Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Monday 4 July 2016**
Time	**9.30 am**
Venue	**Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 8 April 2016 and of the special meetings held on 27 April, 9 May and 24 May 2016 (Pages 1 - 22)
4. Declarations of Interest, if any
5. Any Items from Co-opted Members or Interested Parties
6. Media Issues
7. Care Quality Commission "Shaping the Future - CQC's strategy for 2016-2021" - Report of the Assistant Chief Executive and presentation by Amanda Stanford, Head of Inspection - North East and Cumbria, Care Quality Commission (Pages 23 - 46)
8. Director of Public Health Annual Report 2015/16 - Report of County Durham Director of Public Health presented by Gill O'Neill, Interim Director of Public Health, Durham County Council (Pages 47 - 108)
9. 2015/16 Quarter 4 Performance Management Report - Report of the Assistant Chief Executive, presented by Peter Appleton, Head of Quality and Service Strategy, Children and Adults Services (Pages 109 - 130)
10. Council Plan 2016/2019 - Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee - Report of Assistant Chief Executive (Pages 131 - 140)

11. 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
24 June 2016

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

Councillor J Robinson (Chairman)
Councillor J Blakey (Vice-Chairman)

Councillors J Armstrong, R Bell, P Brookes, J Chaplow, P Crathorne, S Forster, 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

Co-opted Employees/Officers:

Dr L Murthy, Healthwatch

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

DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in **Committee Room 2, County Hall, Durham** on **Friday 8 April 2016** at **9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, P Brookes, M Davinson, E Huntington, J Lindsay, P Stradling and O Temple

Co-opted Members:
Dr L Murthy

Also Present:
Councillor L Hovvels (Cabinet Portfolio Holder for Adult and Health Services)
Margaret Dent and Tony Cooke (representatives from the Rural Ambulance Monitoring Group)
Patrick Scott (Director of Operations, Durham and Darlington TEW NHS Trust)

1 Apologies for Absence

Apologies for absence were received from Councillors P Crathorne, S Forster, K Hopper, M Nicholls, L Pounder, A Savory, Mrs B Carr and Mrs R Hassoon.

2 Substitute Members

There were no substitute members in attendance.

3 Minutes

The minutes of the meeting held on 1 March 2016 were confirmed as a correct record and signed by the Chairman.

The following matters arising were reported.

With reference to item 6 of the minutes of 1 March, which detailed the concerns raised by Dr Murthy that a commission set up by the North East Combined Authority (NECA) to report on health and social care integration, excluded representation from the North East, the Principal Overview and Scrutiny Officer advised that he had contacted the NECA to express the Committee's concerns. A response had been received from Jane Robinson, Chief Executive of Gateshead MBC and project lead, who had given assurances that all local and regional stakeholders will be engaged including local Healthwatch organisations and that a series of listening events is planned.

She also gave a commitment to ongoing communication with stakeholders throughout the process which will identify further opportunities for engagement.

The Principal Overview and Scrutiny Officer informed members that the consultation on proposed changes by Durham Dales, Easington and Sedgefield CCG to urgent care services commenced on Monday 14 March and noted that confirmation had been received and circulated to the Committee in respect of the nine public engagement events that were to be held throughout the County.

4 Declarations of Interest

There were no declarations of interest.

5 Media Issues

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

- **Mental health service appoints new boss – Northern Echo 21 March 2016**
  Colin Martin has been appointed as the new Chief Executive of the Tees, Esk and Wear Valleys NHS Foundation Trust and he will take up the position on 1 May 2016.
- **North East Ambulance Service set for formal inspection – Northern Echo 23 March 2016**
  The Chief Inspector of Hospitals is to lead an inspection of the North East Ambulance Service NHS Foundation Trust starting on 18 April with report on its findings to be published by the Care Quality Commission later this year. The Principal Overview and Scrutiny officer advised that a there will be a submission from the Adults, Wellbeing and Health Overview and Scrutiny Committee.
- **Proposals for changes to urgent care in County Durham announced – Northern Echo 4 April 2016**
  Consultation regarding proposed changes to urgent care services commenced on Monday 14 March 2016.
- **Crippling pressure on NHS in North East has led to missed waiting time targets across the region – Evening Chronicle 19 March 2016**
  Every hospital trust in the North East region had missed their A&E waiting time targets in January, The weakest performer was County Durham where just 87.2% of patients waited less than four hours from arrival to admission, transfer or discharge, which is below the 95% expected standard.
- **Around the clock care for dying 'not good enough' – BBC News Website 31 March 2016**
  A national review of end of life care has found most hospitals are failing to provide face to face palliative care specialists around the clock. Only 16 out of 142 hospital sites in England offer specialists on site 24 hours a day.

Resolved:

1. That the contents of the presentation be noted.

6 Any Items from Co-opted Members or Interested Parties

Councillor Richard Bell referred to the Committee's previous discussions in respect of the availability of performance information from North East Ambulance Service (NEAS) and reported that the members of the Rural Ambulance Monitoring Group (RAMG) / DDES CCG Ambulance Patient Representatives Group had approached him to express their concern at the lack of NEAS monitoring data being made available, and, that the CCG meetings have now changed from quarterly meetings to one meeting every six months. He added that it is becoming difficult to hold NEAS to account in any meaningful way. Margaret Dent from the Rural Ambulance Monitoring Group added that the data had not been made available to them and that she had requested that this be rectified.

The Principal Overview and Scrutiny Officer reminded members that NEAS had given a commitment to provide performance information to the Committee and the RAMG when an agreed format had been endorsed by the Trust that adhered to Information Governance and Data Protection requirements. Performance information reports were received from NEAS on 18 February and 11 March and had been circulated to the Committee electronically. Mark Cotton, Assistant Director of Communications and Engagement, had confirmed by email that these reports were available on the NEAS website and he had provided a link to the site. The Principal Overview and Scrutiny Officer advised that he would highlight the concerns of the Committee on this matter with NEAS and indicated that he would share the link to the NEAS website with the RAMG members.

In response to the second point raised by Cllr Bell, the Principal Overview and Scrutiny Officer replied that whilst representatives from the Committee attended the Ambulance PRG meetings, they were part of the DDES CCG governance arrangements and a matter that this Committee had no control over.

The Committee agreed that an email should be sent to Mark expressing their concerns.

7 2015/16 Quarter 3 Performance Management Report

The Committee noted a report of the Assistant Chief Executive, presented by the Head of Planning and Service Strategy, Children and Adults Services, which presented progress against the Council's corporate basket of performance indicators for the Altogether Healthier theme and reported other significant performance issues for the third quarter of 2015/16 (for copy see file of Minutes).

The Head of Planning and Service Strategy highlighted the key achievements and provided analysis of the report. Information provided included that the Stop Smoking Service is on track to achieve the 2015/16 target and cancer screening rates are higher in County Durham than both regional and national rates. Referring to paragraph 5c of the report, the Head of Planning and Service Strategy commented that the reported delay of transfers from hospital to care are not necessarily attributable to a lack of availability of adult social care. It was reported that the percentage of mothers smoking at time of delivery has improved on the same period last year, and, the number of pregnant women setting a date to stop smoking has continued to rise.

On a less positive note, the number of people receiving NHS health checks is lower than the national and regional performance and this matter is being monitored by the Health and Wellbeing Board. The Head of Planning and Service Strategy commented that an area of particular concern is the deterioration in the number of successful completions from alcohol and drug treatment for opiates. Lyn Wilson, Consultant in Public Health, informed the Committee that that a new, single provider, is now in place and initial baseline work is being carried out prior to a performance plan being established. It is hoped that this will lead to improvements in quarter four.

Tracker indicators show childhood obesity has increased and it is worse than the national and regional averages and the report provided details on the action being taken to reduce this. The suicide rate for County Durham remains higher than the rate in England and the North East. The Chairman expressed his concerns at the increasing rate of suicides in men, in particular, adding that he was aware that reports that had been undertaken on suicides in men in the Consett / Stanley and Easington areas. The Head of Planning and Service Strategy suggested members may find the information contained in the Suicide Audit Report useful and he agreed to circulate the report to the Committee.

Referring to the Government's plans for a tax on sugary soft drinks, Councillor Armstrong remarked on whether the Government had any plans to introduce a similar levy on the sugar in alcoholic drinks.

Members discussed the low take-up of NHS health checks and Dr Murthy queried whether GPs should be offered incentives for every health check undertaken and that take-up of these checks may improve if the incentive was offered to the public. Members commented that this issue of payments to GPs should be investigated. Councillor Hovvels observed that many people have difficulty making appointments with their GP and this may be an obstacle to those wishing to arrange a health check. Councillor Hovvels suggested other avenues could be explored in order to encourage the public to arrange a health check, for example, it may be possible for these health checks to be provided through pharmacies, or, perhaps large groups of people could be targeted by offering checks at workplaces or community events such as football matches. Councillor Huntington pointed out that with the prospect of more urgent care walk-in establishments being closed, more opportunities for the public to access programmes like this are being lost. Councillor Temple commented that he was not aware of exactly who is being targeted for these health checks adding that he would like further information.

The Principal Overview and Scrutiny Officer advised that drug and alcohol treatment and childhood obesity are cross-cutting issues, with the lead Committee for drug and alcohol treatment being the Safer and Stronger Communities Overview and Scrutiny Committee, and, the Children and Young People's Overview and Scrutiny Committee leading on childhood obesity. Members agreed to suggest that the lead Committee should write to the Government to ask whether a tax on the sugar in alcoholic drinks would be considered.

Resolved:

1. That the report and performance issues identified therein be noted.

8 Forecast of Revenue Outturn Quarter 3, 2015/16

The Committee considered a report of the Head of Financial and Human Resource Services, presented by the Finance Manager for Corporate Resources. The report provided details of the updated forecast outturn position for the Children and Adults Services (CAS) service grouping, covering both revenue and capital budgets and highlighting major variances in comparison with the budget, based on spending to the end of December 2015. The Finance Manager delivered a presentation on the Revenue and Capital Outturn Forecast for Quarter 3, 2015/16 (for copy of report and slides see file of Minutes).

The Chairman thanked the Finance Manager for his presentation.

Resolved:

1. That the revenue and capital outturn projections, which form the basis of the budgetary control position reported corporately via Corporate Management Team and Cabinet, be noted.

9 NHS Foundation Trust 2015/16 Quality Accounts

The Committee noted a report of the Assistant Chief Executive which provided information on the proposed process for preparation of the 2015/16 Quality Accounts for:

- County Durham and Darlington NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust

(for copy see file of Minutes).

The Principal Overview and Scrutiny Officer informed the Committee that the draft Quality Accounts are likely to be received during the week commencing 11 April 2016. It was proposed that a special meeting of the Committee be held on 27 April to receive presentations from the Trusts' representatives. A draft formal response will then be considered at a further special meeting of the Committee on 9 May to enable responses to be submitted to the Foundation Trusts within the statutory deadline.

Resolved:

1. That the report and that the process for producing a response to the NHS Foundation Trust Draft Quality Accounts 2015/16 be received and noted.

2. That the new Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust be invited to the Special Meeting of the Committee on 9 May.

10 Council Plan 2016/2019 - Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee

The Committee considered a report of the Assistant Chief Executive which provided information contained within the Council Plan 2016-2019, relevant to the work of the Adults, Wellbeing and Health Overview and Scrutiny Committee, which enabled members to refresh the Committee Work Programme to reflect the four objectives and actions within the Council Plan for the Council's Altogether Healthier priority theme (for copy see file of Minutes).

The Principal Scrutiny Officer presented the report and drew members' attention to the current work programme of the Committee and the cross cutting areas covered across the Children and Young People and Safer and Stronger Communities Overview and Scrutiny Committees. Members were advised that the work programme for 2016-17 would be brought back to the Committee in June further to any discussions and feedback from this meeting.

Members commented that it would be useful to add GP funding and health checks to the programme bearing in mind that timescales and statutory duties also need to be factored in. Cllr Temple suggested the inclusion of a piece of work on the increasing rate of suicide in the County and it was suggested that this may be best undertaken by a small working group. The Head of Planning and Service Strategy agreed that it would be timely to undertake some work on this issue, linking with the wider mental health issues. The Principal Overview and Scrutiny Officer pointed out that the Children and Young Peoples Overview and Scrutiny Committee have carried out some work on self-harm in children, adding that duplication of work should be avoided.

Resolved:

1. That the information contained in the Altogether Healthier priority theme of the Council Plan 2016-2019, be noted.

2. That the comments from the Committee be reflected within the refresh of the Adults, Wellbeing and Health Overview and Scrutiny Committee work programme for 2016-2017.

3. That at its meeting on 30 June 2016, the Adults, Wellbeing and Health Committee receives a further report detailing the Committee's work programme for 2016-2017.

11 Any other business

The Principal Overview and Scrutiny Officer reported upon proposals by North Tees and Hartlepool NHS Foundation Trust to close their Assisted Reproductive Unit facility at University Hospital Hartlepool.

Hartlepool Borough Council's Audit and Governance Committee had met to consider the proposals and requested the Trust to engage in meaningful consultation in respect of the proposals.

The Trust subsequently has requested the constitution of a Joint Health Scrutiny Committee consisting of representatives of the Health Scrutiny Committees of Hartlepool Borough Council, Stockton on Tees Borough Council and Durham County Council to consider this matter.

On investigation, it was found that the closure would affect only a very small number of County Durham residents and these services were available within County Durham and Darlington NHS Foundation Trust and, as such, it was not considered to be a significant development or substantial variation of health service for County Durham under the terms of the Health and Social Care 2012 Act.

Accordingly, the Chair of the Adults Wellbeing and Health OSC had written to the Chair of Hartlepool Borough Council's Audit and Governance Committee with copies sent to North Tees and Hartlepool NHS Foundation Trust and their legal representatives stating that in view of the above, the Committee would decline the opportunity to participate in any joint Health Scrutiny Committee.

The Principal Overview and Scrutiny Officer reported that an application by Hartlepool Borough Council for Judicial Review of the Trust's original decision to close the ARU had been considered by the High Court and a consent order granted which stated that formal consultation upon the future of the ARU at University Hospital of Hartlepool be undertaken either individually with Hartlepool Borough Council or via a joint Health Scrutiny Committee consisting of Hartlepool Borough Council, Stockton on Tees Borough Council and Durham County Council.

In view of the aforementioned judgement, Hartlepool Borough Council and North Tees and Hartlepool NHS Foundation Trust had sought clarification on Durham County Council's position on this matter. The Chair sought endorsement of the Committee's previously declared position that in view of the fact that the closure would affect only a very small number of County Durham residents and these services were available within County Durham and Darlington NHS Foundation Trust, it was not considered to be a significant development or substantial variation of health service for County Durham under the terms of the Health and Social Care 2012 Act and the Committee would decline the opportunity to participate in any joint Health Scrutiny Committee arrangements on this matter.

Resolved:

1. The Committee endorsed the actions of the Chairman and confirmed its previously declared position.

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DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Wednesday 27 April 2016 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, P Crathorne, M Davinson, S Forster, K Hopper, E Huntington, J Lindsay, M Nicholls, A Savory and P Stradling

Co-opted Members:
Mrs R Hassoon and Dr L Murthy

1 Apologies

Apologies were received from Councillors R Bell, P Brookes, L Pounder and O Temple.

2 Substitute Members

There were no substitute members in attendance.

