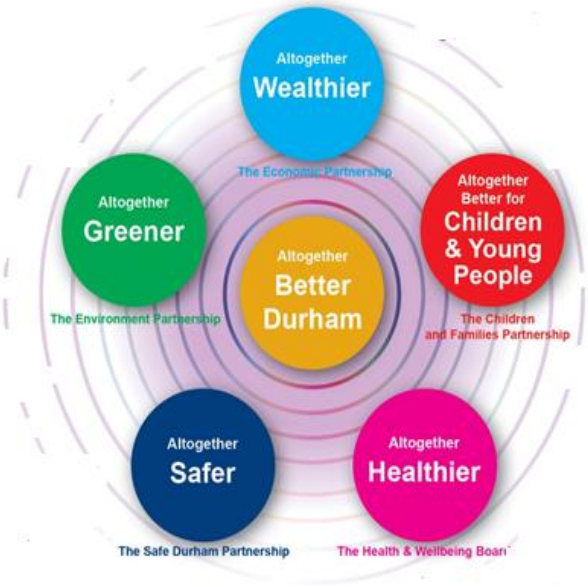
The vision is supported by the following strategic objectives:

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

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

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

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



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

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

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

- Children and young people realise and maximise their potential
- Children and young people make healthy choices and have the best start in life
- A think family approach is embedded in our support for families

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

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

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

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

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

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

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

Poverty

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

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

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

Membership of the Health and Wellbeing Board

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

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

Governance and accountability

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

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

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

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

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

University Hospital North Durham A&E department

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

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

The Health and Wellbeing Board:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

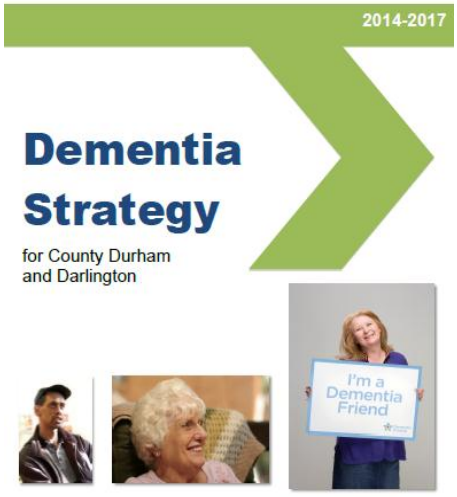
Examples of local projects supporting the Wellbeing for Life approach include:

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

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

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

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



Examples of local projects supporting Dementia include:

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

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

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

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

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

- Agreed the first County Durham Drug Strategy, which aims to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life, whilst minimising the impact on communities and families.

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

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

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

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

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

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

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

Commitments of the Health and Wellbeing Board

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

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

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

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

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

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

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

- Signed up to the Carers' Call to Action to ensure that the vision for carers of people with dementia is achieved. Another Better Care Fund work programme is 'Supporting Carers' which includes carers breaks.

- Signed up to the National Pensioners Convention's Dignity Code, which has been developed to uphold the rights and maintain personal dignity of older people.
  The Dignity Code was discussed at events with Residential Care Home Providers in 2014, who agreed to abide by the code.

- Signed the NHS Statement of Support for Tobacco Control to actively support local work to reduce smoking prevalence and health inequalities.
  A voluntary ban has been implemented across County Durham, encouraging play areas to become smoke free.
  The outdoor play area at Riverside Park in Chester-le-Street became the first park to become a smoke free zone.

Key Performance Achievements 2014/15

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

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

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

Strategic Objective 2: Reduce health inequalities and early deaths

- The long term trend for under 75 mortality from cancers, circulatory diseases and respiratory disease is reducing.
- Patients receiving definitive treatment for cancer within 31 days of diagnosis has exceeded target and is better than national rates.

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

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

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

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

Strategic Objective 5: Protect vulnerable people from harm

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

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

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

4. Engagement

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

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

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

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

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

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

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

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

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

County Durham Adults Learning Disability engagement forum

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

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

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

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

AAP consultation event

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

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

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

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

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

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

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

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

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

Investing in Children Agenda Day

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

The Bridge Young Carers group art day

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

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

5. Local Government Association Peer Challenge

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

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

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

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

Big Tent Engagement Event

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

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

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

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

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

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

IIC Agenda Day

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

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

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

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

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

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

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

6. Future work of the Health and Wellbeing Board

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

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

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

- Agree the refresh of the Joint Health and Wellbeing Strategy 2015-18 Delivery Plan to ensure that the Joint Health and Wellbeing Strategy is implemented and performance managed.
- Implement the actions in the Mental Health Crisis Care Concordat local action plan, which was agreed by both the County Durham and Darlington Health and Wellbeing Boards.
- Receive updates on the performance against targets set within the County Durham Better Care Fund plan, and the financial position relating to the plan.
- Agree the approach to further develop health and social care integration.
- Agree the Cardiovascular Disease (CVD) Prevention Strategic Framework to prevent the disease, which is the second largest cause of death in County Durham.
- Agree the Dual Needs Strategy, which aims to identify people with dual diagnosis (drugs and/or alcohol misuse along with learning disabilities and/or mental illness, including dementia) and ensure they have access to coordinated and responsive services to meet their complex and changing needs.
- Agree the County Durham Physical Activity Delivery Plan, which will provide a greater range of opportunities to increase participation and activity levels in County Durham

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

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

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

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

- Consider safeguarding arrangements for children and adults through the Annual Reports of the Local Safeguarding Children Board and Safeguarding Adults Board.

- Achieve the Tobacco Control Alliance CLeaR creditation, which provides recognition that Durham is providing the leadership required to receive this improvement model.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CAROL HARRIES
Director of Corporate Affairs – City Hospitals Sunderland

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

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

JUDITH MASHITER
Chair - Healthwatch County Durham

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

7. Abbreviations and glossary

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

Joint Health and Wellbeing Strategy (JHWS)	The Health and Social Care Act 2012 places a duty on local authorities and CCGs to develop a Joint Health & Wellbeing Strategy to meet the needs identified in the local Joint Strategic Needs Assessment (JSNA)
Joint Strategic Needs Assessment (JSNA)	The Health and Social Care Act 2012 states the purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages
Local Government Association (LGA)	The LGA is a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. The LGA aims to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems
Long term condition	The Department of Health has defined a Long Term Condition as being "a condition that cannot, at present be cured; but can be controlled by medication and other therapies." This covers a lot of different conditions e.g. diabetes, chronic obstructive pulmonary disease (COPD), dementia, high blood pressure
National dementia declaration	Explains the challenges presented to society by dementia and some of the outcomes that are being sought for people with dementia and their carers
NHS	National Health Service
Reablement	Reablement is about giving people over the age of 18 years the opportunity, motivation and confidence to relearn/regain some of the skills they may have lost as a consequence of poor health, disability/impairment or accident and to gain new skills that will help them to develop and maintain their independence
Special Educational Needs and Disability (SEND)	Children who have needs or disabilities that affect their ability to learn. For example: • Behavioural/social (e.g. difficulty making friends). • Reading and writing (e.g. dyslexia). • Understanding things. • Concentrating (e.g. Attention Deficit Hyperactivity Disorder). • Physical needs or impairments
Social Isolation	A lack of contact with people
Stakeholders	Interested parties or those who must be involved in a service/project or activity
UTASS	Upper Teesdale Agricultural Support Services, supporting local residents with mental health needs

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County Durham Health and Wellbeing Board Annual Report 2014-2015

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CAS14300 Children and Adults Services, CMI Team 2015

Adults Wellbeing and Health Overview and Scrutiny Committee

9 October 2015

Implementing the NHS Five Year Forward View in County Durham

Report of Nicola Bailey, Chief Operating Officer, North Durham CCG and Durham Dales, Easington and Sedgefield CCG

Purpose of the Report

1 The purpose of this report is to advise members of the Adults Wellbeing and Health Overview and Scrutiny Committee of how the NHS Five Year Forward View is to be implemented within County Durham.

Background

2 The NHS Five Year Forward View (FYFV) was published in October 2014. The key principles set in the FYFV are summarised below:

- The NHS has dramatically improved over the past fifteen years with key improvements to outcomes for cancer and cardiac conditions. Inequalities remain deep rooted and quality of care is variable. There are particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

- There is now quite broad consensus on what a better future should be. Change is required and some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

- Future health and economic prosperity depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded -and the NHS is on the hook for the consequences.

- The NHS will back hard-hitting national action on obesity, smoking, alcohol and other major health risks and will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. The NHS will advocate for stronger public health-related powers for local government and elected mayors.

- When people do need health services, patients will gain far greater control of their own care, including the option of shared budgets combining health and social care. The 1.4 million fulltime unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

- The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

New models of care

3 In addition to the above principles, the FYFV set out a number of New Models of Care (NMOC) that will support changing models of service delivery and increased integration. A summary of the new models is below:

4 One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the *Multispecialty Community Provider (MSCP)*. From,October 2014 early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

5 A further new option will be the integrated hospital and primary care provider - *Primary and Acute Care Systems (PACS)* -combining for the first time general practice and hospital services.

6 Across the NHS, *urgent and emergency care services* will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. Smaller hospitals will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services.

7 Midwives will have new options to take charge of the *maternity services* they offer.

8 The NHS will provide more support for frail older people living in *care homes*.

9 The foundation of NHS care will remain list-based primary care. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years.

10 Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

11 This paper will set out the practical steps that have been taken to implement some of these principles and new models of care in County Durham.