3 Declarations of Interest

There were no declarations of interest.

4 Any Items from Co-opted Members or Interested Parties

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

5 NHS Foundation Trust 2015/16 Quality Accounts

The Committee noted a report of the Assistant Chief Executive which provided information on the proposed process for preparation of the 2015/16 Quality Accounts for :-

- Tees, Esk and Wear Valleys NHS Foundation Trust
- North East Ambulance Service NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

The Committee received presentations from the following organisations, setting out their draft Quality Accounts priorities and inviting comment thereon (for copy of report and slides of all presentations see file of Minutes).

(i) Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

The Committee received a presentation from Sharon Pickering, Director of Planning and Performance, Tees, Esk and Wear Valleys NHS Trust, regarding their draft Quality Accounts for 2015/16.

The Chairman thanked Ms Pickering for her presentation and added his congratulations to the team on being recognised as the top Mental Health Trust.

Mrs R Hassoon raised a query regarding delays in discharging elderly patients and how the service ensured that patients were placed appropriately, upon discharge. In response S Pickering advised performance in this area varied with location. It was noted however that access to Care and Nursing Homes had often presented the Trust with challenges especially in more rural areas and this could lead to delays in discharge.

Regarding the CQC Mrs Hassoon further queried whether the 8 areas which had been reported as not performing well, had improved. S Pickering advised that some of the actions put in place by the CQC were a must with others being recommendations. Work, however was progressing well against those actions and recommendations and all were almost complete. She further advised the Trust would be setting up another round of self-inspection which would involve a 3 week programme of mock inspections. Results of which would be considered by the essential standards group.

Councillor Nicholls further added his congratulations to the team. Regarding the issue of falls, Councillor Nicholls asked what more could be done to determine where and how falls were taking place and how they could be better prevented. S Pickering advised that all patients suffering from a fall were inputted into a risk system which recorded in detail the level of harm caused to the patient and how that fall had occurred. This data was assessed and plans were put in place to reduce risk for that individual patient. This fall management plan had worked well and could be attributed to the reducing number of fall incidents.

Councillor Huntington noted that there had been a rise in unexpected deaths and asked whether any trends had been identified. In response S Pickering advised that in terms of mental health there were no identified trends, however nationally there had been a rise in those taking their own lives. The Trust would investigate each suicide case to determine whether anything in the patient's treatment had caused or contributed to the death. The service also relied upon sharing lessons learnt and ensuring that all staff were aware of the signs and prepared to act quickly to alert relevant persons or teams. In addition a regular bulletin was shared with staff which provided updates and information on this topic.

Further discussion ensued regarding suicide and monitoring vulnerable patients. S Pickering advised that patients receiving treatment for mental health illnesses received regular support via community teams or via crisis and home treatment. As part of these ongoing assessments the team would determine whether more intensive treatment or support was required and they could if felt appropriate, admit to a ward. It was noted however that it was important to ensure that patients did not become dependent upon the support offered from a hospital setting as this could prolong treatment/recovery.

Dr L Murthy added that he found the detail of the quality accounts very encouraging and congratulated the team. He further made reference to the smoke free campaign and added that although figures were included for in-patients, there was no data presented on staff smoking. In response S Pickering advised that the initiative had initially focused on in-patients however help had been put in place for staff smokers. A significant number of staff had been trained in smoking cessation however it was noted that there was no robust data available at this time.

A further query was raised regarding delays in issuing 44 Coroner verdicts and it was asked whether there was any update on this. S Pickering advised that although she had no further information to report, full detail would be included within the final report. She further added for clarification that patient deaths were investigated immediately, which meant in some cases before the coroner's verdict had been issued.

(ii) North East Ambulance Service NHS FT (NEAS)

The Committee received a presentation from Maureen Gordon, Head of Clinical and Patient Safety, North East Ambulance Service, regarding their draft Quality Accounts for 2015/16.

The Chairman thanked Ms Gordon for her presentation.

Councillor Forster asked whether counselling was available for ambulance staff as she was aware that this was an extremely stressful job. In response M Gordon advised that each station had access to an Emergency Care Leader who was responsible for their own staff and available for immediate support. In addition the Mind Blue Light campaign, which was specifically aimed at emergency service staff to consider about their own mental health, had been in place since 2015.

Councillor Forster also added that she wanted to congratulate the team on the services work with end of life patients.

Councillor Savoury added that although the priorities and performance data were encouraging, there was no data available relating to response times and asked that an update be provided. In response M Gordon advised that response times were a priority for the NEAS regardless of the clinical priorities as detailed within the report. Further discussion ensued regarding the topic and it was noted that early indications showed that April had seen a performance improvement in response times to emergency calls.

Dr L Murthy raised a point regarding handover times at accident and emergency and whether the NEAS were engaging with the Trust to improve turnaround times. M Gordon reported that NEAS were very aware of turnaround times and the issue was high on both the Trust and NEAS's agenda.

Dr Murthy further commented that it would be interesting to learn what impact stakeholder engagement had on outcomes and how effective any suggestions made had been. Ms M Gordon advised that collaborative work was extremely important, as was stakeholder input in setting the priorities for the coming year.

(iii) County Durham and Darlington NHS Foundation Trust (CDDFT)

The Committee received a presentation from Joanne Todd, Interim Director of Nursing, County Durham and Darlington NHS Foundation Trust, regarding their draft Quality Accounts for 2015/16.

The Chairman thanked Ms Todd for her presentation.

Mrs Hassoon raised a query regarding discharge letters being forwarded to GP's. Ms Todd advised that performance in this area had improved year on year, with letters being aimed to be sent electronically within 24 hours of discharge. Performance in relation to this area was at around 95%, however there was still an element of human error in producing and sending letters. Councillor Lindsay also commented that he would like to see the content of discharge letters written in plain english as often codes / clinical terminology were used and this could be confusing and unclear to many patients. It was noted that work was ongoing to align all systems by 2020 in order to allow easier access to patient information across all services.

Councillor Forster in referencing turnaround times at hospitals between ambulance and hospital staff asked whether it would be possible to have a handover area with dedicated staff. She further in referencing a recent personal experience asked why all patients attending A&E were required to have a cannula fitted.

Ms Todd thanked Councillor Forster for her suggestion acknowledging that it was indeed a logical one, however many patients attending were A&E extremely sick and staff required appropriate facilities, equipment and resources in order to meet that patient's needs. It was noted however that work was ongoing to improve this area of the customer experience. She further advised that a Chaser role had been introduced into Accident and Emergency and this was considered a critical role in ensuring patients were treated as quickly and as efficiently as possible. Regarding the issue of the use of cannula's in A&E, Ms Todd advised that this was not normal procedure and she would personally look into this further.

Further discussion took place regarding the friends and family test and it was noted that a full explanation and analysis of feedback would be provided in the final report. It was noted that this test was also to be rolled out to out-patient and maternity wards.

In conclusion the Principal Overview and Scrutiny Officer advised that any further comments that members wished to make on the draft quality accounts could be forwarded to him and a draft response would be reported to Committee at the special meeting on 9 May 2016.

Resolved:-

(i) That the report be received and noted.

(ii) That any further comments in respect of the draft Quality Account documents be made to the Principal Overview and Scrutiny Officer by the given deadlines.

(iii) That a further report detailing the responses be brought to the special meeting of the Committee on 9 May 2016.

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Monday 9 May 2016 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors P Brookes, M Davinson, S Forster, K Hopper, E Huntington, H Liddle, J Lindsay, M Nicholls, L Pounder and O Temple

Co-opted Members:
Mrs B Carr, Mrs R Hassoon and Dr L Murthy

1 Apologies

Apologies for absence were received from Councillors J Armstrong, R Bell, J Chaplow, P Crathorne, P Lawton, O Milburn, A Savory, W Stelling and P Stradling

2 Substitute Members

There were no substitute members in attendance.

3 Declarations of Interest, if any

There were no declarations of interest.

4 Any Items from Co-opted Members or Interested Parties

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

5 Proposed reconfiguration of Organic Inpatient Wards serving County Durham and Darlington

The Committee considered a report of the Assistant Chief Executive and Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and North Durham CCG/Durham Dales, Easington and Sedgefield CCG (DDES CCG) and Darlington CCG that provided the results of the statutory consultation exercise undertaken in respect of proposals by Tees, Esk and Wear Valleys NHS Foundation Trust and the three CCGs in County Durham and Darlington to reconfigure Organic Inpatient (Dementia) wards serving County Durham and Darlington (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer advised that a consultation exercise had taken place following a special meeting of the Committee held on 14 December 2015.

The Committee had made a number of suggestions at this meeting that were reflected upon by CCGs and TEWV and changes to the consultation process agreed.

The Director of Nursing, DDES CCG reported that the consultation had been positive with a lot of engagement taking place. She congratulated the team at TEWV in setting up the consultation and advised that the feedback and proposed option would be taken to the CCG governing body in the next couple of weeks.

She reminded Members that there was a long list of options but only 3 options were appropriate to take forward:-

Option 1 – To retain the two single-sex wards at Auckland Park Hospital, with a capacity of 15 for each sex, and to close the ward at Lanchester Road Hospital.

Option 2 – To provide two single-sex wards, one at Auckland Park Hospital and one at Lanchester Road, and to close a ward at Auckland Park Hospital.

Option 3 – To provide one mixed-sex ward at each of the sites, one at Auckland Park Hospital and one at Lanchester Road, and to close a ward at Auckland Park Hospital.

She went on to advise that a number of public meetings had taken place with good debate and that had provided useful and excellent suggestions. For example, looking at café opening hours especially for families travelling a long distance. Plus the use of Skype that would give more interaction for families and carers. 66 written responses had been received. Members were informed that the majority of issues raised were around travel. Mixed sex wards had also been raised as an issue of concern when trying to maintain dignity.

Further to a point from the Chairman about some GPs preferring option 2, the Director of Nursing advised that some GPs had not been aware of the layout of the Durham ward and the problems with staff safety if in one area. A locality meeting had been held since the report had been published and GPs felt happier with the recommendation when fully aware of the layout. Further meetings had been arranged to give GPs the opportunity to discuss. No issues had been raised at the Executive meeting.

Members were informed that TEWV had recommended option 1 to the CCGs. The next step would be for the CCG governing body to consider this. The CCG Executive Committee had received the papers and agreed with option 1. Darlington CCG would also be agreeing with option 1.

The Director of Operations, TEWV explained that the board had considered all of the information gathered and had robust discussions with significant amounts of challenge received from the non-executive directors. There had been no clear mandate from the public and the board had been keen to explore the rationale behind the preferred option of the clinicians. Travel had been a very important factor and concerns about people having to travel to Bishop Auckland for those living to the North and East of the County had been expressed. The board took account of the clinicians view that single sex wards were important to maintain the dignity of patients. The Medical Director also emphasised the importance of this. The board also took into account that option 1 created the greatest financial savings. Options 2 and 3 would deliver similar savings but would require

additional staffing on an ad-hoc basis and one to one nursing would be required for some individuals.

She went on to advise that the board were aware of mitigating actions taken in the past when transferring services from one location to another. The closure of Bootham Park in York had allowed protocols to be put in place as families travelled to Roseberry Park in Teesside. The board were therefore keen to ensure that the trust was pro-active in asking people if they needed extra support. The suggestions put forward about extended café opening times and technology were to be explored. She assured Members that discussions had been robust and that the board were keen that everything was in place.

Mrs R Hassoon asked if the one to one nursing was based on clinical need rather than the environment. Ms Sarah McGeorge, Clinical Director, MHSOP, D&D, TEWV advised that the Picktree ward had bedrooms on one corridor that are not suitable for people with dementia as they cannot easily identify their own room.

Councillor O Temple expressed concerns for the people in the North and East of the County as they would suffer in terms of transport. He had attended the consultation meeting in Consett and had expressed the same concerns. He had recently been asked by a local resident if people would have the right to choose where to receive their care. 6 years ago, when mental health provision was reconfigured in North Easington, people had the choice to go to Sunderland. As it could take two hours in a bus from his area to Bishop Auckland, he asked TEWV if the same choice would be afforded to the people of North Durham. The Director of Operations explained that a choice was given to residents in Easington and that choice still remains. The Director of Nursing added that this was a really useful point and advised that all patients have a choice. This would continue for patients seeking care in Northumberland and Tyne & Wear. Councillor Temple asked for confirmation that the choice currently exists for those people in Easington and that it would exist for residents in North Durham. He was advised by the Director of Nursing that all patients had a choice where there was a provider. She said that they could look at which beds were most available in other areas and Councillor Temple said that this would be helpful.

The Director of Operations said that receiving care from a different provider could bring additional challenges for an individual if they require additional support from the local authority – such as social workers.

Councillor M Davinson said that he lives 5 miles away from Gateshead but that it would be at least a 40 minute trip to Bishop Auckland. He added that he would rather sort out any problems with access to a social worker than travel the additional miles.

Referring to the transport issue, Councillor P Brookes asked if it had been explored in detail. In particular he wanted to know that if someone was admitted to hospital what would be the level of support offered with transport and for how long. He asked if the support would be sustainable and would it be means tested. He felt that people needed assurances that help and support would be available as the public transport system was often inadequate to get people across the County. The Chairman added that the Trust had carried this out previously when there was a transfer to Darlington.

The Director of Operations said that there were a number of examples of what they had done previously and they were currently talking with families of those patients that had been transferred from York. People would be reimbursed for fuel or public transport costs. There would be no means testing as everyone would be reimbursed. She added that for those people who could not travel on public transport or have their own vehicle then an appointed taxi firm would be used. Councillor Brookes asked if a taxi would be used for a number of weeks for a relative and the Director of Operations advised that discussions would take place with family members as part of the admissions process.

Councillor M Nicholls asked if this information could be relayed to everyone who needs to move to this hospital as some travel would often involve two buses. He was advised that the Trust were being pro-active in terms of looking at options available and when someone was admitted, transport would be discussed.

Following on from Councillor Temple's point, the Chairman said that it was important for the Trust to fully inform people before they chose to be cared for by another provider, or there would be a danger that they would lose them.

Mrs Hassoon said that choice was a good thing but that there should be a defined pathway of care for those with dementia that were at the end of capability of looking after themselves. She said that all information should be available of what was available locally, within the Trust and laid down in a specific pathway. She referred to reimbursements for travel and expressed concerns that some people would not have the funds up front on a daily basis to visit their family members.

Councillor S Forster said that a simple and easy to read sheet should be prepared asking people if they were aware of all of these issues. The Director of Nursing said that this was a valuable point and was something that they could use with all GPs and would provide a helpful solution.

With reference to the long list of options, Dr L Murthy asked how much input there had been from service users as 14 options were available but only 3 have been considered. The Director of Operations said that there had not been a great deal of input. Only those options that were realistic and could be implemented were recommended. Dr Murthy re-iterated his point about input from service users and the public as there had been no demand for this to take place. He asked how the Trust could make a recommendation when no costs had been factored in. The Director of Operations advised that the people who need beds are very poorly and are often known to the service. She explained that there were very few people who were admitted and not known to one of the teams. There was usually an awareness of them and would be working with them. Dr Murthy asked how much information was made available to someone in a way that they understood in order to get the best out of the services available. The Clinical Director advised that a lot of information was given to patients and their families and a care plan was developed in conjunction with them. She confirmed that a lot of patients admitted were known to them. Dr Murthy said that this was assuring to hear but said that he would appreciate feedback from the service users.

The Chairman asked that the Trust provide the Committee with a copy of a full mitigation plan. The Principal Overview and Scrutiny Officer suggested that officers come back to Committee 6 months after the implementation of the agreed option to report on how many

patients and carers they have assisted with travel plans and to provide feedback from service users of their difficulties faced and what steps have been taken to address those.

Councillor Davinson added that he would be interested to know how many people had chosen to receive their care from another provider.

Councillor Temple asked that a full and costed plan be brought back to Committee.

Referring to transport costs, Councillor Nicholls asked for information on how much had been spent compared to the projected savings planned.

The Chairman asked what would remain at Bowes Lyon and was advised that there would be a 15 bed ward with a community led team offering patient clinics.

The Chairman thanked the Officers for their attendance and asked Members to consider the recommendations as set out within the report. He said that TEWV had carried out the consultation process and had kept us informed throughout. Members agreed that the consultation process had been fair.

The Principal Overview and Scrutiny Officer asked that full mitigation details were provided, details of how information was provided to service users/carers given and that feedback was given 6 months after implementation. He asked the Committee if they had a preference on the options recommended.

The Chairman asked Members to decide if they agreed with the recommendation of option 1 or they would prefer to submit the comments raised at the Committee to be submitted to the Foundation Trust and CCGs and for this to be treated as a holding decision.

Councillor Nicholls said that as this was new for everyone he would recommend that it was a holding decision and that the Committee continue to monitor after implementation.

The Director of Operations said that she was more than happy to come back to Committee with a progress report but advised that it would take several months to implement after the final decision had been made.

Resolved:

(i) That the report be received.
(ii) That the comments of the Committee in respect of the consultation and engagement responses be noted and submitted to the Foundation Trust and CCGs as a holding decision.
(iii) That a further report be received by the Adults, Wellbeing and Health Overview and Scrutiny Committee 6 months after the implementation of the agreed option.

6 NHS Foundation Trust Quality Accounts 2015/16

The Committee noted a verbal report of the Principal Overview and Scrutiny Officer that gave an update on the draft formal responses of the 2015/16 Quality Accounts for County Durham and Darlington NHS Foundation Trust (CDDFT), Tees, Esk and Wear Valleys

NHS Foundation Trust (TEWV) and North East Ambulance Service NHS Foundation Trust (NEAS).

The Principal Overview and Scrutiny Officer circulated the draft responses for TEWV and NEAS and advised that the NEAS response had been submitted by their deadline of 8 May 2016, one typographical error had been noted in the last paragraph that should read 2016 and not 2017. This would be amended and NEAS notified. The deadline for TEWV was 15 May 2016.

It was proposed that the draft response for CDDFT be reported to the special meeting of the Committee be held on 24 May 2016.

Resolved:

(i) That the response for NEAS be retrospectively be endorsed.
(ii) That the response for TEWV be commented upon and agreed.
(iii) That the response for CDDFT be brought to the special meeting of the Committee on 24 May 2016.

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber, County Hall, Durham on **Tuesday 24 May 2016 at 9.30 am**

Present:

Councillor S Forster (Chairman)

Members of the Committee:
Councillors J Armstrong, J Chaplow, M Davinson, E Huntington, J Lindsay, L Pounder, P Stradling and O Temple

Co-opted Members:
Mrs R Hassoon

Also Present:
Mr S Palombella (Healthwatch County Durham)

1 Apologies for absence

Apologies for absence were received from Councillors R Bell, P Brookes, P Crathorne, K Hopper, P Lawton, H Liddle, O Milburn, M Nicholls, J Robinson, A Savory, W Stelling, Mrs B Carr and Dr L Murthy

2 Substitute Members

There were no substitute members in attendance.

3 Declarations of Interest, if any

There were no declarations of interest.

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 Urgent Care Services

The Committee considered a Joint Report of the Assistant Chief Executive and Chief Clinical Officer, Durham Dales, Easington and Sedgefield CCG that provided details of the three proposed options for Urgent Care Services in Durham Dales, Easington and Sedgefield (DDES) from April 2017 (for copy see file of Minutes).

Members were shown a short video detailing information regarding the CCG's proposed options for the future of Urgent Care Services within DDES that had been shared at the public consultation meetings, followed by a presentation from the Director of

Commissioning, DDES CCG (for copy see file of Minutes). She highlighted the following points:-

- Why urgent care services needed to change –
    - The cost at 3 centres is more than what is paid to a GP for the whole year.
    - Funding had increased at a lower rate than actual spend as we have an increasing population, increasing elderly population and new technologies
    - In the five year forward view, £150m of savings needs to be reached for each CCG
    - Need to make the best use of every £1 spent
    - Improve poor health outcomes as people were still dying from treatable illnesses
    - Urgent Care centres were not designed to treat long term conditions
    - There is still confusion over what to access with people travelling to multiple locations for their care
    - Need to improve the best use of money and only pay once for treatment
    - Duty to review the contracts
    -

She went on to advise of the following:-

- What we are keeping?
- Sedgefield – Key Facts
- What is included in the consultation?
- Further proposed new developments
- Members questions from the last meeting, including
    - Reduction in pharmacy funding
    - Availability of GPs
    - Access to Services and Transport Options
    - Helping the public to understand our proposals

In conclusion, the Director of Commissioning highlighted:-

- Engagement
- External oversight
- Feedback to date – over 2400 responses received
- Issues raised during public meetings

The Chairman thanked the Director of Commissioning for very detailed and informative presentation and invited Members to ask questions.

Mrs R Hassoon referred to a PPI survey on Pharmacies and it was found that the majority of pharmacists working in local areas were locums. She asked if the pilot would see employed pharmacists. The Director of Commissioning explained that pharmacists were employed by independent contractors and therefore would be unlikely to be placed into hubs. The Director of Primary Care, Partnerships and Engagement, DDES CCG advised that not enough information was known yet about the restructure of the pharmacies. He explained that the pilot would look at how the pharmacists could help support and supplement the work of the GP practice. By offering services such as repeat prescriptions this would help the GPs concentrate on seeing more patients. This model would be rolled

out where the population exceeded 30,000 patients and would see a shift of the pharmacy role from retail to help strengthen general practice.

The Chairman referred to the 111 service and the fact that the system had let her down personally on two occasions. She would therefore welcome every effort to help improve the service. She felt that people needed to be educated with information and the steps they should take readily available and easy to understand. The Director of Commissioning agreed that people do not know where to go and they need to be advised where to go for treatment first time. She advised that a plan was ready to go as soon as the consultation period ends with targeted work for groups who use the service. She added that communication would be continued with the public and work on how the message could constantly be shared with the public was ongoing. It had been suggested that people need a way of retaining information as leaflets were often discarded, such as fridge magnets.

Councillor J Armstrong commented that this had been a full and comprehensive consultation with no stone left unturned. He added that the next stage may be difficult as he felt that there were not enough GPs available to provide the service expected.

The Director of Primary Care, Partnerships and Engagement said that the CCG were very proud of their high standards that were evidenced by the CQC rating and the performance targets. He commented that it had been alluded to that there was a GP shortage and measures were being taken to address this through the GP career start. Together with the pharmacy pilot and the inclusion of advanced nurse practitioners would help to get the right skills mix. He recognised that some GP appointment systems were outdated and the demand for appointments should be structured for each day. It was also recognised that until there was a functional appointment system available people would still use a walk in facility.

Referring to reception areas within GP practices, Councillor E Huntington suggested that there needs to be change to allow more confidentiality for patients.

The Director of Primary Care, Partnerships and Engagement advised that they were actively looking at this issue and were providing specific training for receptionists. The five year forward view advised of an improvement grant available to GP practices that gave the opportunity for 100% of funding for the development of surgeries including providing glass screens in reception areas. This gave each practice the incentive to make improvements.

The Chairman commented that at her own GP surgery if people ring up on the day a GP would ring back within two hours and either arrange an appointment or arrange a prescription if required. The Director of Primary Care, Partnerships and Engagement said that this triage system was the methodology that would be rolled out or standardised. He referred to the surgery in Councillor Huntington's ward and advised that this had undergone some recent improvements. The Chairman asked that the word triage was replaced with assessment as people did not understand the meaning.

In terms of the consultation, Councillor P Stradling said that Scrutiny were satisfied with the work undertaken. He said that it was disappointing that there had been a lack of

attendance at the consultation events, especially as there had been excellent transport arrangements put in place. He looked forward to receiving the full results in September.

The Chairman thanked the officers for their report and reminded Members that the consultation period would end on 6 June 2016 and that a special meeting would be held on 1 September 2016 to receive all information from the consultation.

Resolved:

(i) That the report be received;

(ii) That comments on the documents including the consultation and engagement process, the consultation materials and the consultation feedback received to date be noted and a letter be sent on behalf the Committee setting out these comments as its formal response to the consultation process;

(iii) That an additional special meeting of the AWH OSC be held on 1st September 2016 to enable the Committee to consider all of the consultation feedback, determine whether the consultation and engagement process has met the statutory requirements of section 244 of the NHS Act 2006 and agree any final representations it wishes to make to DDES CCG prior to its Governing body agreeing its preferred option.

6 County Durham and Darlington NHS Foundation Trust Quality Account 2015/16

The Committee noted a verbal report of the Principal Overview and Scrutiny Officer that gave an update on the draft formal responses of the 2015/16 Quality Accounts for County Durham and Darlington NHS Foundation Trust (CDDFT).

The draft response was circulated and Members were notified that the deadline was 25 May 2016.

Resolved:

That the response for CDDFT be agreed.

Adults Wellbeing and Health Overview and Scrutiny Committee

4 July 2016

Care Quality Commission 5 Year Strategy

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with background information on the Care Quality Commission' s five year strategy prior to an overview presentation by Amanda Stanford, Head of Inspection – North East and Cumbria, Care Quality Commission.

Background

2 The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England.

3 Its purpose is to make sure that health and social care services provide people with safe, effective, compassionate and high quality care and to encourage care services to improve.

4 The CQC monitor, inspect and regulate services to make sure that they meet fundamental standards of quality and safety and then publish what is found , including performance ratings to help people choose care.

Services regulated by the CQC

5 The CQC is responsible for the regulation and inspection of:-

- Adult social care
- Acute Hospitals
- Community health services
- Mental health services
- Primary medical services (G.P. practices and G.P. Out of hours) services
- Ambulances
- Independent healthcare providers.

Care Quality Commission Five Year Strategy

6 In May 2016, the Care Quality Commission published "Shaping the Future – CQC's strategy for 2016-2021" which sets out an ambitious vision: a more targeted, responsive and collaborative approach to regulation so more people get high-quality care. A copy of the strategy is attached to this report at Appendix 2.

7 Amanda Stanford will be in attendance at today's meeting to give a presentation to members of the Committee to highlight the key issues from the CQC Five year strategy and the potential implications for Health Scrutiny.

Recommendations and reasons

8 The Adults Wellbeing and Health Overview and Scrutiny Committee is asked to note and comment upon this report and the information provided within the presentation.

Background papers

"Shaping the Future – CQC's strategy for 2016-2021"

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

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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Care Quality Commission

Shaping the future

CQC's strategy for 2016 to 2021




CQC is the independent regulator of health and adult social care in England.
We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Enter

OUR STRATEGY AT A GLANCE

Our ambition for the next five years is

A more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We will achieve this by focusing on four priorities

1. **Encourage improvement, innovation and sustainability in care**
2. **Deliver an intelligence-driven approach to regulation**
3. **Promote a single shared view of quality**
4. **Improve our efficiency and effectiveness**

We will know we have succeeded when

- **People trust and use our expert, independent judgements about the quality of care.**
- **People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.**
- **Organisations that deliver care improve quality as a result of our regulation.**
- **Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.**

READ OUR STRATEGY

Foreword

David Behan
Chief Executive

Peter Wyman
Chair

We have radically changed our approach to regulating health and social care services over the last three years. Soon we will have completed inspections of all the services we rate, providing a powerful baseline understanding of the quality of care in England. We ask the same five questions of every service – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? – and publish our findings and ratings. We know that our work is leading to better care – providers tell us our reports help identify areas for improvement, and we regularly see improvements when we re-inspect.

Over the next five years the health and social care sector will need to adapt, and we do not underestimate the challenges that services face. Demand for care has increased as more people live for longer with complex care needs, and there is strong pressure on services to control costs. Success will mean delivering the right quality outcomes within the resources available.

We know providers are committed to addressing these challenges. Services are innovating, using technology and new ways of working to deliver care that is more person-centred. We will do all we can to encourage improvement, but we cannot do this alone. Providers, professionals, staff, commissioners, funders and other regulators need to work together, with people who use services, their families and carers, towards a shared vision of high-quality care.

Our strategy has been developed based on what thousands of people, providers, staff and partners have told us and what we have learned from more than 22,000 inspections. It sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

As we move into this period of change, we will have fewer resources to deliver our purpose – so we need to use them as effectively as possible. We will always stay committed to our purpose, role and statutory objectives as we enter the next five years with energy, determination and passion.

Introduction

Health and social care regulation makes a real and practical difference to people's lives. There needs to be a strong, independent regulator that will always act on the side of people who use services. Our new strategy describes how we will build on what we have learned so we can continue to improve what we do. We will keep fulfilling our purpose to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

What we know

CQC's purpose and role remain of critical importance. Our assessments and inspections tell us that there is still significant variation in quality across different sectors and between services in each sector. In particular we are concerned about safety, which remains a serious challenge for those we have rated inadequate. Our assessments also tell us that effective leadership is very important to providing high-quality care – the overwhelming majority of good and outstanding services also feature good or outstanding leadership.

We are working in a challenging context. Demand for care has increased as more people live for longer with complex care needs. There is also strong pressure on services to control costs. To help meet these challenges, services are changing the way they organise and deliver care, and our approach needs to evolve too. We need to develop our monitoring to make best use of available information, especially from the public, who can be our eyes and ears in services. We must adapt to new models of care and work with others to support services to improve, particularly those with poor quality. We need to become more efficient in our operations, and reduce the process requirements we put on those we regulate.

Our ambition for the next five years

We are building a unique baseline of knowledge that provides critical insights into the quality of care people are receiving and we will soon complete inspections of all the services we rate. When we have finished, the answer is not simply to start again, but to use what we have learned – and what people tell us – to target our inspections where poor care, or a change in quality, is more likely.

We will focus on four priorities to deliver our ambition:

1 Encourage improvement, innovation and sustainability in care – we will work with others to support improvement, adapt our approach as new care models develop, and publish new ratings of NHS trusts' and foundation trusts' use of resources.

2 Deliver an intelligence-driven approach to regulation – we will use our information from the public and providers more effectively to target our resources where the risk to the quality of care provided is greatest and to check where quality is improving, and we will introduce a more proportionate approach to registration.

3 Promote a single shared view of quality – we will work with others to agree a consistent approach to defining and measuring quality, collecting information from providers, and delivering a single vision of high-quality care.

4 Improve our efficiency and effectiveness – we will work more efficiently, achieving savings each year, and improving how we work with the public and providers.

Our new strategy sets out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care.

We have produced an accompanying document, *What our strategy means for the health and adult social care services we regulate*, that describes how we will regulate and encourage improvement in each sector. As we work towards achieving our ambition we will develop the detail of our plans with people who use services and their carers, providers, staff and partners. We will also address the risks and opportunities for equality and human rights as outlined in our *Equality and human rights impact analysis*. We will consult, where appropriate, on changes to our inspection approach, and measure and report on whether we have achieved our ambition (see page 19).