The Funding Challenge

12 A combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2010/21. To sustain a comprehensive high-quality NHS action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

13 It is expected that over time a bigger share of the efficiency will come from system wide improvements (including health and social care), implementation of the new models of care, action on prevention and sustaining social care services.

New care models - vanguard sites

14 In January 2015, the NHS invited organisations and partnerships to apply to become 'vanguard sites' for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.

15 In March, the first wave of 29 vanguard sites was chosen. There were three vanguard types – integrated primary and acute care systems; enhanced health in care homes; and multi-specialty community provider vanguards. In July, a second wave of eight vanguards was announced, known as urgent and emergency care vanguards.

16 Each vanguard site will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward and the inspiration to the rest of the health and acre system. A further wave of vanguards will be announced in the autumn – known as acute care collaborations, they aim to link local hospitals together to improve their clinical and financial viability.

Urgent and Emergency Care Vanguards (UECV)

17 County Durham is part of the North East Urgent Care Network (NEUCN) that was selected as a successful UECV earlier this year. The NEUCN is chaired by Dr Stewart Findlay, Chief Clinical Officer for DDES CCG. The NEUCN covers a population of 2.71 million spread across diverse geographies incorporating large pockets of both densely populated and dispersed populations.

18 The NEUCN application is supported by the following organisations:

North East Ambulance Service NHS FT, 111 and 999 Regional Provider	NHS Northumberland CCG
Northumberland Tyne & Wear NHS FT	NHS North Tyneside CCG
Tees, Esk and Wear Valley NHS FT	NHS Newcastle Gateshead CCG
Northumbria Healthcare NHS FT	NHS South Tyneside CCG
Newcastle Hospitals NHS FT	NHS Sunderland CCG
Gateshead Health NHS FT	*NHS North Durham CCG*
South Tyneside NHS FT	*NHS Durham, Dales Easington and Sedgefield CCG*
City Hospitals Sunderland NHS FT	NHS Darlington CCG
County Durham and Darlington NHS FT	NHS Hartlepool, Stockton and Tees CCG
North Tees and Hartlepool NHS FT	NHS South Tees CCG
South Tees Hospitals NHS FT	Nine SRGs and associated members
Regional Out of Hours Providers	Clinical Health Information Network
Royal College of Psychiatry	*North East Local Authorities*
Academic Health Science Network	North of England Commissioning Support (NECS)
Health Education North East	Voluntary Organisations' Network North East

19 The network bid also benefits from support across both North Cumbria and Hambleton & Richmond Strategic Resilience Groups (SRGs).

20 The NEUCN vision is to:
"reduce unwarranted variation and improve the quality, safety and equity of urgent and emergency care provision by bringing together SRGs and stakeholders to radically transform the system at scale and pace which could not be delivered by a single SRG alone."

21 The principles of the NEUCN Vanguard are:

- High quality, safe, urgent and emergency care services available 7 days of the week addressing our population health needs, balanced against requirements of personalisation.
- Simple to access integrated care pathways, delivered as close to home as possible, provided across a full range of care settings, enabling good choices by patients and clinicians.
- Improved patient experience and clinical outcomes delivered through care in the right place, at the right time, provided by those with the right skills.

22 Key Deliverables of the NEUCN Vanguard:

Systems Leadership	By April 2016	By April 2017
	- Create an overarching framework to deliver the objectives of the UEC review, including a stock take of services, regional action plan and implementation of revised NHS 111 Commissioning Standards. - Address fragmentation and nomenclature of UEC services. - Implement standardised system wide metrics, supported by academic partners to ensure rigour and benefits realisation. - Ensure consistent delivery of High Impact Interventions by SRGs. - Deliver improved intelligence and modelling via the 'flight deck'. - Undertake baseline assessment to inform proposed new costing models and agree scenarios for shadow monitoring	- Implement outcomes of the regional UEC review stock take. - Outcome of payment reform shadow monitoring implemented.
Self-care	- Promote self-care for minor ailments and self-management for long term conditions through the development of online health tools, initially focusing on parents of children under 5 years.	- Extend personal health budgets to support Integrated Personal Commissioning
Primary care	- Increase direct booking into GP appointments, in and out of hours, to 50% of practices. - Standardise minor ailment schemes in pharmacies.	- Further increase direct booking into GP appointments and expand direct booking to other UEC services.
Integration	- Expand the Directory of Services (DoS) to include social care. - Implement information sharing between providers, allowing analysis of pathways and outcomes, by linking NHS identifiers from 111, 999, A&E and admission data. This will inform future pathway changes and payment reform. - Enhance Summary Care Records in association with HSCIC.	- Achieve greater integration between 111 and OOH provision.

Out of hospital	- Implement 24/7 early clinical assessment of green ambulance and ED dispositions. - Implement 24/7 senior clinical decision Support through an enhanced clinical hub, accessible by 111/999 and external clinicians, including GPs, pharmacists, mental health, dental and social care professionals. - Improve See & Treat and Hear & Treat. - Enhance mental health integration through rollout of 24/7 triage services, psychiatric liaison, 7 day MH consultant working and 7 day street triage with mobile access to health records.	- Utilise ambulance trauma consultants to enhance secondary care treatment in the community. - Mobile access to DoS for all services.

MSCP in County Durham - Diabetes

23 Durham Dales, Easington and Sedgefield (DDES) and North Durham (ND) CCGs selected diabetes as one of their seven key priorities in their operational commissioning plan. Clinicians from the County Durham CCGs, Darlington CCG, community diabetes services, three local acute trusts and consultant in public health for County Durham have worked together to develop a Case for Change for diabetes services. The case for change incorporated the results of major public and stakeholder engagement exercise.

24 The key issues summarised in the Case for Change are:

- Increasingly diabetes patients have a complex set of long term care needs (social, physical and mental) that are not well served by the current fragmented service. Rising prevalence of diabetes means the current model of care for diabetes is not financially sustainable.
- Existing diabetes services are struggling to meet the changing nature of demand – where increasingly the ageing population has ongoing complex care needs. Currently, services typically offer a largely reactive and fragmented experience which results in a poor quality of life for both the patients and their carers.
- County Durham diabetes health outcomes are no better than average for England, but are not significantly worse. However the incidence of microvascular complications (which are indicative of poor glycaemic control) are above the England average. In addition there is considerable local variation in quality outcomes between GP practices.
- In 2013/14 County Durham spent over £8m on diabetes prescribing. This is the largest single element of spend in diabetes care and this cost is increasing at around 5% per year. DDES & ND spend more per patient than the England or North East average. Spend per practice on

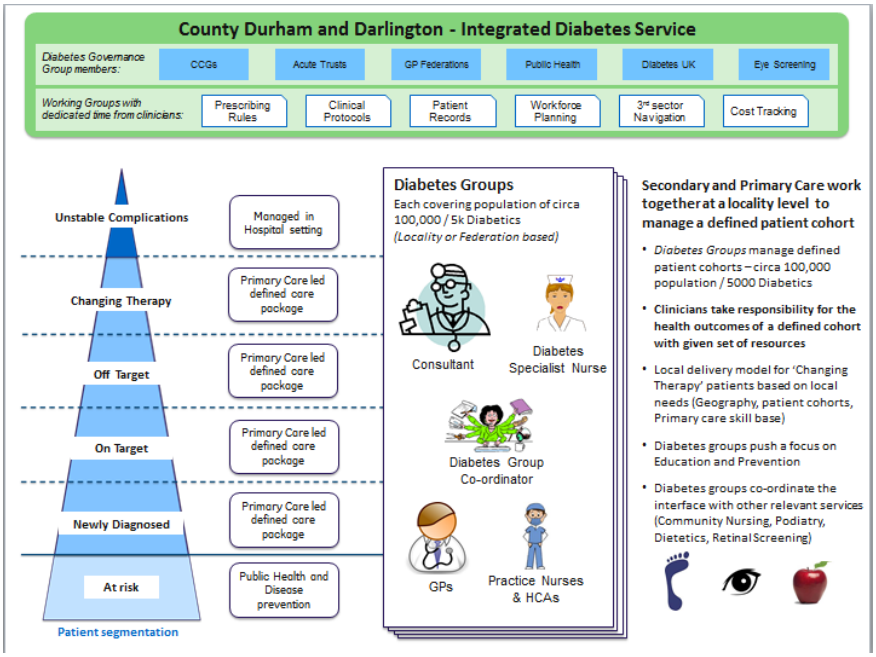
diabetic drugs varies considerably with little correlation to glycaemic control (HbA1c) outcomes.

- Given the expected growth in prevalence and the need for increased funding required for diabetes care in the future there is a need for a much greater focus on prevention given 80% of the type 2 diabetes is preventable.
- It is clear that savings can be made in diabetes health care, but in order to manage the rising prevalence of diabetes the savings need to be reinvested in the diabetes system, covering the whole pathway from prevention to end of life.