What will stay the same

- Our purpose, role and operating model – inspections will continue to be central to our assessments of quality.
- Our work with the public to understand and focus on what matters to people.
- Our role in protecting and promoting equality and human rights, including for people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.

What will be different

We will develop our approach so that we:

- Put more of our resources into assessing the quality of care for services with poor ratings and those whose rating is likely to change, and less on those where care quality is good and likely to remain so.
- Better monitor changes in quality by bringing together what people who use services are telling us, knowledge from our inspections, and data from our partners.
- Make more use of unannounced inspections focused on the areas where our insight suggests risk is greatest or quality is improving – with ratings updated where we find changes.
- Have a more robust registration approach for higher-risk applications and a more streamlined approach for those that are low-risk.
- Focus more on the quality of care that specific population groups experience and how well care is coordinated across organisations.
- Learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models.
- Develop a shared data set with partners, other regulators and commissioners, so providers are only asked for information about care quality once.
- Use online processes as the default to make interactions with providers and the public easy and efficient.
- Introduce new ratings of how well NHS trusts are using their resources to deliver high-quality care.

PRIORITY 1

Encourage improvement, innovation and sustainability in care

What we know

People's health and social care needs are increasing and changing, and there are limited resources to meet those needs. Some providers have found they cannot deliver services in the same way. Boundaries between hospital care, primary care, community care and adult social care services are blurring as providers look to new models and technology to efficiently deliver person-centred care.

There is a growing awareness that for care to be sustainable and meet people's needs, improvements have to be led by providers and commissioners, and planned across local areas with local communities. Across health and adult social care, local areas are developing plans, including through devolution, guided by the *Five Year Forward View*.

We expect to see some radical innovation and change, while some services will stay the same.

What we will do

We will continue to look for good care as well as poor care, and highlight examples of good practice and innovation, to enable learning and encourage improvement. We will do more to assess quality for population groups and how well care is coordinated across organisations, through our provider inspections and our thematic work. We will adapt our approach so we can effectively register and inspect providers who have new and innovative care models. With NHS Improvement, we will begin publishing ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

Learn how we will do it

How we will do it

When we register services, we will:

- Use a flexible approach that supports new ways of providing health and care, such as integrated care that cuts across organisational boundaries.
- Make sure that the person ultimately responsible for care can be held accountable for quality, for example registering a provider at a corporate level if it delivers care through subsidiary providers.

When we monitor quality, we will:

- Work more effectively to share information about how quality is changing locally, regionally and nationally. We will work with the Healthwatch network and other organisations that represent the public, with commissioners through our overview and scrutiny work, and with the Sustainability and Transformation Plan process.
- Use our information on a geographical basis to identify quality priorities and risks for local areas.
- Continue to use our market oversight function to monitor the financial health of difficult-to-replace adult social care providers.

When we inspect services, we will:

- Continue to encourage improvement by sharing what providers are doing well, and monitoring the impact our approach has on providers and staff, including incentives for improvement.
- Strengthen our assessment of how well providers work with others to share information and coordinate care.
- Assess how well providers deliver care for specific populations groups, for example whether end of life care is meeting the needs of different groups.
- Build our capability to inspect new models of care, such as care that is organised around conditions or population groups, or where hospitals, GP practices and care homes work together to deliver care.
- Make the most effective and efficient use of Experts by Experience to make sure we hear the views of people who use services and their families, and make clear how they have informed our judgements and ratings.

When we rate services, we will:

- Continue to publish ratings, incentivising providers to improve and recognising those who deliver high-quality care.
- Make our ratings available by area to inform planning and improvement.
- Work with NHS Improvement to publish ratings for NHS trusts and foundation trusts on how efficiently and effectively they use their resources.

When we need to enforce, we will:

- Inform and work closely with local organisations when we consider closing services, to ensure people can continue accessing their care.

When we use our independent voice, we will:

- Publish examples of good practice and innovative care to encourage improvement, for example through our *State of Care* report to Parliament.
- Continue producing national reports that support improvement by highlighting care quality for different population groups and pathways of care, such as *Right here, right now* our mental health crisis care review.
- Begin to publish estimates of the populations covered by good and outstanding care, to further encourage improvement.

PRIORITY 2

Deliver an intelligence-driven approach to regulation

What we know

We have powerful insights into the quality of health and social care and when we complete our comprehensive inspections we will be even clearer about the data that tells us most about quality. Technology has made it easier for people to leave instant feedback about services, and new tools to analyse data are constantly evolving. We are seeing this change across the health and care system, but there is more we can do to improve how we use and capture the views and experiences of people.

Inspections are critical to our work, as the factors affecting quality cannot be assessed from data alone. By bringing together information from people who use services and their carers, knowledge from our inspections, and data from our partners, we will be better equipped to monitor changes in quality.

What we will do

We will build a new insight model that monitors quality. We will inspect all new services, but then focus our follow-up inspections on areas where our insight suggests risk is greatest or quality is improving. We will update ratings where we find changes. By targeting our inspections, we will recognise improvement, and identify and act on poor care. We will make more use of unannounced inspections and focus on building a shared understanding of the local context and the quality of services between inspectors, providers and partners. When we register new services, we will look at risk levels and be flexible in our approach.

Learn how we will do it

How we will do it

When we register services, we will:

- Take a more robust approach for higher-risk applications and a more streamlined approach for those that are lower-risk, for example by considering the track record of a provider and who will be using the service.
- Strengthen the link with inspection by sharing information more effectively.
- Move all our interactions with providers online.

When we monitor quality, we will:

- Look at potential changes in quality by bringing together relevant information about a provider – our new insight model.
- Find new and better ways to encourage the public to tell us about their care and improve how we monitor, analyse and respond to their information.
- Use our insight model to make decisions about what action to take, such as responsive inspections triggered by information that highlights concerns or suggests quality has improved.
- Publish information about services so the public can access this between inspections.

When we inspect services, we will:

- Inspect all services that have not yet had a comprehensive inspection or who are newly registered with us.
- Continue to assess how well services meet the needs of those who may be more vulnerable due to their circumstances, including people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards.
- Continue to inspect all services using a tailored approach driven by the data we gather and what people tell us.
- Change the frequency of re-inspections so that services rated good and outstanding are inspected less often than those that require improvement or are inadequate, for example moving to maximum intervals of five years for inspections of good and outstanding GP practices.
- Use the information we have about a service to focus our inspections on specific areas – such as maternity care – rather than the whole provider.
- Make more use of unannounced inspections in all sectors.
- Build an in-depth and shared understanding of the local context and the quality of services with inspectors, providers and partners.

When we rate services, we will:

- Update ratings on the basis of both comprehensive and focused inspections, for example we may inspect and rate a whole hospital or focus just on one or two core services.
- Publish ratings alongside shorter reports that make clear how we have come to our decisions.

When we need to enforce, we will:

- Continue to use the full range of our enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where we find poor care below the fundamental standards, to make sure people's rights are protected and those responsible are held to account.

PRIORITY 3

Promote a single shared view of quality

What we know

Care providers and other oversight bodies have welcomed the introduction of a clear way of assessing quality around the five key questions that we ask of every service: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? Some providers have aligned their governance processes around these questions. However, multiple definitions of care quality are still being used and we do not always make the best use of the information that services give us. As a result, providers are committing resources to meeting different information requests.

We know that regulation alone cannot improve quality, but requires the combined efforts of providers, professionals and staff, commissioners and funders, and regulatory bodies, all listening to the views of people who use services and their carers and working towards a single vision of high-quality care.

What we will do

We will work with our partners, providers and the public to agree a definition of quality and how this should be measured based on the five key questions. We will strengthen relationships with our partners to encourage improvement, and work towards a shared data set so that providers are only asked for information once. We will encourage providers to develop their own quality assurance based on the five key questions and to share this with us as part of an ongoing conversation about quality. We cannot achieve a single shared view of quality alone and we invite our partners to join us in delivering this ambition.

Learn how we will do it

How we will do it

When we register care services, we will:

- Improve the way we request information by using a consistent framework based around our five key questions.
- Work with newly registered services to embed the key questions at the heart of their understanding of high-quality care.

When we monitor care quality, we will:

- Work with providers and other system partners to make sure quality is measured transparently and consistently.
- Improve mechanisms for services to share information, including moving all transactions with them online.
- Develop systems for providers to make ongoing updates to information about their services – so we have an open flow of information in both directions.
- Expect providers to describe their own quality against our five key questions, including what has changed, their plans for improvement, and examples of good practice as part of annual reporting processes.
- Make use of relevant standards, such as National Institute for Health and Care Excellence (NICE) guidance, when defining what good quality care looks like.
- Share our monitoring data with partners to improve efficiency and reduce duplicate requests for information from services.

When we inspect services, we will:

- Build ongoing relationships between providers and CQC to have transparent conversations about care quality.
- Use information submitted by providers and from people who use services and their carers to inform what to inspect and where to inspect, but never use this alone to make a judgement about quality.
- Work with local partners to support services to improve after inspection, for example making sure the Healthwatch network is part of quality summits that follow inspections.

When we need to enforce, we will:

- Work closely with others to share information and align actions taken against services providing poor quality care.
- Make it clear how our enforcement against the fundamental standards relates to concerns under the five key questions.

When we use our independent voice, we will:

- Make sure that we put the five key questions at the heart of how we report quality issues.

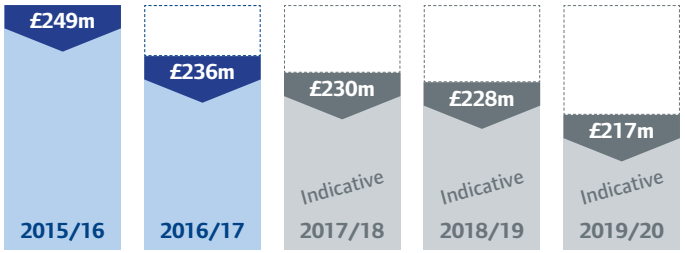
PRIORITY 4

Improve our efficiency and effectiveness

What we know

Our overall budget will reduce by £32 million by 2019/20, so we need to deliver our purpose with fewer resources. At the same time, the main source of our funding is switching from the Department of Health to fees paid by providers. We have a responsibility to use our resources as efficiently as possible, to make sure we deliver value for money for taxpayers and providers. The commitment of our staff has been critical to delivering our registration and inspection programme over the last three years and will continue to be fundamental to delivering our purpose, building on the foundations we have in place, and helping us to find innovative cost-saving measures.

CQC budget levels, 2015/16 to 2019/20



What we will do

We will work to keep our costs as low as possible as well as minimising the process requirements we have of providers. We will work more efficiently, delivering savings each year as identified in our business plans, to be a more effective regulator with a lower cost base by 2019/20. This means delivering a workforce strategy that ensures we have recruited, trained and retained the right level of skilled and expert staff. We will invest in our systems and in time-saving and online processes, so that we can improve how we work with the public and providers. We will continue to learn, share best practice, and

Learn how we will do it

collaborate with other regulators in the UK and internationally. And we will continue to regularly assess and report on our value for money to understand the impact of the changes we make on providers and partners.

How we will do it

We will develop our people by:

- Continuing to recruit the right people at the right time and developing the skills and knowledge of all employees through effective and tailored training programmes.
- Continuing to embed our values – excellence, caring, integrity, teamwork – to maintain and improve the culture we have worked hard to build.
- Promoting equality and celebrating diversity to get the best from our people and to ensure we are well-placed to identify equality issues when we monitor and inspect services.

We will ensure that we have the right systems and tools in place for our people and providers by:

- Building and improving quick and efficient systems for providers to submit information – such as our online provider portal.
- Improving the ways we make information available to the public, for example our website.
- Developing tools to support our regulatory activities and manage our resources – such as the national resource planning tool, which will improve how we schedule inspections.
- Supporting our people with the technology they need to work effectively and efficiently – for example by improving our IT infrastructure, our intranet and our flexible working.

We will save time and reduce bureaucracy by:

- Producing shorter, more consistent inspection reports more quickly.
- Removing and improving registration processes that are no longer required or are overly detailed.
- Continuing our work with partners to consider the impact of our regulation on business, including the Focus on Enforcement and Cutting Red Tape reviews for adult social care, the new Business Impact Target, and innovation and growth duties.

We will be more efficient by:

- Ensuring we are getting good value for money when we buy goods and services.
- Making the best use of the skills we have to deliver what we need.
- Ensuring we have robust financial management and reporting in place, with clear accountability and effective monitoring and escalation of risk.

What this strategy means for people who use services

We always act on the side of people who use services to make sure they get the right quality of care. Our strategy is clear that we will continue to work with the public to focus on what matters to people, to listen and act on people's views and experiences of care, and to protect people's rights, especially people in the most vulnerable circumstances. We will keep building public trust in our work and understanding of our role and purpose. And we will make sure people understand the quality of care they should expect and how to choose between local services. People will notice some changes as a result of this strategy, including:

- More information about the quality of services, that is easy for people to use and understand, and is up-to-date and available in-between inspections.
- Information from inspection that is accessible and available to the public more quickly after inspections.
- Better access to consistent and clear information about what quality care looks like – a single shared view of quality.
- Better use of information from the public to help us spot problems quickly, so we can prevent poor care and abuse happening to others in the future, and to celebrate improvements.
- Better customer service and online communications
- Close working with the Healthwatch network and our partners to hear about people's experience of care.
- More information in our reports on how well services deliver care for specific population groups, such as people with mental health needs in an acute hospital, and how new care models affect quality.
- New ratings of how well NHS trusts and foundation trusts are using their resources to deliver high-quality care.

We will renew and publish our Public Engagement Strategy towards the end of 2016.

Achieving our ambition together

We have set out a strategy for a more targeted, responsive and collaborative approach to regulation that ensures we continue to fulfil our purpose. We cannot do this alone and we will work closely with others to deliver our shared goal – that more people get high-quality care.

Our business plan each year will detail what we need to do to achieve our ambition over the five years of the strategy. For 2016/17, we will inspect, and where appropriate rate, all remaining services and locations at the same time as developing our approach. Changes to our inspections will come into effect from the start of 2017/18.

Over the course of the five years, we will improve our efficiency and effectiveness and develop new ways of working to adapt to the changes in the health and care sector.

We will work closely with the public, providers and our partners to develop our detailed plans for each sector we regulate, building on the approach set out in this strategy and the accompanying document, *What our strategy means for the health and adult social care services we regulate*. We will use a set of measures to check our progress and know when we have succeeded.

Working together

The **public and people who use services** have a crucial role to play in improving quality by sharing their experiences of care and speaking out when it needs to improve. We will:

- Co-produce our plans with people who use services, their carers and representative organisations.
- Work with the Healthwatch network, advocacy organisations and the voluntary and community sector to encourage people to share their experiences with us.

- Always speak to people who use services, their families and carers as part of our inspections.
- Make better use of people's experiences and views in our monitoring, inspections and ratings, including the expertise of Experts by Experience on our inspections.
- Build a culture that values public engagement throughout our work and equip our inspection teams to engage the public, and organisations that represent them, as part of our inspections and monitoring work.

Health and social care professionals and staff are the main drivers of innovation and improvement in the care that people receive. We will:

- Co-produce our approach with professionals and staff, and work with professional bodies.
- Involve professionals and staff in our inspections as specialist professional advisors.
- Always speak to staff as part of our inspections through focus groups and interviews.
- Draw directly on the expertise of our national professional advisors to inform our approach.
- Work closely with the National Freedom to Speak Up Guardian to support a culture of openness in the NHS, so that the concerns of staff are valued, encouraged, listened to and acted on.

Providers themselves must take responsibility for the quality of their services and drive continuous improvement and sustainable change. We will:

- Be responsive and make it as easy as possible for providers to work with us, for example through online systems.
- Co-produce our approach with providers, including through their trade associations and representative bodies.
- Reduce process requirements by streamlining data requests.
- Work together to encourage improvement at all levels, as well as holding services to account for the quality of care they deliver.

National regulators, oversight bodies and commissioners need to work to a single shared goal of high-quality care for people who use services. We will:

- Work through the National Quality Board and with leaders in the adult social care sector to agree and implement a single framework for defining and measuring quality.
- Contribute to the shared plans for delivering the *Five Year Forward View*.
- Continue to work with strategic partners, to ensure we are able to share information about risk quickly and effectively and work together efficiently.
- Work with NHS Improvement to develop a single view of success for NHS trusts and foundation trusts.

- Continue to work through the Future of Dental Regulation Programme Board to improve the system-wide approach to dental regulation.
- Build on the joint statement of intent with NHS England and the General Medical Council to improve how the system works with general practice by establishing a Future of General Practice Regulation Programme Board.
- Work with the Association of Directors of Adult Social Services and NHS England to find ways of creating greater consistency in how CQC, local authorities and clinical commissioning groups collect information from adult social care providers.
- Continue our current approach to joint inspections, such as the multi-agency work with HMI Prisons, HMI Constabulary, Ofsted and HMI Probation for children's services and in the criminal justice system, and look for opportunities to develop future joint inspection programmes.

Our measures for 2016 to 2021

In order to know whether we have achieved our ambition, we will need to measure how we are doing. We will keep these measures under review.

How we will measure whether we have achieved our ambition	
People trust and use our expert, independent judgements about the quality of care.	**Measure 1:** People reading our reports say they help them make choices.
	Measure 2: People tell us they trust that CQC is on the side of people who use services.
People have confidence that we will identify good and poor care and that we will take action where necessary so their rights are protected.	**Measure 1:** The number of newly registered services where a regulatory response is required.
	Measure 2: The range of ratings across all four rating categories (outstanding, good, requires improvement and inadequate).
	Measure 3: The number of services that are removed from the market where they fail to improve following enforcement action.
Organisations that deliver care improve quality as a result of our regulation.	**Measure 1:** The number of services that agree our standards, guidance and reports and inspections help them to improve.
	Measure 2: The number of services rated inadequate or requires improvement that improve on re-inspection.
Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.	**Measure 1:** (starting from 2017/18) The number of NHS trusts and foundation trusts that agree that the assessments and ratings we publish with NHS Improvement help them to improve the efficiency with which they use resources.
	Measure 2: (starting from 2017/18) The number of NHS trusts and foundation trusts rated inadequate or requires improvement for the efficiency with which they use resources that improve on re-inspection.

About CQC

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation.

Caring – treating everyone with dignity and respect.

Integrity – doing the right thing.

Teamwork – learning from each other to be the best we can.

Our statutory objectives

Our strategy is based on our main statutory objectives, which remain the guiding reason for doing what we do. These are: to protect and promote the health, safety and welfare of people who use health and social care services by encouraging improvement of those services; encouraging the provision of those services in a way that focuses on the needs and experiences of people who use those services; and encouraging the efficient and effective use of resources in the provision of those services.

How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission**
Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

Follow us on **Twitter @CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

Please contact us if you would like this report in another language or format.

CQC-318-1400-WL-052016

Adults Wellbeing and Health Overview and Scrutiny Committee

4 July 2016

Annual report of the Director of Public Health

Anna Lynch, Director of Public Health, County Durham

Purpose of the Report

1. This report asks AWH OSC to receive the 2015 annual report of the Director of Public Health for County Durham.

Background

2. Under the Health & Social Care Act 2012, one of the statutory requirements of each Director of Public Health is to produce an annual report about the health of the local population. The relevant local authority has a duty to publish the report. The government has not specified what the annual report might contain and has made it clear that this is a decision for individual Directors of Public Health to determine.

3. It is important to note that most data and information on the health status of the communities in County Durham is detailed in the Joint Strategic Needs Assessment available on the Council's website. Further information on public health programmes can also be found in the joint health & wellbeing strategy. Detailed information on health protection issues for County Durham residents is contained in a Public Health England report – *Protecting the population of the North East from communicable diseases and other hazards – Annual Report 2014/15.* This is available on request.

4. The 2015 Director of Public Health annual report focuses on tackling obesity and the action that needs to be taken by a range of organisations to reduce the impact on the health and wellbeing of communities. County Durham needs to work together to prevent the continuing rise in overweight and obesity, to understand the barriers our residents face and focus on how to support and enable them to live healthy and fulfilling lives. This report aims to develop an understanding of the issues and help create the collective action that is needed.

5. The annual report will be uploaded onto the council website and hard copies provided to a range of organisations and individuals including the County Durham clinical commissioning groups, NHS England, third sector organisations, foundation trusts, Public Health England, North of England Commissioning service etc. In addition, copies will be made available to the members library, to individual members (where requested), Cabinet, Overview & Scrutiny Committees and officers.

6. The annual report recommendations are found in Appendix 2.

Recommendations

7. The AWH OSC is requested to:

   a. Receive the 2015 annual report of the Director of Public Health, County Durham.
   b. Note that the report is used to inform commissioning plans, service developments and assessment of need to support a range of funding bids, particularly by third sector organisations.

Background Papers

Contact: Anna Lynch, Director of Public Health, County Durham
Email: anna.lynch@durham.gov.uk Tel: 03000 268146

Appendix 1: Implications

Finance
The publication of the report is funded by the ring fenced public health grant.

Staffing
No impact

Risk
No impact

Equality and Diversity / Public Sector Equality Duty
No impact

Accommodation
No impact

Crime and Disorder
No impact

Human Rights
No impact

Consultation
This is the independent report of the Director of Public Health and is not subject to consultation

Procurement
No impact but should inform council commissioning plans in relation to services that impact on the health of the population

Disability Issues
No impact

Legal Implications
No impact

Appendix 2

RECOMMENDATIONS

Elected members

Elected members have an influential role and could:

- Support the inclusion of changes that impact on obesity in appropriate strategies and plans. These plans may not always be directly about obesity but may still have an impact.
- Consider lobbying government over issues such as a sugar tax, or advertising restrictions on unhealthy foods and drinks aimed at children
- Think about championing a healthy diet and a more active lifestyle in your community. Does the local neighbourhood make it easy for everyone to be active? Are there plenty of places for children to play?

Employers

Initiatives aimed at our workplaces may help to create a healthy and productive workforce. Employers could:

- Promote physical activity in the workplace especially those aimed at every day activity e.g., use stairs not lifts.
- How healthy is your canteen? Is having a healthy choice enough or should the majority of the food provision be healthy? Do you promote healthy options?
- Is water readily available to drink? Are unhealthy drinks heavily promoted?
- Do all policies consider the impact upon the health of your workforce, customers or your community?
- Review your vending machine procurement.

Workplace canteens

- Consider using the Government Buying Standard for Food and Catering, to improve quality and sustainability.
- How appropriate are the food portion sizes?
- Could you reduce the sugar content in the food and drinks you serve?
- How healthy or appropriate are your vending machines? Do they provide healthy alternatives?
- Is nutritional information available so that your colleagues can make informed choices about that they eat or drink?
- Can you promote healthier choices or initiatives such as the Change4life sugar swap or snack swap initiatives?

Health professionals

All health professionals have a role in helping their patients to improve their health related behaviour.

- Midwives, GPs, health visitors, school nurses and their teams should provide information and advice to pregnant women and parents of young children about nutrition and physical activity for the whole family.
- Consider closer working with the public health team to explore all opportunities to tackle obesity.
- Health professionals should look at every contact with a patient as a health promoting opportunity and use this opportunity to provide guidance around healthier lifestyles and specifically around obesity.

Takeaways, cafes and local shops
There is no reason why this sector cannot consider healthier options.

- Consider healthy catering standards and provide food labelling.
- Could you join with your local community in their efforts to make the healthy choice easier?
- Promote healthy options in partnership with local schools or workplaces
- Contact the public health team to explore opportunities to provide greater choice to your customers.

Child care settings
All settings where children spend time such as schools, child-care settings, children's sports facilities and events should have healthy food environments.

- Ensure only healthy foods, beverages and snacks are consumed on the premises. Use water not juice.
- Champion being physically active and explore all opportunities for active play and learning.
- Use Change4Life and capitalise on the national approach to tackling obesity
- Involve parents and the wider community in healthy eating projects.

Social care and carers

- Provide clear guidance and support to carers and service users around healthier nutrition.
- Ensure that staff have basic and current nutrition training.
- Promote all opportunities to be active.

Planning
Planners have an important role in creating an environment that makes the healthy behaviour easier.

- New developments should create opportunities for physical activity.
- Ensure there are always opportunities for active travel such as cycling and walking routes.
- Explore how regulations and bye laws may help to make the healthy choice the easiest choice?

Procurement
Procurement often influences and determines the choices people make.

- All establishments that provide food should consider healthy and sustainable food procurement.
- Consider the impact of policies that inadvertently promote unhealthy choices and make the healthy option difficult.

Area Action Partnerships, parents and communities
There are many examples of communities that are making a real effort to improve health and wellbeing.

- Consider what you could champion in your local area.
- Could allotments or green places be used as a community garden to share skills and produce?
- Could you support your local school or community organisation in their efforts to make their environment healthier?
- Join Change4Life, the fun and friendly way to make the healthy choice.
- Work with local retailers to promote healthy options.

- Organised community events can promote healthier choices and options.

OBESITY

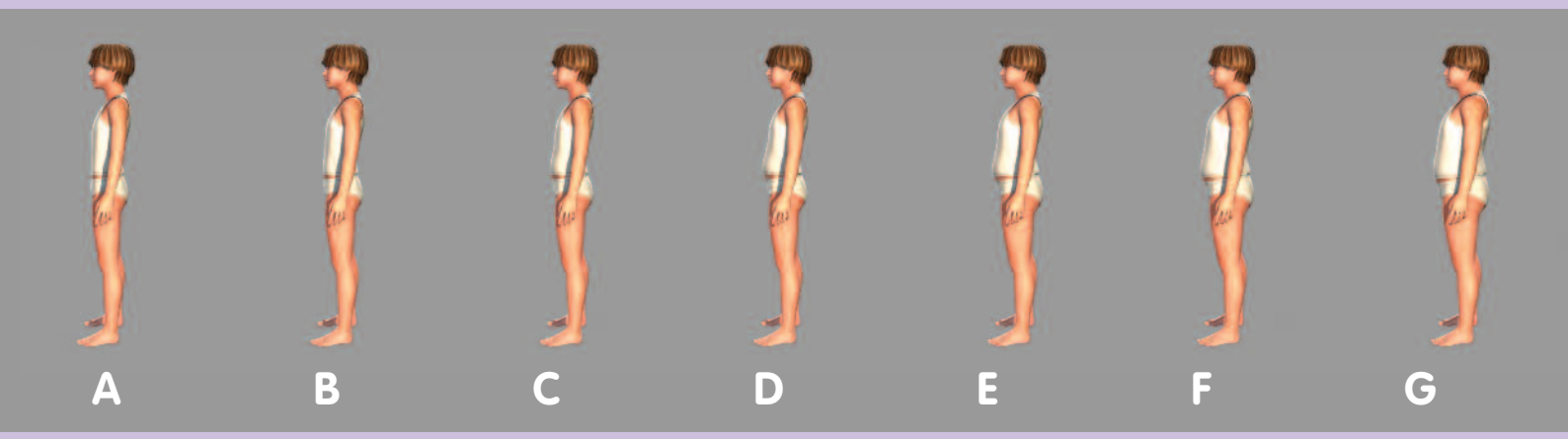
An issue too big to ignore... or too big to mention?

Report of the Director of Public Health County Durham

2015

Durham County Council

Which child, or children are underweight, healthy weight, overweight or obese?



Answers

A underweight
B healthy weight
C healthy weight
D healthy weight
E overweight
F overweight
G obese

Newcastle University Map Me Study.

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Acknowledgments:

Many thanks to Chris Woodcock, Public Health Portfolio Lead, for his support in pulling this report together and to Gill O'Neill, Consultant in Public Health for her oversight and guidance.

Introduction

This year my Director of Public Health Annual Report focuses on obesity and how we can tackle the issue. I realise this is a sensitive area for many people but we really need to stop dancing around the edges of this issue. Overweight and obesity continue to be a high priority for County Durham and I am sure will be for the foreseeable future. We continue to grapple with the issue and prevent the many health conditions associated with being overweight and obese. At the present time we are going in the wrong direction with our obesity trends and need to try new and innovative approaches as well as implementing evidence based interventions. The evidence is very clear - we need to learn from progress we have made in relation to tackling tobacco and smoking. We need national legislation, regulations, advertising controls and other measures such as a tax on sugar if we are to make significant in-roads to tackling and reducing obesity. In the absence of these there is much that can be achieved both at a local levels as well as striving to influence and change national policy. I am convinced that change is only possible if we do this collectively, sharing resources and harmonising our efforts to meet a common goal.

This report focusing on obesity could easily be a lengthy affair full of detailed data and referenced research. The subject is extremely well researched and there is a large amount of data and evidence to underpin the work we want to take forward. However, I do not want a report that is full of graphs and tables but one that reaches out to you, the reader to explain our direction of travel and what we can do together.

Obesity is a complex issue and as I was thinking about this report's structure I found myself drawn back to the powerful Foresight Report first published in 2007[1]. The Foresight Report[1] highlighted the wide range of factors that contribute towards obesity. These factors can be largely grouped into seven domains: energy balance, physical activity, the activity environment, food consumption, food environment, individual psychology and social influences. For ease of reading the sections of this report will be broadly built around these domains.

Whilst we await the new national strategy to reduce obesity in children due out in early 2016 this report has drawn upon the most up to date evidence available on the links between sugar and obesity and also on some fascinating research being conducted by Newcastle University on parental perceptions of childhood obesity. I am delighted to include a guest contribution in the report from Professor Ashley Adamson and her team at the Institute of Health & Society, Newcastle University.

Overweight and obesity continue to be a high priority for County Durham and will be for the foreseeable future.

In County Durham we already have a Healthy Weight Alliance and members are working together to deliver the County Durham Healthy Weight Framework. We are also on the cusp of launching a physical activity framework which will galvanise partners to mobilise our residents to become more physically active. This is also really important if we are serious about tackling obesity in County Durham.

This report predominantly focuses on the power and influence of food and, more specifically, on sugar and energy dense food. This is not only about the food we eat as an individual or family but also about community influence and ways we can work together as a whole system. I also touch upon the influence of the food industry and suggest ideas about how we might approach this in County Durham.

Throughout the report there are some examples of good practice I want to share, both existing and planned, showing how we are striving to tackle overweight and obesity issues with a range of partners.