25 Clinicians reached consensus on the new model of care for diabetes across County Durham and Darlington. They key characteristics are described below:

- Secondary and primary care work together in 'diabetes groups' at a locality level to manage a defined patient cohort in a community setting
- Diabetes groups manage defined patient cohorts – circa 100,000 population / 5000 diabetics (including the care home population)
- Clinicians take responsibility for the health and system outcomes ~~of~~ for a defined cohort with a given set of resources
- There will be a local delivery model for 'Changing Therapy' patients based on local needs (geography, patient cohorts, primary care skill base)
- The new system will be based around individualised care planning
- Diabetes groups push a focus on education and prevention
- Diabetes groups co-ordinate the interface with other relevant services (community nursing, podiatry, dietetics, retinal screening)
- The diabetes groups will be responsible for the management of the budget for their population with a risk and gain share mechanism in place
- Any savings realised will be re-invested in diabetes treatment and prevention

26 The diabetes groups will be overseen by a governance board which will be clinically led. This will include representation from the Durham County Council public health team. There will be supporting work streams reporting to the governance group. This is set out in the diagram below:



27 This model has a strong focus on shifting resource to prevention which is very much in line with the principles of the FYFV. It is expected that this model will be developed for the management of other chronic diseases so that they are all managed in a similar way i.e. with primary and secondary care clinicians working together with shared objectives and outcome targets.

28 Durham County Council has agreed in principle to align the budge for linked services i.e. Wellbeing for Life, NHS Healthchecks and the Family Initiative Supporting Child Health budgets to the NHS budget for diabetes services and will commission services for diabetes in a joined up and collaborative way.

Primary and Acute Care Systems (PACS)

29 PACS models combine General Practice and Acute Care services. There are currently no plans to implement PACS services in County Durham although Northumbria Healthcare NHS Foundation Trust, Northumberland CCG and Northumberland County Council are one of the successful PACS vanguard sites.

30 Nearby in Sunderland, City Hospitals Sunderland delivers primary care (GP services) for some of the local population.

Care Homes

31 County Durham CCGs and Durham County Council has commissioned the Intermediate Care + service (formerly the Integrated Short Term Intervention Service) to support avoidance of admission to hospital and facilitate early discharge where appropriate. This service places high expectations on care homes with patients being admitted either as step up or step down from hospital.

32 A programme of training and support for care home staff has been developed by CCGs and DCC.

Midwifery

33 The CCGs are working with colleagues in the Public Health team at DCC to develop a new specification for maternity services delivered by County Durham and Darlington Foundation Trust (CDDFT). This specification will include an increased emphasis on health improvement of both mother and baby. This is an enhancement to the existing service rather than a new model of care.

Securing Quality in Healthcare Services (SeQiHS)

34 The SeQiHS programme is what was formerly known as the Acute Quality Legacy project instigated by the former Durham, Darlington and Tees Primary Care Trusts.

35 As part of the SeQiHS project, clinicians agreed what the appropriate clinical standards should be for acute medicine, surgery, obstetric and paediatric services and sought to map current performance against those standards. Where individual Trusts are not meeting the clinical standards this is largely linked to lack of availability of appropriate clinicians both now and in the future, or changes and developments in evidence based clinical practice

Primary care commissioning

36 DDES and North Durham CCGs have delegated authority from NHS England to commission GP primary care services. Both CCGs have developed primary care strategies that are aligned to the FYFV and will inform commissioning plans for GP services over the next five years. Key priorities over the next five years include:

- GP practice federated working, to enable practices to offer more services for their patients outside of hospital over seven days e.g. urgent care, diabetes care
- Workforce development, education and training
- Access to GP services
- Use of information and technology

.

FYFV - The Next Three Years

37 CCGs are about to commence development of three year plans (2016/2010). These plans will set out the implementation and expansion of new models of care as described in this paper. Feedback and lessons learnt from the original Vanguard sites will be fed into the planning process.

38 These plans are developed with Durham County Council colleagues, patient participation/reference groups, voluntary sector, existing services providers and members of the community at key stages. Local communities are also involved via Area Action Partnerships.

Recommendations

39 The Adults Wellbeing and Health Overview and Scrutiny Committee are asked to note the information contained within this report and agree to further updates being brought to future meetings of the Committee.

Background papers

Contact: Nicola Bailey, Chief Operating Officer, North Durham and Durham Dales and Easington CCGs

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation - None

Procurement - None

Disability Issues - None

Legal Implications - None

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Adults, Wellbeing and Health Overview And Scrutiny Committee

9th October 2015

Care Act and Adult Social Care Transformation Update

Rachael Shimmin, Corporate Director of Children and Adults Services

Purpose

1. The purpose of this report is to provide an update to Adults, Wellbeing and Health Overview and Scrutiny Committee on the local and national developments in relation to the implementation of the Care Act 2014 and the transformation of Adult Care services, focussing on changes to deliver Phase 1; the new care and support duties from 1st April 2015.

2. The report also provides an update on the recent announcement by Government to postpone the Phase 2 reforms until 2020 which were due to come into effect from 1st April 2016, which includes the cap on care costs and appeals system.

Background

3. On 8th December 2014 this committee received a report together with a presentation covering the duties and responsibilities of the Care Act 2014 and outlining how the adult social care reforms would be implemented in Durham. Cabinet have received subsequent reports in March and September 2015 providing updates on the Care Act 2014 and transformational change within Adult Care Services.

4. The Care Act seeks to help and promote people's independence and wellbeing and embeds in legislation people's rights to choice, personalised care and support and personal budgets. Established under the Care Act the Better Care Fund (BCF), is a £3.9bn single pooled budget to support health and social care services to work more closely together in local areas. The BCF brings together NHS and Local Government resources that are already committed to existing core activity and provides a real opportunity to improve services and value for money.

5. The Act also introduces a new duty to provide preventative services, a national minimum eligibility threshold and a duty to offer information and advice to help people plan what care and support they may need for the future.

6. To meet the requirements of the Care Act the Social Care Reform Project Board chaired by the Corporate Director of Children's and Adult Services has monitored implementation and managed the risks associated with the reforms through a comprehensive project plan.

Care Act Implementation in Durham

7. Care Act implementation and adult care transformation has sought to provide a flexible, innovative and outward facing service with the primary aim of helping people to help themselves. There is a focus on prevention and building resilience by working to ensure that there are universal local voluntary and community services available for the public to access.

8. Adult Care Staff continue to support those people with long term needs but work proactively to ensure that service users remain as independent as possible.

9. The Health and Wellbeing Board is committed to promoting integrated working between commissioners of health services, public health and social care to enhance the health and wellbeing of people living in County Durham.

10. The Better Care Fund (BCF) as part of the Care Act, commenced on the 1st of April 2015 following the agreement of the BCF plan by NHS England in December 2014. County Durham's allocation from the fund is £43.735m in 2015/16.

11. The seven key initiatives that the fund has been committed to are as follows:

- **Short term intervention services** which includes intermediate care community services, reablement, falls and occupational therapy services **(£13,428,000)**
- **Equipment and adaptations for independence** which includes telecare, disability adaptations and the Home Equipment Loans Service **(£8,562,000)**
- **Supporting independent living** which includes mental health prevention services such as counselling **(£5,005,000)**
- **Supporting Carers** which includes breaks for carers **(£1,361,000)**
- **Social isolation** which includes working with the voluntary and community sector **(£1,121,000)**
- **Care home support** which includes dementia services **(£1,774,000)**
- **Transforming care** which includes maintaining the current level of eligibility criteria **(£12,484,000)**

12. The overall aim of the BCF is to transform local health and social care services to make them more responsive and personalised to individual need. This includes making services available seven days a week, improving information and advice and clarifying lines of responsibility for coordinating care.

Implementation of Phase 1 Reforms – Care and Support

13. The Council has embarked upon a number of service developments which support Care Act implementation.

14. A new Wellbeing for Life (WBL) service has recently been commissioned across County Durham. The service works with the public on an individual or group basis with staff and volunteers helping people to achieve their health goals. Service provision includes sign posting and advice, adult learning and participation in community opportunities to reduce social isolation.

15. The service is being targeted at the most deprived geographical areas of the County and aims to take a community approach to improving health and wellbeing. The focus is upon specific communities and is based around three areas; North, South-West and East Durham. Programmes are already working in communities within Shildon, mid-Durham and South Moor/Quaking Houses to improve the overall levels of wellbeing.

16. There are currently over 6,000 people with dementia in County Durham and with the number of people aged 60 and over with dementia expected to double by 2030. A new Dementia Strategy has been developed for County Durham and Darlington. The Council is working with NHS organisations, Darlington Borough Council and a range of voluntary and community services to implement the strategy. Actions and initiatives are planned to improve early diagnosis and give the right support to people with dementia, their carers and families.

17. A Palliative and End of Life Care Social Work Awareness Project has commenced which aims to promote and develop awareness and to establish improved pathways for service users.

18. A new equipment demonstration centre has recently opened in Spennymoor for people who have difficulty carrying out day to day activities due to illness or disability. A range of products are on display to show some of the equipment and adaptations that are available to make everyday life easier, including walking frames, perching stools, stairlift, bathlift, telecare equipment and specialist sensory support products.

19. In April 2015 the Council contracted with G4S for the delivery of social care into County Durham Prisons. Demand for prison social care assessments since 1st April, 2015 has not been as high as expected. As at 14th July 2015 there have been twelve assessments, resulting in seven people needing ongoing care and support and one person's need being met by the provision of equipment.

20. The County Durham Information Strategy 2014-16 supports delivery of the Care Act as well as enhancing our existing information service. The key outcome of this strategy is that people, including those who are most vulnerable, who want information about adult care and support, will know what is available and where to find it easily, in formats that work and make sense to them and that the information requirements within the Act are met.

21. New ways for people to contact the Council, through a comprehensive E-marketplace system have been developed. The Council's new website Locate - care and support in County Durham went live in April, 2015 and a publicity campaign began in September 2015. Locate provides a central point for all

information about adult care and support and the services available empowering people to make informed decisions about their own needs.