There is already a vast amount of good work taking place across County Durham and I don't want this report to be seen as a criticism of current and previous activities. We are making some progress but need to do even more. As you read the report you will hopefully become aware of the challenges we face and the complexity of tackling obesity. I want to acknowledge and thank all of our partners who have been supporting efforts to prevent overweight and obesity for many years and I hope we can continue to work together for the foreseeable future.

Throughout the report you will see examples of action that we can take forward locally and make progress. We cannot sit back and wait for national policy to change.

I want this report to be a call to action. As a County Durham community we **need** it to be a call to action. We must prevent the continuing rise in overweight and obesity and we need to work together to understand the barriers our residents face and focus on how to support and enable them to live healthy and fulfilling lives. I look forward to working with you on this challenging area of the public's health over the next few years.

Obesity is harmful.

We cannot accept

this status quo.

Background

Obesity levels are on the rise. This statement alone is hardly new. Most of us are aware of the rising levels of obesity, but frequently the views surrounding the agenda are created through media or cultural norms and stereotypes. We are all aware of the overly simple approaches to the problem and the incorrectly held belief that there is a quick and simple solution. There is not!

This challenge requires a sustained response. We need to influence at all levels and across a range of areas if we are to address an issue that is having profound long term consequences for the health and wellbeing of our communities in County Durham.

Obesity is harmful. We cannot accept this status quo. The crux of the problem is an imbalance between energy intake and energy expenditure, yet this is impacted by a complex mix of biology, social and environmental factors over a period of time. As human beings we evolved in a world of relative food scarcity and hard physical work. Many believe obesity is the result of our biology interacting with the modern world where energy dense food is readily available and the world around us helps us move less and less[1]. This is often called the obesogenic environment.

Tackling obesity is a challenge for society and for policy makers. It is not simply a matter of individual choice. The factors that contribute towards obesity are complex and multiple. They interact with each other in a way that means tackling any of them in isolation will have limited effect in improving our population's health and wellbeing.

Weight, once gained, is challenging to lose. It requires a change in mind set for the individual and, for some, possibly services and interventions to help them achieve their weight loss goals. There are already significant numbers of obese people in County Durham and action is required to help them lose weight and to reduce the chance of them developing further health complications associated with their weight.

We must take a preventative approach to stop the rising tide of obesity. To do this requires a systemic shift to really change our current pattern and trends. Change needs to be made at many levels across County Durham if we are to have the impact on the population that is needed. This presents many challenges for partners and organisations and our communities.

Hopefully, this report will help to create that collective action and response we so badly need.

What do we mean by obesity and how do we measure it?

Adults

Obesity is a term used to define someone who is very overweight, with a high degree of body fat that may have an adverse effect on health and wellbeing.

It is more than an issue of appearance. The body mass index (BMI) gives a measure which provides an indication of whether a person is a healthy weight for their height, and allows categorisation of weights into what is normal and healthy, overweight, or obese for someone of a particular height and gender. This allows for trends in population levels of obesity to be tracked over time[2].

The measure uses weight as measured in kgs divided by height in metres squared (m^2):

$$\text{BMI} = \frac{\text{weight (kg)}}{\text{height (m)} \times \text{height (m)}}$$

Adult classification	BMI range (kg/m^2)	What it means for you
Underweight	Under 18.5	Being underweight is not healthy. If you have a BMI under 18.5 this may mean that you need to build your weight up.
Healthy weight	18.5 to 24.9	Being a healthy weight means you are at a lower risk of heart disease, stroke and type 2 diabetes than someone who is overweight or obese.
Overweight	25.0 to 29.9	If you are overweight, you are at a higher risk of diseases such as heart disease, stroke and type 2 diabetes.
Obese	30.0 to 39.9	Being obese or morbidly obese means you are at a greater or increased risk of health problems.

After www.nhs.uk/conditions/obesity/pages/introduction.aspx

Body fat can be measured in several ways, with each assessment method having pros and cons. The method most widely adopted and used within this report is the body mass index (BMI), though it is acknowledged that it is not a perfect measure.

Other approaches such as waist circumference, waist to hip ratio, skinfold thickness, bioelectroic impedance through to more complex approaches associated with research settings, may be used to provide measures of body fat and implications for the individual's health.

What do we mean by excess weight?

Excess weight is a term used to describe a combined population above the healthy weight range. This is used intermittently throughout this report.

Overweight + obese = excess weight

The method of assigning a BMI classification is different for children and adults.

Defining overweight and obesity in children

Defining children as overweight or obese is a complex process, given that their height and weight changes quickly. The method of assigning a BMI classification is different for children than for adults. This difference is important and explained on this page.

Measuring and interpreting BMI in children

It is important when using BMI in children that age and gender appropriate growth references are used to correctly determine weight status. In England the British 1990 (UK90) growth reference charts are used to determine the weight status of an individual child and population of children.

A review of the issues around the use of BMI centile thresholds for defining underweight, overweight and obesity in children aged 2-18 years in the UK, was published in 2012[3].

Measuring an individual child:

Clinical definitions of weight status: When measuring an individual child (for example in clinic or feeding back the National Child Measurement Programme (NCMP) results to parents) weight status is defined using the UK90 clinical cut points which are as follows:

Clinically very under weight: ≤ 0.4th centile

Clinically low weight: ≤ 2nd centile

Clinically healthy weight: > 2 - < 91th centile

Clinically overweight: ≥ 91st centile

Clinically obese*: ≥ 98th centile

Clinically extremely obese: ≥ 99.6th centile

*This is also called 'very overweight' in the NCMP parental feedback letters.

What is the national child measurement programme (NCMP)?

The National Child Measurement Programme (NCMP) measures the height and weight of children in reception class (aged 4-5 years) and year 6 (aged 10-11 years) to assess overweight and obesity levels in children within primary schools. This data can be used to support local public health initiatives and inform the local planning and delivery of services for children. Local authorities are mandated under the Health & Social Care Act 2012 to ensure the delivery of this programme at a local level.

The programme is recognised internationally as a world-class source of public health intelligence and holds UK National Statistics status[4].

The NCMP was set up in line with the Government's strategy to tackle obesity and to:

- ✓ **inform** local planning and delivery of services for children.
- ✓ **gather** population-level data to allow analysis of trends in growth patterns and obesity.
- ✓ **increase** public and professional understanding of weight issues in children and be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

Children's heights and weights are measured and used to calculate a body mass index (BMI) centile. The measurement process is overseen by trained healthcare professionals in schools.

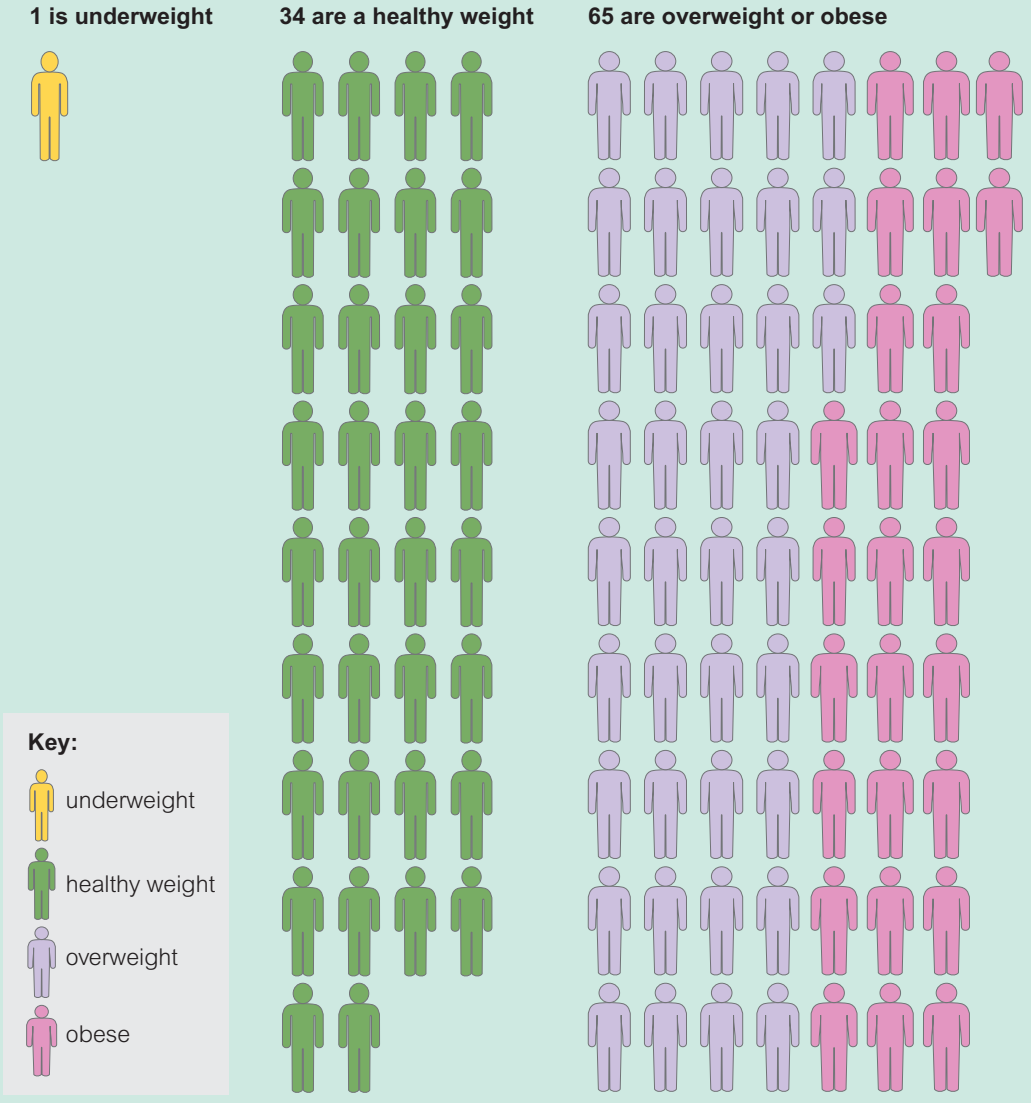
The current picture in England and County Durham

This section highlights the national trend data in obesity and also County Durham data for both adults and children.

Adults

In England most adults (around 65%) are overweight or obese[5].

In every 100 adults in England...



More women than men are a healthy weight

Having too much weight increases risk of **diabetes, heart disease and cancer**

In England, **average weight** is now **overweight**

Source: After Public Health England

Nationally, 65% of adults have excess weight[5]. Prevalence was higher for men (65.3%) than women (58.1%). This has seen little change since 1993.

Whilst the proportion of adults with excess weight has seen little change since 1993 the prevalence of obesity has increased substantially: for men a rise from 13% to 24%, for women a rise from 16% to 27%[6].

In County Durham

24%
4-5 year olds
have excess weight

that's almost **1,300** aged 4-5

36%
10-11 year olds
have excess weight

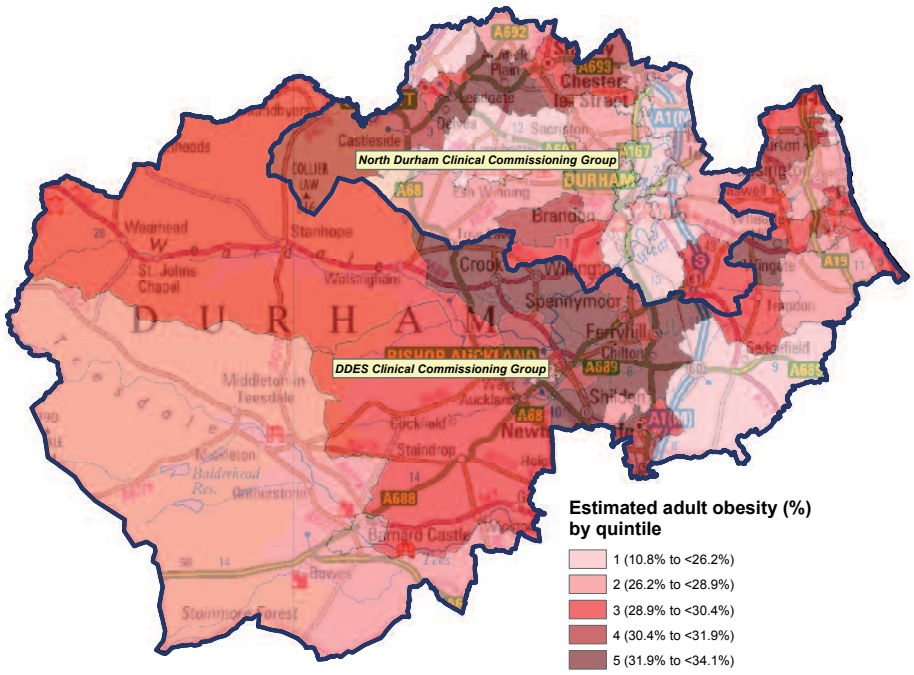
that's over **1,800** aged 10-11

72.5%
of adults
are estimated to be of excess weight

around **310,000** adults

Percentage of the population of County Durham aged 16+ with a BMI of 30+, modelled estimates, 2006-2008.

Source: PHE, NHS IC, 2010



The 2015 County Durham Health Profile[7] shows that:

The level of **adult obesity** (27.4%) is higher than the England average (23.0%).

The level of **excess weight** (72.5%) is higher than the England average (65%).

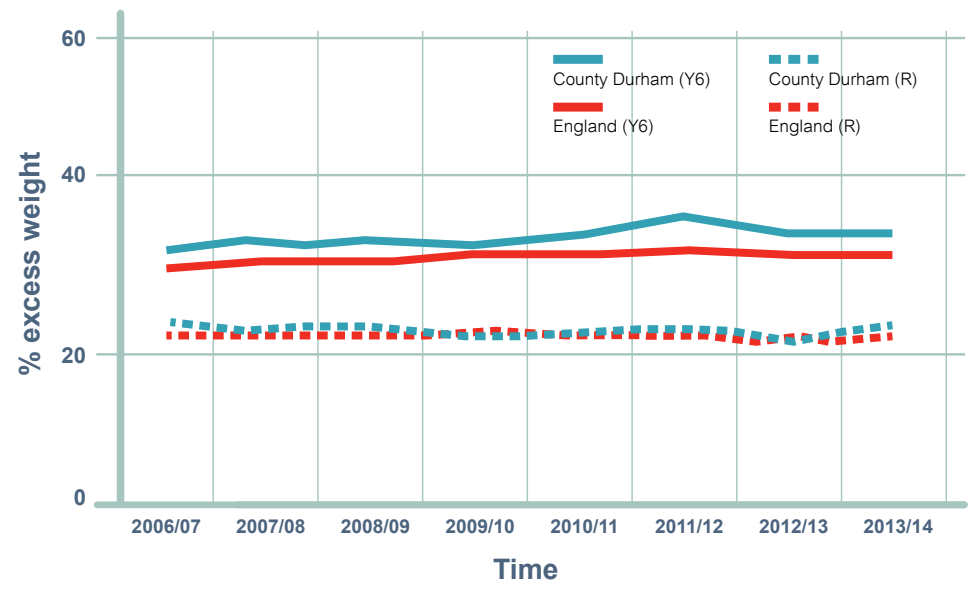
The level of **physically active adults** in County Durham (52.2%) is lower than the England average (56.0%).