22. The Care Act 2014 places adult safeguarding on a statutory footing and requires the local authority to make enquiries, or cause others to do so, if it believes an adult is experiencing or is at risk of abuse or neglect.

23. County Durham Local Safeguarding Adults Board (LSAB) recognises the need to provide a proportionate response to all safeguarding concerns and has agreed that in County Durham the multi-agency process previously known as "safeguarding" will now be called "adult protection".

24. For the first time, carers are recognised in the law in the same way as those they care for. Carer's procedures and operating processes have been reviewed and revised along with links to carers centres. Work has been undertaken on the implications for practitioners in relation to the Care Act including carers assessments and support.

25. The transition service has reviewed its existing arrangements and by 1st April 2016 a countywide provision for 14-25 year olds serving disabled children and young people and their carers will be in place.

26. A policy for the deferred payments scheme (DPS) has been agreed. From April 2015 Council's no longer have the power to put a legal charge on a property for people entering residential care, unless the service user signs up to a deferred payment agreement (DPA). A deferred payment must be offered to people who meet the eligibility criteria and are able to supply adequate security for the debt.

Implications and Challenges

27. To date the transformation programme within Adult Care Services has led to a number of service improvements and efficiencies as follows:
    - Partnership working with NHS colleagues has resulted in the service successfully improving performance in supporting people from requiring long-term care. The number of beds commissioned for residential/nursing care has reduced by 6.6% (between March 2013 and June 2015) and the number of service users requiring long term care packages has reduced by 5.8% since March 2013.

28 However, the service is aware of the challenges which remain including:
- increasing access and take up of Direct Payments.
- consistent and effective application of eligibility criteria.
- increases in the 65+ and 85 and over populations, 24.1% (101,500 people) and 36.5% (11,200 people) respectively between 2001 and 2014
- developing a more outcomes focussed approach both in terms of commissioning services and to achieve improved outcomes for people in need of care and support and

Phase 2 Reforms including Cap on Care Costs and Appeals System

29. In response to concerns expressed by the Local Government Association and many other stakeholders about the timetable for implementing the cap on care costs in April 2016, together with the impact on public sector spending and uncertainties in developing a private insurance market, the Government announced on 17th July, 2015 that it had decided to delay its implementation until April 2020.

30. The Government instead, will continue with other efforts to support social care, in particular through the Better Care Fund, to drive the integration of social care and the NHS going forward.

Regional Context

31. Regional links are well established and have helped support co-operation, collaboration and sharing of knowledge in relation to Care Act implementation. In summary work is ongoing as follows:
    - regional work programme 2015/16 in place covering the priorities of the 2015 reforms
    - e-learning package rolled out across all twelve North East Councils, based on Skills for Care material for generic training needs provided by ME Learning and facilitated through ADASS
    - Launch of Transforming Care a programme designed to improve care and support for people with learning disabilities and/or autism, and behaviour that challenges, A progress report on next steps and a six month progress report by the Transforming Care and Commissioning Steering Group, were published in July 2015.
    - Publication of practice guidance and advice by the Carers' Network and other organisations supplementing statutory guidance and covering Investment in Carers and whole family approaches
    - A new forum has been set up to discuss the challenges facing commissioners and providers of preventative services. It's a new feature on the Prevention Library, run by SCIE.
    - New guidance produced following extensive input from councils and providers, which aims to help directors of adult social services and commissioners assess the sustainability of their local care markets and the providers within them in order to promote and maintain the wellbeing of their local populations.
    - Regional resources have been used to produce a resource for independent financial information that can be used by LA's across the region

National Policy Context

32. Since the last report a number of key national policies have been announced, relating to adult social care services.

33. Published on 23 October 2014 the NHS Five Year Forward View sets out a vision for the future of the NHS, and details how through improvements to quality

of care, staff productivity, and better procurement and with additional funding confirmed in the Budget 2015, the NHS will deliver £22 billion in efficiency savings by 2020-21. For local authorities the Government advocates:

- models of joint commissioning between the NHS and local government, including Integrated Personal Commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. care plans and voluntary sector advocacy and support.
- Better Care Fund-style pooling budgets for specific services.
- under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards.

34. In January 2015, the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme, one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.

35. In March, the first wave of 29 vanguard sites was chosen and in July, a second wave of eight vanguards was announced. Durham were successful as part of the North East Urgent Care Network (NEUCN) which also covers areas around Northumberland, Tees, Esk and Wear Valley, Newcastle, Northumbria, Gateshead, Tyneside, Sunderland, Darlington and Hartlepool

36. The eight new vanguards will spearhead this work and, will benefit from a programme of support and investment from the £200m transformation fund. Six vanguards will cover smaller local systems which may include hospitals and surrounding GP practices and social care, while two network vanguards will be working with much larger populations to integrate care on a greater scale.

37. The **NHS Bodies and Local Authorities Partnership Arrangements (Amendment) Regulations 2015 Consultation** proposed changes include widening the potential scope of pooled budgets to include funding for primary medical care and pave the way for greater integration across community health, social care and primary care.

38. **Making it better together: A call to action on the future of health and wellbeing boards (30th June 2015)** launched by the LGA and NHS Clinical Commissioners is an ambitious call to action and a set of proposals to local system leaders and the Government to strengthen the impact and leadership of health and wellbeing boards across the country. Proposals include:

- A national five-year funding settlement across health and care.
- A national strategy for coordinated workforce planning and integrated workforce development across health, public health and social care
- A single national outcomes framework for health, public health and social care enabling HWBs to determine their priorities locally.
- An integrated, proportionate, place-based commissioning framework which supports accountability.

Next Steps

39. Consideration will be given as to how the announcement by the government to delay the implementation of the cap on care costs and appeals system until April 2020 will be communicated to stakeholders and the public and the impact on the delivery of the Social Care Reform programme.

40. Further redesign and improve the delivery of Adult Social Care Services.

41. Building on the use of new technology to allow more flexibility and responsiveness in the delivery of services to clients.

42. Ensuring the duties of prevention and wellbeing run through the whole service system from information and advice to Social Care Direct through to the specialist teams.

43. Future national policies and developments will be implemented as and when required.

44 The Social Care Reform Project Board having monitored the successful implementation of the Phase 1 Care Act reforms is to be suspended, until such time as the financial reforms and appeals system are reintroduced.

Recommendations

45. The Adults, Wellbeing and Health Overview and Scrutiny Committee is recommended to:
    - Note the content of this report.
    - Agree to receive further updates in relation to Adult Social Care transformation.

Contact: Paul Copeland, Strategic Programme Manager – Care Act Implementation and Integration Tel. 03000 256190

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.

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 social care services and the protection of adults remains robust and the system is not de-stabalised during transition.

Equality and Diversity / **Public Sector Equality Duty –** None

Accommodation – None at this stage, although modern ways of working may impact on accommodation requirements in due course.

Crime and Disorder – The local authority has responsibility for the care and support needs of people in prisons and approved premises, with effect from 1st April 2015.

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 Adult Care Transformation agenda in County Durham. All changes must be compliant with the Care Act.

Adults, Wellbeing and Health Overview and Scrutiny Committee

9 October 2015

Quarter 1 2015/16 Performance Management Report

Report of Corporate Management Team
Lorraine O'Donnell, Assistant Chief Executive
Councillor Simon Henig, Leader

Purpose of the Report

1. To present progress against the council's corporate basket of performance indicators (PIs), Council Plan and service plan actions and report other performance issues for the Altogether Healthier theme for the first quarter of the 2015/16 financial year, covering the period April to June 2015.

Background

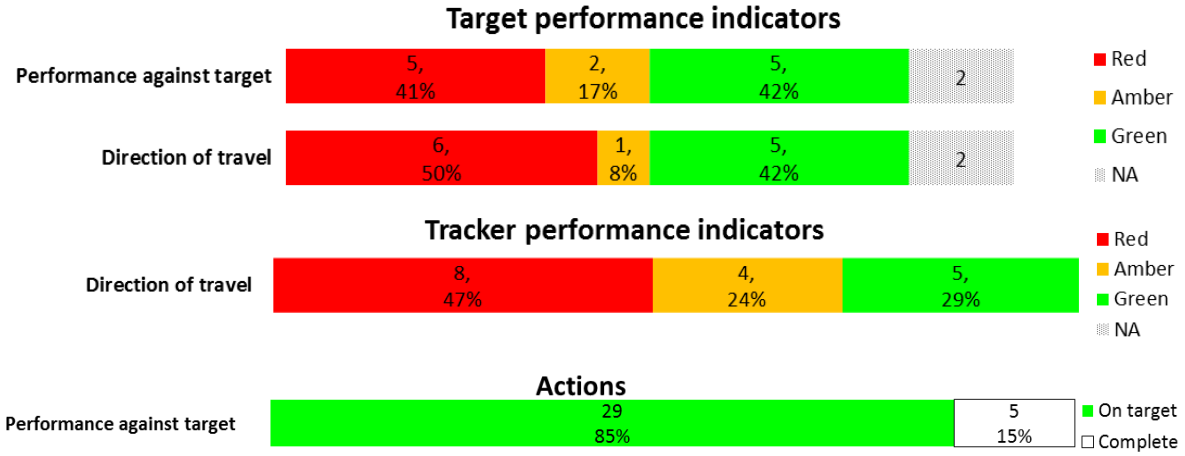
2. The report sets out an overview of performance and progress by Altogether priority theme. Key performance indicator progress is reported against two indicator types which comprise of:

    a. Key target indicators – targets are set for indicators where improvements can be measured regularly and where improvement can be actively influenced by the council and its partners (see Appendix 3, table 1); and
    b. Key tracker indicators – performance will be tracked but no targets are set for indicators which are long-term and/or which the council and its partners only partially influence (see Appendix 3, table 2).

3. The report continues to incorporate a stronger focus on volume measures in our performance framework. This allows us to better quantify productivity and to monitor the effects of reductions in resources and changes in volume of activity. Charts detailing some of the key volume measures which form part of the council's corporate set of performance indicators are presented in Appendix 4.

4. The corporate performance indicator guide has been updated to provide full details of indicator definitions and data sources for the 2015/16 corporate indicator set. This is available to view either internally from the intranet (at Councillors useful links) or can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

Altogether Healthier: Overview



Council Performance

5. Key achievements this quarter include:

   a. During the period April to May 2015, 91.2% of adult social care service users reported that the help and support they received made their quality of life better. This is exceeding the 2015/16 target of 90% but has reduced from 94.3% in the same period last year.

   b. Between January and March 2015, 599 older people received a reablement service following their discharge from hospital. Of these, 519 remained living independently in their own home 91 days after their discharge. This equates to 86.6%, which is exceeding the 2015/16 target of 85.7% but is slightly below performance in the same period last year (87.9%). Performance is above the 2013/14 statistical neighbour (85.3%) and England (82.5%) averages but is slightly below the North East average (87.2%).

   c. Of the 1,201 people in alcohol treatment between April 2014 and March 2015, 456 successfully completed. This equates to a 38% successful completion rate, which is an increase from 34.8% in 2013/14 and has exceeded the 2014/15 target of 36.6%. Performance is slightly below the 2014/15 national outturn of 39.2%.

   d. Tracker indicators show:

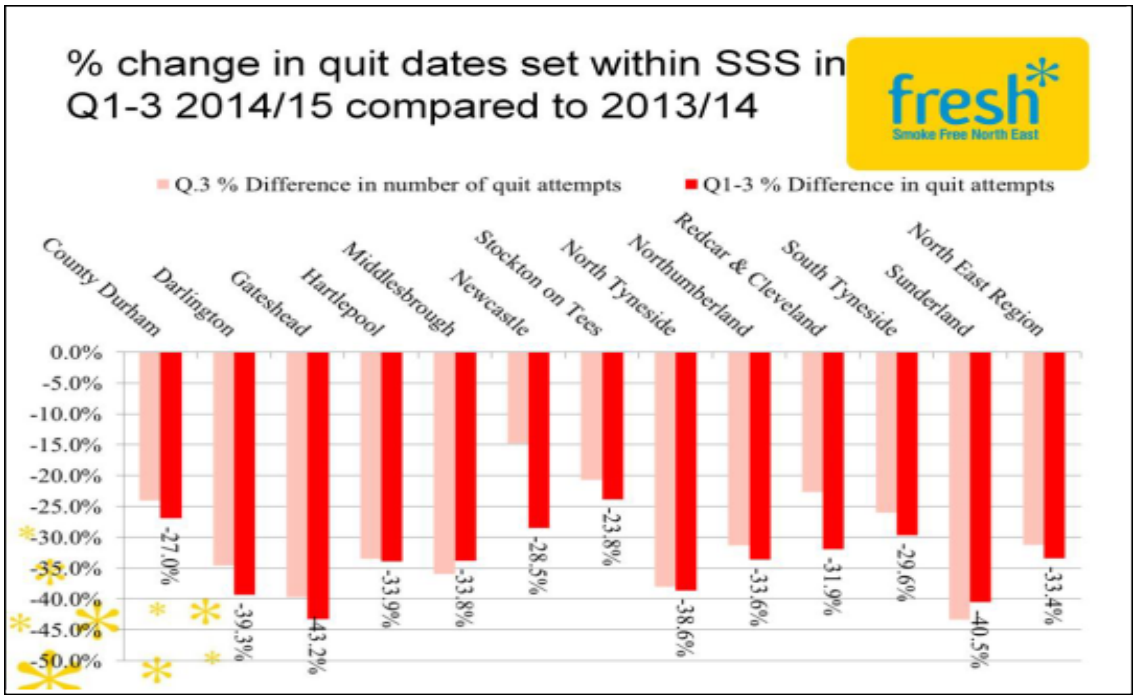
      i. In the two snapshot periods in April and May 2015 there were 37 delayed transfers of care which equates to a rate of 4.5 delays per 100,000 population. This is an improvement from 6.4 delays per 100,000 in the same period last year and is better than the 2013/14 England (7.9), regional (8.1) and 2014/15 statistical neighbour (11.2) averages.

      ii. There were nine delays which were attributable to social care, a rate of 1.08 delays per 100,000 population per day. This is better than the 2013/14 England (3.1), regional (2.0) and 2014/15 statistical neighbour (3.7) averages.

6. Underlying health issues continue to be a challenge in terms of differences in life expectancy and prevalence of a range of health conditions from the national picture. We monitor a number of health indicators across our corporate indicator set and updated annual data will be reported in subsequent quarters.

7. The key performance improvement issues for this theme from data released this quarter are:

   a. Latest provisional figures show that there were 3,068 smoking quitters through the Stop Smoking Service (SSS) during 2014/15, which equates to a rate of 717.5 per 100,000 population. This is below the target of 1,126 per 100,000 (4,813 quitters) and is less than 971 per 100,000 (4,134 quitters) during 2013/14. All stop smoking services (national and regional) have seen a drop in access over the past two years. Regional data available for quarter one to three 2014/15 shows the drop in access in County Durham is the second lowest of all regional stop smoking services (see graph below). Smoking has been identified as being responsible for one in five of all deaths in adults aged 35 and over. This is more than all deaths caused by alcohol, car accidents, suicide, AIDS, murder and illegal drugs combined.



   The SSS has developed a plan to increase uptake in 2015/16 including:

   - Increased marketing of services to key target groups
   - Marketing services to attract e-cigarette users e.g. e-cigarette friendly services
   - Undertaking a review of clients who initially access stop smoking services but subsequently disengaged within a four week period

   The contract for the SSS ceases in March 2016. Public health are currently undertaking a full service review of the SSS in preparation for tendering out the service in 2016/17 onwards.

b. In 2014/15, 7.4% of eligible people in County Durham (12,137 of 163,364) received an NHS health check, which did not achieve the target of 8% and is a reduction from 10.3% in 2013/14. Performance is below regional (8.3%) and national (9.6%) averages. It is important to note that the focus of health checks in County Durham was changed for 2014/15, from a universal to a targeted service aimed at those people with a high prevalence of cardiovascular disease (CVD) risk factors. The contract with GPs for the provision of health checks for 2015/16 was issued to providers on 29 May 2015 and performance against the contract will be monitored by the Public Health lead.

c. For the period April to June 2015, 186 older people were admitted to permanent residential or nursing care. This equates to 178.5 per 100,000 population and has not achieved the quarter one target of 149 per 100,000. This is also higher than the same period in 2014/15 when there were 158 admissions (a rate of 163.6 per 100,000 population). Factors which have contributed to an increased number of permanent admissions include:

- Increased pressures on the wider health community in County Durham, with older people a particularly vulnerable group. There has been a 6.1% increase in presentations to Accident and Emergency during April and May 2015 compared to the same period of 2014.
- Increasing complexity of cases, with an additional 19 admissions to specialist dementia beds between April and June 2015 when compared to the same period in 2014.

Robust panels operate to ensure that only those in most need, who can no longer be cared for within their own home, are admitted to permanent care. Permanent admissions are not all funded by the council as some will be self-funded and some may receive non- council financial support. The total number of bed days purchased by the council between April and June 2015 decreased by 4.1% (9,689 bed days) from 238,557 at the same period last year (April to June 2014) to 228,868 this year.

d. The number of people in drug treatment for opiate use between October 2013 and September 2014 was 1,454, of which 103 successfully completed, i.e. they did not re-present between October 2014 and March 2015. This equates to a 7.1% successful completion rate, which is below the target of 7.9% and national performance of 7.6% but an increase in performance from the same period in the previous year (6.1%). Following a procurement exercise in 2014/15, Durham County Council awarded the contract for an integrated drug and alcohol treatment service for adults and young people to Lifeline Project Ltd. A performance management framework has been developed with LifeLine.

e. There are no Council Plan actions which have not achieved target in this theme.

8. There are no key risks which require any mitigating action in delivering the objectives of this theme.

Recommendation and Reasons

9. That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising there from.

Contact:	**Jenny Haworth, Head of Planning and Performance**
Tel:	**03000 268071** **E-Mail** jenny.haworth@durham.gov.uk

Appendix 1: Implications

Finance - Latest performance information is being used to inform corporate, service and financial planning.

Staffing - Performance against a number of relevant corporate health PIs has been included to monitor staffing issues.

Risk - Reporting of significant risks and their interaction with performance is integrated into the quarterly monitoring report.

Equality and Diversity / Public Sector Equality Duty - Corporate health PIs are monitored as part of the performance monitoring process.

Accommodation - Not applicable

Crime and Disorder - A number of PIs and key actions relating to crime and disorder are continually monitored in partnership with Durham Constabulary.

Human Rights - Not applicable

Consultation - Not applicable

Procurement - Not applicable

Disability Issues - Employees with a disability are monitored as part of the performance monitoring process.

Legal Implications - Not applicable

Appendix 2: Key to symbols used within the report

Where icons appear in this report, they have been applied to the most recently available information.