Diabetes prevalence (6.8%) is higher than England (6%), and has risen locally from 4.1% in 2007/08. This increase places a significant burden on local health care costs. There is more information about diabetes in County Durham on pages 41-42.

Childhood obesity – the national picture

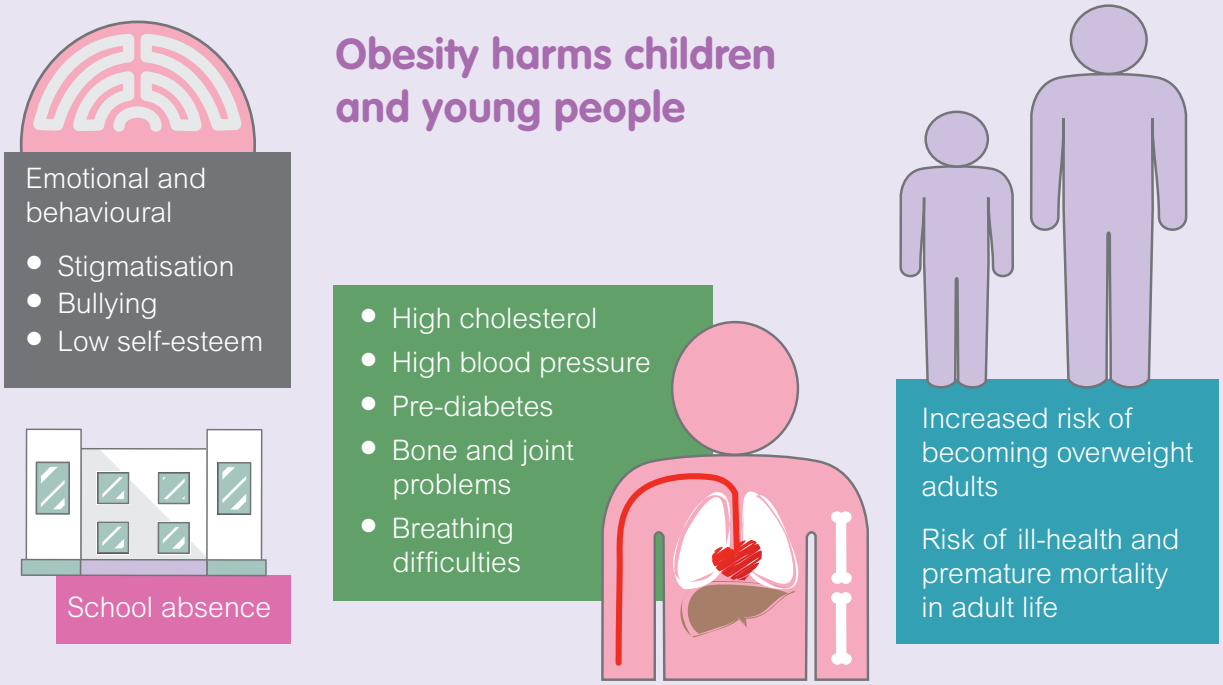
The prevalence of childhood obesity has more than doubled in the UK in the last 25 years. Those who are obese as children are more likely to be obese in adulthood. Of those who are obese at preschool age, research suggests that between 26% and 41% will go on to be obese in adulthood[1]. Addressing obesity during early years is therefore an important prevention opportunity.

Percentage of children with excess weight, and change over time, Reception and Year 6, 2006/07-2013/14, NCMP[4]



Source: After Public Health England

Obesity harms children and young people



Source: After Public Health England

The World Health Organisation (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems and also more likely to become obese adults[8].

Nationally, the Government has set an ambition for local areas to 'achieve a sustained downward trend in the level of excess weight in children by 2020'.

Childhood obesity – the local picture

Latest figures from the National Child Measurement Programme identified the prevalence of obesity in County Durham to be 9.3% at reception and 21.4% at year 6 and prevalence of excess weight (overweight and obese) as 23.0% and 36.5% respectively in 2014/15.

Levels of excess weight and obesity in County Durham in both reception and year 6 are significantly higher than England[4].

	Reception (age 4-5 years)				Year 6 (age 10-11 years)			
	Number excess weight	% excess weight	Number obese	% obese	Number excess weight	% excess weight	Number obese	% obese
England		21.9%		9.1%		33.2%		19.1%
County Durham	1,339	23.0%	542	9.3%	1,879	36.5%	1,104	21.4%

Significantly higher than England

See time series chart on page 11 for NCMP over time.

Obesity in children and young people has been identified through the Joint Strategic Needs Assessment, the County Durham Children, Young People and Families Plan, Health and Wellbeing Strategy for County Durham and Clinical Commissioning Groups' commissioning intentions as a priority for improving health outcomes for children and young people.

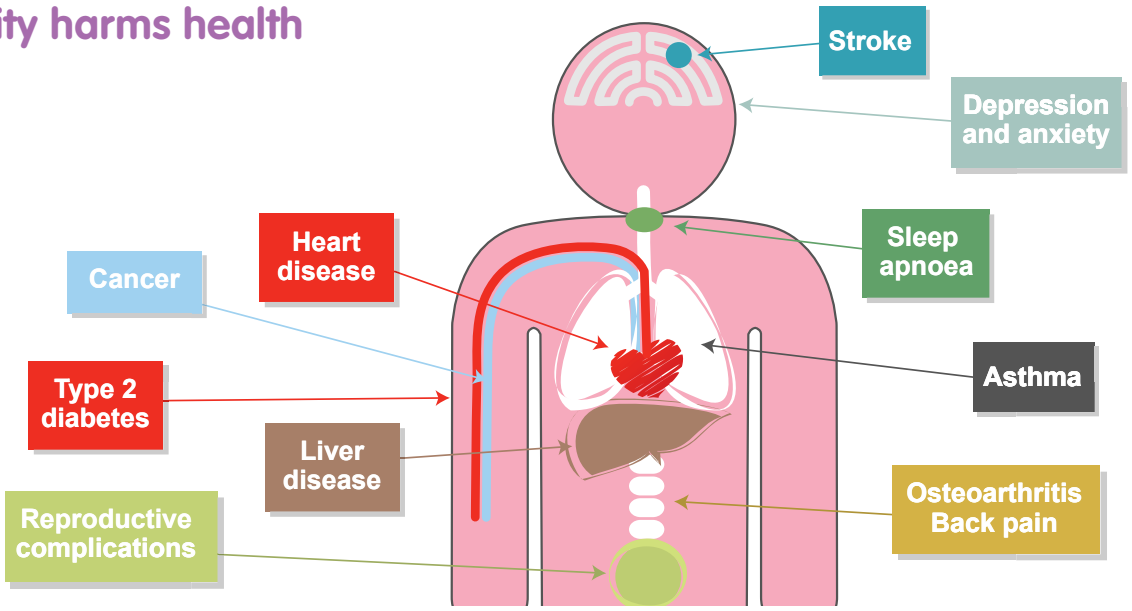
The impact of obesity

The impact of obesity can be felt at an individual level through to a societal scale due to the social and economic burden it can cause.

Obesity and health

If an individual is overweight or obese they are more prone to a range of serious health problems. These include cardiovascular disease; type 2 diabetes; endometrial, breast and colon cancer[9]; as well as psychological and social problems such as stress, low self-esteem, depression, stigma, prejudice and bullying[10].

Obesity harms health



Source: After Public Health England

The costs of overweight and obesity

There are significant health and social care costs associated with the treatment of obesity and its consequences, as well as costs to the wider economy arising from chronic ill health.

The House of Commons Health Select Committee estimated that the total annual cost of obesity and overweight for England was nearly £7 billion of which £1 billion is the direct health service costs attributable to obesity alone[1].

The National Audit Office highlighted significant indirect costs due to the higher levels of sickness and absence from work that obese people suffer, reducing productivity and imposing costs on business[11].

It has been estimated that lost earnings attributable to obesity are around £2.3-3.6 billion per year nationally[12]. The costs for an organisation employing 1,000 people, could equate to £126,000 a year in lost productivity[13] and on average, obese people take four extra sick days per year[14]. The estimated annual social care costs* of obesity to local authorities is estimated at £352m[15].

The costs of decreased household incomes, earlier retirement and higher dependence on state benefits such as ill health or unemployment benefits that arise from obesity-related conditions also need to be considered. In 2013 welfare costs were estimated to be between £1 billion and £6 billion[16].

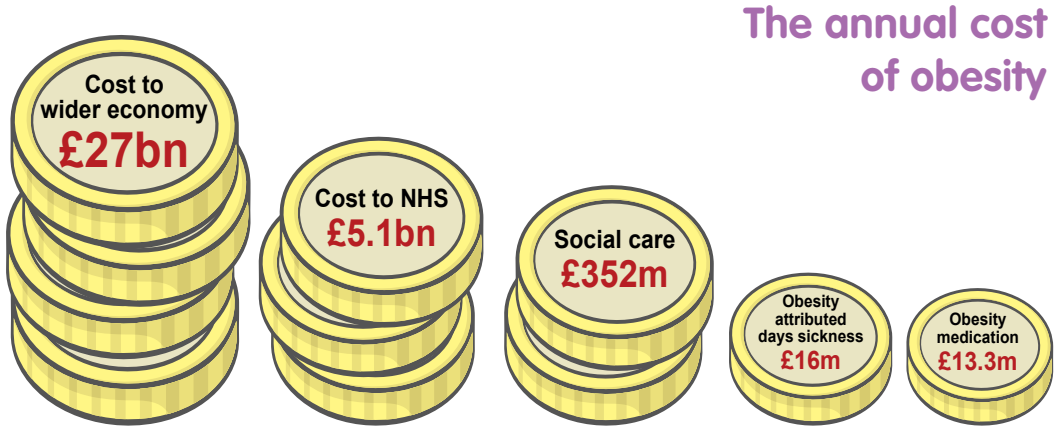
In addition, there is evidence that obesity may reduce the wage levels of those in employment[17,18] and that obese people are less likely to be in employment than people of a healthy weight.

**Cost of extra formal hours of help for severely obese compared to healthy weight people.*

Children

These costs will be compounded as the weight problems of children and teenagers lead to increased levels of chronic disease, mental health and other social costs[19]. For example, studies have shown that compared with adolescents of normal weight, overweight and obese adolescents had over a third more sick days annually[20].

The rise in childhood obesity is also a concern as overweight and obese youth have an increased risk of becoming overweight adults which could further increase the scale of the issue[21].



Source: After Public Health England

Obesity and mental health

There is a relationship between common mental health disorders and obesity. An obese person has a 55% increased risk of developing depression over time, whereas a depressed person has a 58% increased risk of becoming obese.

A report from the National Obesity Observatory highlighted that there is not enough emphasis on the association between mental health, emotional wellbeing and obesity. The relationship is complex with some researchers suggesting that obesity can lead to common mental health disorders, whilst others have found that people with mental health problems are more prone to obesity[10].

Obesity and social care

Severely obese people are over three times more likely to need social care than those who are a healthy weight[22].

Obese adults may have physical difficulties which affect day to day living. This can have implications for social care services such as housing adaptations for example toilet frames, hoists and stair lifts[23].

Specialist carers trained in the manual handling of severely obese people are required for people who are house bound and have difficulties caring for themselves.

The provision of appropriate transport and facilities, such as bariatric patient transport and specialist hospital beds are also required.

Obesity and the link with inequalities

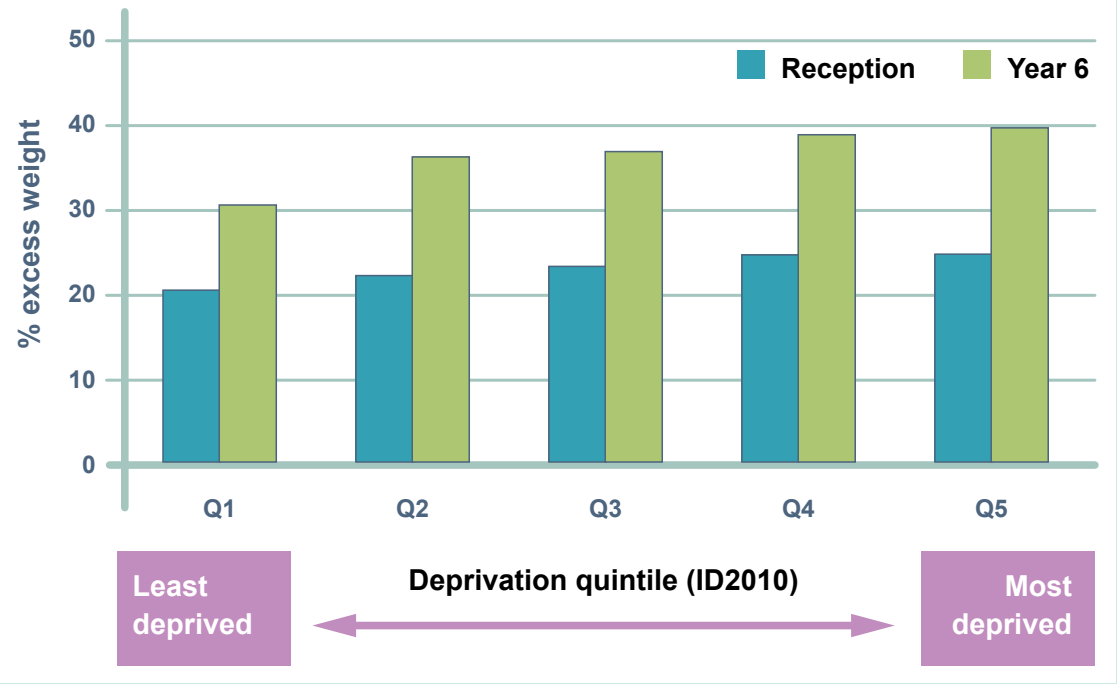
Obesity prevalence in England is known to be associated with many indicators of socioeconomic status, with higher levels of obesity found among more deprived groups. The association is stronger for women than for men. Overall, for women, obesity prevalence rises with increasing levels of deprivation, regardless of the measure used. Nationally, women living in more deprived areas are more likely to be obese. Obesity prevalence rises from 20.1% in the least deprived quintile to 33.0% in the most deprived quintile. For men, only occupation based and qualification-based measures show differences in obesity rates by levels of deprivation[24].

Factors associated with a healthy diet also show the impact of deprivation. Fruit and vegetable consumption is greater in those living in higher income households. Data from the Health Survey for England shows that children living in households with the highest income levels eat the most fruit and vegetables[25]. There is also evidence that a high sugar intake is associated with deprivation. The National Diet Nutrition Survey[26] found there to be higher sugar intakes in adults with the lowest income compared to all other income groups. Consumption of sugary soft drinks in particular was found to be higher among adults and teenagers in the lowest income group.

Physical activity levels are related to household income. Nationally, men and women from the lowest income group are least likely to meet the Government recommendations of a minimum of 150 minutes of moderate intensity per week in bouts of at least ten minutes[27]. Low levels of physical activity in children can be statistically associated with household income, with those in the lowest income bracket more likely to report low levels of activity. Among boys, 47% in the lowest income group and 26% in the highest did less than 30 minutes of moderate activity each day[28].

Nationally, in children aged 4-5 years and 10-11 years, obesity prevalence in the most deprived tenth of the population is approximately twice that in the least deprived tenth[4].