Performance Indicators:

Direction of travel		Performance against target
Latest reported data have improved from comparable period	GREEN	Performance better than target
Latest reported data remain in line with comparable period	AMBER	Getting there - performance approaching target (within 2%)
Latest reported data have deteriorated from comparable period	RED	Performance >2% behind target

Actions:

WHITE	Complete (Action achieved by deadline/achieved ahead of deadline)
GREEN	Action on track to be achieved by the deadline
RED	Action not achieved by the deadline/unlikely to be achieved by the deadline

Benchmarking:

GREEN	Performance better than other authorities based on latest benchmarking information available
AMBER	Performance in line with other authorities based on latest benchmarking information available
RED	Performance worse than other authorities based on latest benchmarking information available

Appendix 3: Summary of Key Performance Indicators

Table 1: Key Target Indicators

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier											
24	CASAH2	Percentage of eligible people who receive an NHS health check	7.4	2014/15	8.0	RED	10.3	RED	9.6 RED	8.25* RED	2014/15
25	CASAH3	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period	Definition under develop ment	NA	NA	NA	NA	NA			
26	CASAH10	Percentage of women eligible for breast screening who were screened adequately within a specified period	77.9	2014	70.0	GREEN	78.6	AMBER	75.9 GREEN	77.1* GREEN	2014
27	CASAH4	Percentage of women eligible for cervical screening who were screened adequately within a specified period	78.0	2014	80.0	RED	77.7	GREEN	74.2 GREEN	76.1* GREEN	2014
28	CASAS23	Percentage of successful completions of those in alcohol treatment **(Also in Altogether Safer)**	38.0	2014/15	36.6	GREEN	34.8	GREEN	39.2 RED		2014/15
29	CASAS7	Percentage of successful completions of those in drug treatment - opiates **(Also in Altogether Safer)**	7.1	Oct 2013 - Sep 2014 (Re-presen tations to Mar 2015)	7.9	RED	6.1	GREEN	7.6 RED		Oct 2013 - Sep 2014

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
30	CASAS8	Percentage of successful completions of those in drug treatment - non-opiates **(Also in Altogether Safer)**	40.1	Oct 2013 - Sep 2014 (Re-presentations to Mar 2015)	40.4	AMBER	34.2	GREEN	39.0 GREEN		Oct 2013 - Sep 2014
31	CASCYP8	Percentage of mothers smoking at time of delivery **(Also in Altogether Better for Children and Young People)**	19.0	2014/15	20.5	GREEN	19.9	GREEN	11.4 RED	19.9* GREEN	2014/15 (NE - Durham, Darlington and Tees area team)
32	CASAH1	Four week smoking quitters per 100,000 smoking population	718	2014/15	1,126	RED	971	RED	688 GREEN	932* RED	2013/14
33	CASAH11	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	178.5	Apr - Jun 2015	149.0	RED	163.6	RED			
34	CASAH12	Percentage of adult social care service users that receive self-directed support such as a direct payment or personal budget	89.9	As at Jun 2015	90.0	AMBER	New definition	NA [1]			
35	CASAH13	Percentage of service users reporting that the help and support they receive has made their quality of life better	91.2	Apr - May 2015	90.0	GREEN	94.3	RED	90.0 GREEN	91* GREEN	2013/14
36	CASAH14	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	86.6	Apr - Jun 2015	85.7	GREEN	87.9	RED	82.5 GREEN	85.3** GREEN	2013/14

Ref	PI ref	Description	Latest data	Period covered	Period target	Current performance to target	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
37	CASAH24	Percentage of people who use services who have as much social contact as they want with people they like	48.9	2014/15 (provisional)	Not set	NA	51.0	RED	44.5 GREEN	48.6* GREEN	2013/14

[1] Due to changes to the definition data are not comparable/available

Table 2: Key Tracker Indicators

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
Altogether Healthier											
136	CAS CYP18	Percentage of children aged 4 to 5 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	23.8	2013/14 ac yr	21.9	RED	21.9	RED	22.5 RED	24.4* GREEN	2013/14 ac yr
137	CAS CYP19	Percentage of children aged 10 to 11 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	36.1	2013/14 ac yr	35.9	AMBER	35.9	AMBER	33.5 RED	36.1* AMBER	2013/14 ac yr
138	CAS CYP25	Prevalence of breastfeeding at 6 to 8 weeks from birth **(Also in Altogether Better for Children and Young People)**	28.9	2014/15	28.5	GREEN	28.5	GREEN	43.8 RED	27.6* GREEN	2014/15 (NE - Durham, Darlington and Tees area team)
139	CASAH 18	Male life expectancy at birth (years)	78.0	2011-13	77.9	GREEN	77.9	GREEN	79.4 RED	78* AMBER	2011-13
140	CASAH 19	Female life expectancy at birth (years)	81.3	2011-13	81.5	AMBER	81.5	AMBER	83.1 RED	81.7* RED	2011-13
141	CASAH6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population	88.8	2011-13	91.3	GREEN	91.3	GREEN	78.2 RED	88.9* GREEN	2011-13
		Under 75 mortality rate	166.6	2011-13	164.2	AMBER	164.2	AMBER	144.4	169.5*	2011-13

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
		from cancer per 100,000 population							RED	GREEN	
143	CASAH9	Under 75 mortality rate from respiratory disease per 100,000 population	43.4	2011-13	40.1	RED	40.1	RED	33.2 RED	42.6* RED	2011-13
144	CASAH8	Under 75 mortality rate from liver disease per 100,000 population	21.9	2011-13	21.7	RED	21.7	RED	17.9 RED	22.3* GREEN	2011-13
145	CASAH 23	Percentage of registered GP patients aged 17 and over with a diagnosis of diabetes	6.9	2013/14	6.77	RED	6.77	RED	6.2 RED	6.5* RED	2013/14
146	CASAH 20	Excess winter deaths (%) (3 year pooled)	19.0	2010-13	16.8	RED	16.8	RED	17.4 RED	16* RED	2010-13
147	CASAH 22	Estimated smoking prevalence of persons aged 18 and over	22.7	2013	22.2	RED	22.2	RED	18.4 RED	22.3* RED	2013
148	CASAH 25	Number of residential/ nursing care bed days for people aged 65 and over commissioned by Durham County Council	228,868	Apr - Jun 2015	229,737	GREEN	238,557	GREEN			
149	CASAH 20i	Delayed transfers of care from hospital per 100,000 population	4.5	Apr - May 2015	7.7	GREEN	6.4	GREEN	7.9 GREEN	8.1* GREEN	2013/14
150	CASAH 20ii	Delayed transfers of care from hospital, which are attributable to adult social care, per 100,000 population	1.1	Apr - May 2015	1.5	GREEN	1.0	AMBER	3.1 GREEN	2* GREEN	2013/14
151	CASAH	Suicide rate (deaths from suicide and injury of undetermined intent) per	13.4	2011-13	11.3	RED	11.3	RED	8.8	10.6*	2011-13

Ref	PI ref	Description	Latest data	Period covered	Previous period data	Performance compared to previous period	Data 12 months earlier	Performance compared to 12 months earlier	National figure	*North East figure **Nearest statistical neighbour figure	Period covered
		100,000 population **(Also in Altogether Safer)**							RED	RED	
152	NS11	Percentage of the adult population (aged 16+) participating in at least 30 minutes sport and active recreation of at least moderate intensity on at least three days a week	24.9	Apr 2013 - Mar 2015	26.0	RED	28.2	RED			

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Adults Wellbeing and Health Overview and Scrutiny Committee

9 October 2015

Revenue and Capital Outturn 2014/15

Report of Paul Darby, Head of Finance (Financial Services)

Purpose of the Report

1. To provide the committee with details of the final budget outturn position for the CAS service grouping, highlighting major variances in comparison with the (revised) budget for the year, based on the position to the end of March 2015, as reported to Cabinet in July 2015. The report focuses on the Adults Wellbeing and Health services included in CAS.

Background

2. County Council approved the Revenue and Capital budgets for 2014/15 at its meeting on 26 February 2014. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

    - *CAS Revenue Budget - £252.133m (original £275.232m)*
    - *CAS Capital Programme – £46.894m (original £74.322m)*

3. The original CAS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

Reason For Adjustment	**£'000**
Original Budget	275,232
Transfers to other services	(909)
Purchase of annual leave reduction	(103)
Car mileage reduction	(89)
Use of (+)/contribution to Corporate reserves (-)	(15,523)
Use of (+)/contribution to reserves (-)	(6,475)
Revised Budget	**252,133**

4. The use of / (contribution) to reserves consists of:

Reserve	**£'000**
Corporate Demographics Reserve	(15,900)
Corporate other	377
Social Care Reserve	(4,830)
CPD Reserve	5
Special Reserve	23
Education Reserve	(1,262)
Public Health GRT Reserve	88
Public Health Assets Reserve	42
Public Health Redundancy Reserve	15
Secure Services Trading Reserve (R&M)	360
Tackling Troubled Families Reserve	(916)
Total	**(21,998)**

5. The summary financial statements contained in the report cover the financial year 2014/15 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the outturn;
- For the CAS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn

6. The CAS service **outturn was a cash limit under budget of £873k** against a revised budget of £252.133m. This compares with the quarter 3 forecast of a break-even position, after contributions to and from reserves in year. The cash limit outturn is net of a £15.15m contribution to the Demographics / Hyper Inflation Reserve to offset and delay MTFP pressures in future years.

7. The tables below show the revised annual budget, actual expenditure to 31 March 2015 and the variance at year end. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for CAS, and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	Outturn £000	Variance £000	Conts to/from Reserves / Items Outside Cash Limit £000	Cash Limit Variance £000
Employees	114,326	107,729	(6,597)	3,324	(3,273)
Premises	8,383	8,942	559	(1,122)	(563)
Transport	18,279	17,621	(658)	(11)	(669)
Supplies & Services	20,326	18,092	(2,234)	(1,655)	(3,889)
Third Party Payments	194,296	184,808	(9,488)	13	(9,475)
Transfer Payments	11,978	11,072	(906)	47	(859)
Central Support & Capital	49,661	33,605	(16,056)	29,409	13,353
Income	(165,116)	(171,396)	(6,280)	10,782	4,502
Total	**252,133**	**210,473**	**(41,660)**	**40,787**	**(873)**

Analysis by Head of Service Area

	Revised Annual Budget £000	Outturn £000	Variance £000	Conts to/from Reserves / Items Outside Cash Limit £000	Cash Limit Variance £000
Adult Care	137,856	132,166	(5,690)	(1,330)	(7,020)
Central/Other	(3,734)	8606	12,340	2,663	15,003
Commissioning	1,662	(2,410)	(4,072)	536	(3,536)
Planning & Service Strategy	11,342	10,131	(1,211)	96	(1,115)
Central Charges (CYPS)	6,375	2950	(3,424)	3,412	(13)
Childrens Services	59,817	52,908	(6,909)	3,662	(3,247)
Education	38,501	5,763	(32,739)	31,793	(945)
Public Health	314	359	45	(45)	0
	252,133	**210,473**	**(41,660)**	**40,787**	**(873)**

8. The table below provides a brief commentary of the cash limit variances against the revised budget, analysed by Head of Service for those areas which relate to the Adult's area of the service, which is of specific interest to the Adults Wellbeing and Health Overview and Scrutiny Committee. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£276k under budget on employees due mainly to early achievement of future MTFP savings £151k over budget on transport, supplies and services and other costs £583k over budget on care packages £893k net additional income in respect of fees and charges and CCG contributions to care	(435)
Ops Manager OP/PDSI Services	£544k under budget on employees, mainly in respect of early achievement of MTFP savings £219k under budget on transport costs, due mainly to a reduction in day care activity linked to early achievement of MTFP savings £23k under budget on supplies and services and other costs £5,115k under budget on care activity due to consistent application of existing eligibility criteria £473k under achievement of income, mainly from fees and charges in respect of reduced care activity	(5,428)
Ops Manager Provider Services	£311k under budget on employee costs due mainly to early achievement of future MTFP savings, offset by timing issues linked to residential homes closures £225k under spend on premises, mainly in respect of early achievement of MTFP savings £73k under budget re transport costs £369k under budget on supplies and services and other costs, mainly in respect of early achievement of MTFP savings	(978)
Safeguarding Adults and Pract.Dev.	£86k under budget on employee costs re vacant posts £93k net under budget re supplies and services/other costs	(179)
		(7,020)
Central/Other		
Central Charges / Other	£32k under budget on employees due mainly to early achievement of MTFP savings £119k over budget on premises/supplies and services/other £15,150k contribution to the demographic/hyperinflationary pressures reserve £234k over achievement of income mainly in respect of accommodation recharges and procurement rebates	15,003
		15,003

Service Area	Description	Cash limit Variance £000
Commissioning		
Adult Care / Other	£157k over budget on employees £180k under budget on car mileage and transport for service users £218k under budget on supplies and services / other £3,001k under budget on agency and contracted services/transfer payments, mainly in respect of under spends on non-assessed services/one-off funds £169k net over achievement on income	(3,411)
Financial Services	£76k under budget on employees due to vacant posts £27k under budget on transport, mainly in respect of a new assessment process £13k over budget on supplies and services £35k additional income mainly in respect of financial protection	(125)
		(3,536)
Planning & Service Strategy		
Performance & Information Mgt	£71k under budget on employees due mainly to early achievement of MTFP savings £2k over budget on transport £21k under budget on supplies and services £9k under achievement of income	(81)
Policy Planning & Partnerships	£42k under budget on employees due mainly to early achievement of MTFP savings £29k under budget on supplies and services/other	(71)
PSS Management	£19k under budget on supplies and services/other re early achievement of MTFP savings	(19)
Service Quality & Development	£96k under budget on employees mainly re early achievement of MTFP savings £411k under budget on supplies and services/other	(507)
Service Support	£179k under budget on employees mainly re early achievement of MTFP savings £258k under budget on supplies and services/other budgets	(437)
		(1,115)
Public Health		
Cancer Awareness/ Physical Activity Adults /GRT	Expenditure on Gypsy Romany Travellers and Pharmacy Advice is £42k lower than the £430k budget due to delays in recruitment of provider organisations. Social marketing also spent £19k less than the £80k budget. Managers agreed additional non recurrent investment in Cancer Awareness services of £342k.	281
Capacity Building/Health Trainers	Managers agreed additional non recurrent investment of £918k in a number of service areas, including older people, health trainers, 20mph zones and assistance with patient transport. Expenditure on the Workplace Health contract was £77k lower than the £100k budget available due to extended contract negotiations.	841

Service Area	Description	Cash limit Variance £000
Health Checks/Smoking Cessation	Health Checks and Smoking Cessation spent £862k less than the £4.17m budget available, due to lower than anticipated activity, the majority of which was on smoking cessation services.	(862)
Oral Health and Services to Children	There was an additional non recurrent investment of £830k in One Point services for wider determinants of Public Health. Services to Children spent £221k less than the budget available due to delays in recruitment of provider organisations.	609
Public Health Grant and Reserves	Actual transfers from the Earmarked Reserve were £62k lower than the planned £150k budget due to the delays in Health Visitor recruitment for the GRT contract.	(62)
Public Health Specialist Training Prog (HENE)	Income of £35k received in 14-15 from the Health Education North East Training body was transferred to the Earmarked Reserve leaving a nil variance against this budget.	-
Public Health Team	A small number of vacant posts within the Public Health Team lead to expenditure of £122k less than the £1.4m budget available. This was offset by £158k for support staff redundancies funded by Public Health.	36
Safer Stronger Communities	£21k less than the £40k budget available due to delays in contract start dates.	(21)
Sex Health/Alc/Subs Misuse/Domestic Vlnce/Mental Hlth	Sexual Health services spent £169k less than the £5.4m budget available, mainly due to lower than anticipated activity on out of area services. Drug and Alcohol services spent £553k less than the £10m budget available, due to lower than expected activity and recharges from NHS Property services. Mental Health and Domestic violence services spent £100k less than the £2.8m budget due to delays in commencement of new contracts.	(822)
		(-)

9. In summary, the service has maintained spending within its cash limit. The outturn position incorporates the MTFP savings built into the 2014/15 budgets, which for CAS in total amount to £12.430m.

Capital Programme

10. The CAS capital programme was revised earlier in the year to take into account budget reprofiled from 2013/14 following the final accounts for that year. This increased the 2014/15 original budget. Further reports during the year to MOWG have detailed further revisions to the CAS capital programme, adjusting the base for grant additions/ reductions, budget transfers and budget profiling into later years. The revised capital budget currently totals **£46.894m.**

11. Summary financial performance to the end of March is shown below.

CAS - Service Area	2014-15 Budget	Actual Expenditure (to 31 March 2015)	2014/15 Remaining Budget
	£000	£000	£000
Adult Care	62	-	(62)
Commissioning	101	121	20
Childrens Care	71	14	(57)
Early Intervention & Involvement	-	(5)	(5)
Early Years	692	635	(57)
Free School Meals Support	1,126	1,067	(59)
Planning & Service Strategy	40	13	(27)
Public Health	469	233	(236)
SCP - LEP	23,379	22,786	(593)
School Devolved Capital	4,623	2,767	(1,856)
School Related	16,331	13,970	(2,361)
CAS Total	**46,894**	**41,601**	**(5,293)**
% Annual Budget Expended to 31 March		**88.7%**	

Recommendations:

21. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Members note the revenue and capital outturn included in the report, which are summarised in the outturn report to Cabinet in July.

Contact: Andrew Gilmore – Finance Manager Tel: 03000 263 497
Andrew Baldwin – Finance Manager Tel: 03000 263 490

Appendix 1: Implications

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital projected outturn position.

Staffing

There are no implications associated with this report. Any over or under spending against the employee budgets are disclosed within the report.

Risk

The management of risk is intrinsic to good budgetary control. This report forms an important part of the governance arrangements within CAS. Through routine / regular monitoring of budgets and continual re-forecasting to year end the service grouping can ensure that it manages its finances within the cash envelope allocated to it.

Equality and Diversity / Public Sector Equality Duty

There are no implications associated with this report.

Accommodation

There are no implications associated with this report.

Crime and Disorder

There are no implications associated with this report.

Human Rights

There are no implications associated with this report.

Consultation

There are no implications associated with this report.

Procurement

There are no implications associated with this report.

Disability Issues

There are no implications associated with this report.

Legal Implications

There are no implications associated with this report.

Adults Wellbeing and Health Overview and Scrutiny Committee

9 October 2015

Quarter 1: Forecast of Revenue and Capital Outturn 2015/16 – Children and Adult Services

Report of Paul Darby, Head of Finance (Financial Services)

Purpose of the Report

1. To provide the committee with details of the forecast outturn budget position for Children and Adult Services (CAS), highlighting major variances in comparison with the budget for the year, based on the position to the end of June 2015, as reported to Cabinet in July 2015. The report focuses on the Adults Wellbeing and Health services included in CAS.

Background

2. County Council approved the Revenue and Capital budgets for 2015/16 at its meeting on 25 February 2015. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

    - *CAS Revenue Budget - £251.484 (original £252.931)*
    - *CAS Capital Programme* – £50.723m *(original £45.453)*

3. The original CAS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

Reason For Adjustment	**£'000**
Original Budget	251,450
Transfers to other services	(61)
Energy Efficiency Reduction	(148)
Transfer From Contingency - Soulsbury Pay award	111
Contribution To Capital	(1,002)
Use of (+)/contribution to CAS reserves (-)	26
Use of (+)/contribution to Corporate reserves (ERVR) (-)	2,555
Revised Budget	**252,931**

4. The use of / contribution to CAS reserves consists of:

Reserve	**£'000**
Social Care	87
EBP	120
Emotional Wellbeing	(5)
Mental Health Counselling	18
Movement Difficulties Service	(13)
Re-Profiling Activity	(175)
SEND reform Grant	239
Swimming	(66)
Secure Services Capital	1,002
Tackling Troubled Families	281
Transformation	(1,528)
Remodelling of Health Improve Service	(300)
Accumulated fund CPD	366
Total	**26**

5. The summary financial statements contained in the report cover the financial year 2015/16 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the forecast outturn;
- For the CAS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn

6. The CAS service is reporting a cash limit under budget of £7.613m against a revised budget of £252.931m which represents a 3.0% under budget.

7. The tables below show the revised annual budget, actual expenditure to 30 June 2015 and the updated forecast of outturn to the year end, including the variance forecast at year end. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for CAS, and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Items Outside Cash Limit £000	Contribution To From Reserves £000	Cash Limit Variance £000
Employees	115,938	31,317	112,511	(3,427)	-	-	(3,427)
Premises	7,002	648	7,095	93	-	-	93
Transport	17,360	2,896	16,994	(366)	(76)	-	(442)
Supplies & Services	19,176	1,808	18,345	(831)	-	-	(831)
Third Party Payments	238,673	47,680	232,468	(6,205)	-	-	(6,205)
Transfer Payments	13,069	1,876	12,789	(280)	-	-	(280)
Central Support & Capital	64,389	2,471	65,018	629	-	-	629
Income	(222,677)	(79,746)	(219,827)	2,850	-	-	2,850
Total	252,930	8,950	245,393	(7,537)	(76)	-	(7,613)

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Items Outside Cash Limit £000	Contribution To From Reserves £000	Cash Limit Variance £000
Head of Adults	124,305	27,802	119,733	(4,572)	(9)	-	(4,581)
Central/Other	8,847	86	8,643	(204)	-	-	(204)
Commissioning inc Supporting People	10,141	(27,255)	8,416	(1,725)	(3)	-	(1,728)
Planning & Service Strategy	11,689	2,765	11,202	(487)	(4)	-	(491)
Central Charges (CYPS)	4,393	(2,204)	4,393	-	-	-	-
Childrens Services	53,156	14,655	53,414	258	(48)	-	210
Education	39,699	(2,845)	38,893	(806)	(13)	-	(819)
Public Health	701	(4,055)	701	-	-	-	-
Total	252,931	8,949	245,395	(7,536)	(77)	-	(7,613)

8. The table below provides a brief commentary of the forecast cash limit variances against the revised budget, analysed by Head of Service for those areas which relate to the Adult's area of the service, which is of specific interest to the Adults Wellbeing and Health Overview and Scrutiny Committee. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£116k under budget on employees through effective vacancy management. £35 net under budget on care provision. £21k over budget in respect of premises/transport/supplies and services	(130)
Safeguarding Adults and Pract.Dev.	£123k under budget on employee costs due to vacant posts. £97k projected over budget on supplies and services, mainly in respect of professional fees linked to Deprivation of Liberty cases. £14k net under budget on transport/other costs.	(40)
Ops Manager OP/PDSI Services	£536k under budget due to early achievement of employee-related MTFP savings. £2,849k net under budget on direct care-related activity. £164k under budget in respect of premises/transport/supplies and services costs.	(3,549)
Ops Manager Provider Services	£578k under budget on employees in respect of early achievement of future MTFP savings. £275k under budget on supplies and services in respect of early achievement of future MTFP savings. £9k net under budget on premises/transport/other costs.	(862)
		(4,581)
Central/Other		
Central/Other	£108k under budget on employee-related costs in respect of future MTFP savings. £36k under budget on premises/transport/other costs. £60k additional income mainly in respect of salary recharges.	(204)
		(204)
Commissioning		
Commissioning Management	Under budget mainly in respect of future MTFP savings, particularly agency and contracted services budgets held.	(1,630)
Financial Services	Mainly in respect of under budgets on employees, (£55k) due to effective vacancy management, and associated travel costs (£25k). £17k over budget on supplies and services. Additional income receivable of £35k.	(98)
		(1,728)

Service Area	Description	Cash limit Variance £000
Planning & Service Strategy		
Performance & Information Mgmt	£83k under budget on employees re future MTFP savings.	(83)
Policy Planning & Partnerships	£78k under budget on employees re future MTFP savings. £8k under budget on transport/supplies and services/other budgets. £24k under achievement of income.	(62)
Service Quality & Development	Future MTFP savings linked in the main to employees (£134k) and supplies and services (£88k). £7k under budget on other areas.	(229)
Service Support	£99k under budget on employees re future MTFP savings. £18k under budget on transport/supplies and services/other budgets.	(117)
		(491)
Public Health		
Cancer Awareness/ Physical Activity Adults /GRT	The variance relates to a non-recurrent planned investment in commissioned activity relating to cancer awareness and pharmacy advice.	96
Capacity Building/Health Trainers	Primarily related non recurrent activity connected with Patient transportation to GP and hospital appointments	158
Health Checks/Smoking Cessation	Forecast activity within the smoking cessation services is expected to generate expenditure £530k less the £2.6m budget available. This is partially offset by non-achievement of budgeted income (£158k) related to the Diabetes prevention programme and increased equipment costs (£36k)	(336)
Oral Health and Services to Children	Activity forecast in line with budget	-
Public Health Specialist Training Prog (HENE)	Activity forecast in line with budget	-
Public Health Team	Commissioning decisions related to c£2.6m budget are being held in abeyance pending final notification of the value of the Central Government imposed in year reduction in Public Health Grant. Employee's costs are projected to spend £220k less than current budget due to vacancies and secondment arrangements. Forecast in line with budget as any underspend achieved is likely to be required to finance in Year Government Imposed Funding Cut.	-
Sex Health/Alc/Subs Misuse/Domestic Vlnce/Mental Hlth	One-off non budgeted decommissioning costs related to redundant Drug and Alcohol Treatment centres (£124k) combined £126k investment in domestic abuse pilot is leading to forecast in year underspend.	252
		-

9. The following is a breakdown of items outside of the cash :

- Adjustment for delayed reduction in Car Mileage allowance rate 48p to 45p per mile - £76,434

10. In summary, the service is on track to maintain spending within its cash limit. The outturn position incorporates the MTFP savings built into the 2015/16 budgets, which for CAS in total amount to £8.590m.

Capital Programme

11. The CAS capital programme was revised earlier in the year to take into account budget reprofiled from 2014/15 following the final accounts for that year. This increased the 2015/16 original budget. Further reports to MOWG in May and July have detailed further revisions to the CAS capital programme, adjusting the base for grant additions/ reductions, budget transfers and budget reprofiling into later years. The revised capital budget currently totals **£50.723m.**

12. Summary financial performance to the end of June is shown below.

CAS -Service Area	2015-16 Total Budget	Actual Expenditure (30-6-15)	Remaining Budget
	£000	£000	£000
Adult Care	901	-	901
Commissioning	-	-	-
Social Inclusion	-	-	-
Childrens Care	58	2	56
Early Intervention and Involvement	-	2	(2)
Early Years	48	(7)	55
Free School Meals Support	190	70	120
Secure Services	1,002	21	981
Planning & Service Strategy	132	94	38
Public Health	1,396	36	1,360
School Devolved Capital	4,529	203	4,326
School Related	25,193	2,695	22,498
SCP - LEP	17,274	7,286	9,988
Total	50,723	10,402	40,321

Recommendations:

13. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Members note the financial forecasts included in the report, which are summarised in the Quarter 1 forecast of outturn report to Cabinet in July.

Contact: Andrew Gilmore – Finance Manager Tel: 03000 263 497
Andrew Baldwin – Finance Manager Tel: 03000 263 490

Appendix 1: Implications

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital projected outturn position.

Staffing

There are no implications associated with this report. Any over or under spending against the employee budgets are disclosed within the report.

Risk

The management of risk is intrinsic to good budgetary control. This report forms an important part of the governance arrangements within CAS. Through routine / regular monitoring of budgets and continual re-forecasting to year end the service grouping can ensure that it manages its finances within the cash envelope allocated to it.

Equality and Diversity / Public Sector Equality Duty

There are no implications associated with this report.

Accommodation

There are no implications associated with this report.

Crime and Disorder

There are no implications associated with this report.

Human Rights

There are no implications associated with this report.

Consultation

There are no implications associated with this report.

Procurement

There are no implications associated with this report.

Disability Issues

There are no implications associated with this report.

Legal Implications

There are no implications associated with this report.

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