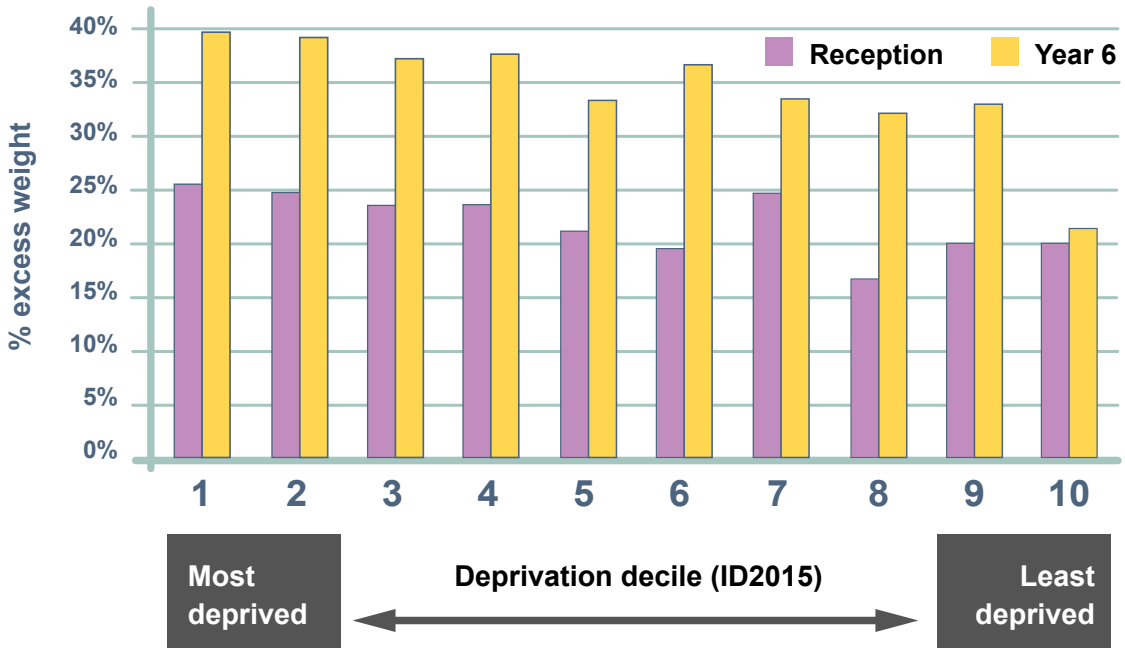
National prevalence of excess weight by deprivation decile and school year, 2011/12 to 2012/14, NCMP[4]



Source: NCMP

Locally the picture in County Durham is not quite as pronounced but still indicates inequalities among our communities.

Excess weight in Reception and Year 6 (%), by deprivation decile (ID2015 overall score), County Durham Middle Super Output Areas*, 2011/12 to 2013/14



Source: NCMP

* Middle super output areas are local populations based on minimum 5,000 and 7,200 people.

The future

If we fail to halt the rise in obesity then by 2050, obesity, in England is predicted to affect 60% of adult men, 50% of adult women and 25% of children[1].

Recently reported modelling suggests that by 2030 41-48% of men and 35-43% of women could be obese, if the trends continue[29].

NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year[1].

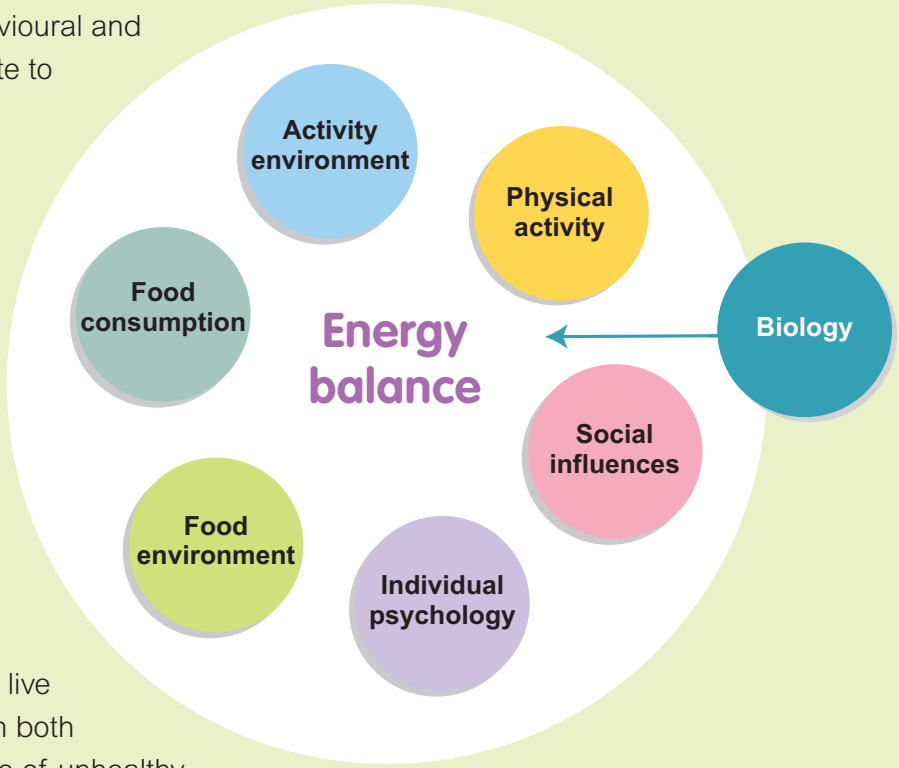
What are the causes of obesity?

The rest of this report showcases some of the challenges and the breadth and complexity of this agenda using the Foresight factors. The report also highlights some of the good practice already taking place in County Durham. The report is not intended to be an exhaustive list of everything that contributes towards achieving a healthy weight but hopefully will stimulate discussion and gain commitment from many partners to work collectively to tackle obesity in County Durham.

Energy balance

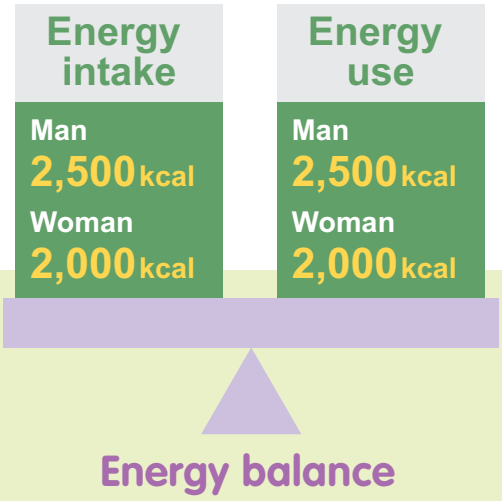
Obesity develops when energy intake from food and drink consumption is greater than energy expenditure through the body's metabolism and physical activity over a period of time.

There are, however, many complex behavioural and societal factors that combine to contribute to the causes of obesity.



The Foresight Report[1] suggested the wide range of factors that contribute towards obesity. These can be loosely grouped into seven main categories. Apart from the individual's own biological make up, all factors have the potential for change. This is where the opportunity to make a difference in County Durham lies.

Foresight developed the concept that it was not as simple as the energy taken in and the energy expended. The world we live in greatly impacts the choices we have in both those areas. Access to shops, the volume of unhealthy food available, access to green space are all factors which impact upon obesity and over which the individual has little control. A review by the Department of Health's Expert Advisory Group on Obesity in 2011, concluded that the new evidence generally confirmed the analysis of the causes of obesity in the Foresight Report and that it remains a robust foundation for future action[30].



Yet, even where access to shops etc is excellent, there are a number of other factors that impact our choices. These include the cultural norms in relation to obesity, the promotion and advertising of unhealthy products, the rise of convenience food and even stress. Only when looking across all of the possible factors does the scale and complexity of the issue and challenge become clear.

Biology

Obesity can be a consequence of a biological system that battles to maintain energy balance to keep the body at a constant weight. Food is fundamental and the human body has evolved to make sure that its needs are met. The hunger drive is very powerful but by contrast, there is limited biological sensitivity to abundance. The feelings of having had enough are weak and easily overridden[31].

Whilst there is a well-established body of evidence highlighting the importance of controlling energy intake to avoid weight gain, research into the metabolic aspects of energy expenditure in humans has shown little to explain the impairment of the regulatory mechanism that governs energy balance[32].

Whilst human biology plays a very important and complex role in obesity, it is not something that is easily modifiable. The remaining focus of this report is the 'outside' world, much of which, we can attempt to influence and change.

Spotlight on:

Activity environment

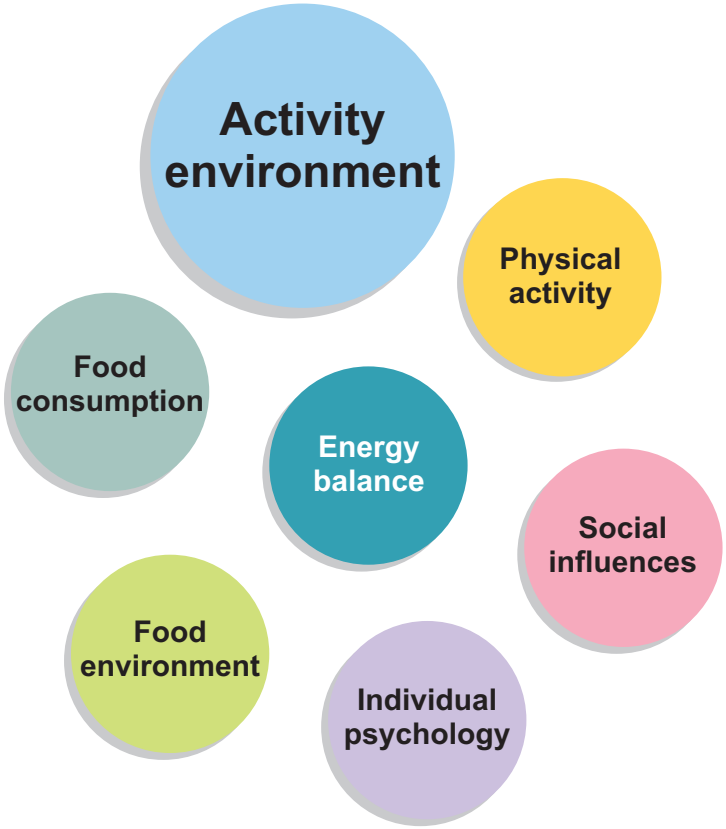
Aspects of the environment found to be associated with physical activity include:

- access to physical activity facilities
- distance to destinations
- levels of residential density
- type of land use
- urban walkability
- perceived safety
- availability of exercise equipment

One important action is to modify the environment so that it does not promote sedentary behaviour. The aim is to enable people to make the healthy choice the easy choice. By creating an environment where people actively choose to walk and cycle as part of everyday life a significant impact can be made at an individual and population level[33].

The role of planners is crucial in ensuring that new developments create opportunities that encourage active rather than sedentary behaviour.

Durham County Council has recently started a programme to develop part time 20mph speed limits in areas of County Durham. The purpose of this scheme is to reduce traffic speeds around schools during drop off and pick up times. This will improve road safety for vulnerable road users as well as making walking, cycling and outdoor play more attractive. In conjunction with the school based road safety programme, children will have increased knowledge and skills to enable them to be safer pedestrians and cyclists.



A physically active *environment includes aspects that may help or block access to physical activity such as the cost, safety in the surrounding environment, ease of walking etc. It also includes areas that reflect cultural values associated with activity patterns, such as the dominance of the car.*

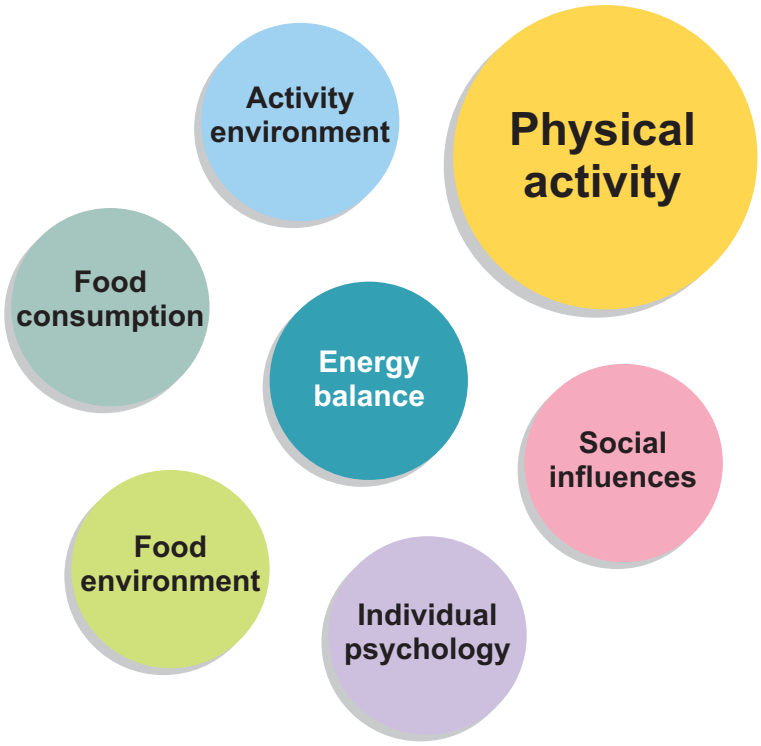
Spotlight on:

Physical activity

The physical activity cluster consists of variables such as an individual's level of recreational, domestic, occupational and transport activity and parental modelling of activity. The higher the level of fitness, the easier it is to engage in physical activity and conversely, for someone who is physically unfit, physical activity is difficult.

Physical activity is a key determinant of energy expenditure and a fundamental part of energy balance and weight control. Regular physical activity can reduce the risk of obesity, as well as many chronic conditions including coronary heart disease, stroke, type 2 diabetes, cancer, mental health problems and musculoskeletal conditions.

Physical activity includes all forms of activity, such as walking or cycling for everyday journeys, active play, work-related activity, active recreation (such as working out in a gym), dancing, swimming, housework, gardening or playing games as well as competitive and non-competitive sport. The evidence is very clear that it can also reduce costs by significantly easing the burden of chronic disease on the health and social care system. Even relatively small increases in physical activity are associated with some protection against chronic diseases and an improved quality of life.



The Health Survey for England 2012 showed that **67% of men and 55% of women meet new government recommendations for levels of physical activity** (minimum of 150 minutes of moderate intensity per week in bouts of at least ten minutes)[27].

Nationally **more boys (21%) than girls (16%) aged 5-15 years met the national physical activity target in 2012**, achieving an hour of moderate activity every day[28].

In County Durham the recent Student Voice Survey for Secondary Schools (2015) showed that **30% of students sampled (N = 8,148) stated that they were physically active for 60 mins, every day in the last week, with only 7% stating that this never occurred**.

The Government recommends that adults spend minimal time being sedentary for long periods. The Health Survey for England (2012) showed that on weekdays **31% of men and 29% of women spend six hours or more being sedentary, increasing to 40% of men and 35% of women on weekend days**[27].

Whilst physical activity is clearly an important factor in our plans to tackle obesity, its benefits to an individual's health are such that it warrants a focus in its own right. The County Durham Physical Activity Framework is a collective strategic approach to this agenda which aims to make a significant impact on the quality of life in County Durham. However for the purpose of this report, the focus remains primarily around energy intake. Readers interested in the physical activity framework can access it on the council website.

Physical activity benefits for adults and older adults

- ✓ Benefits health
- ✓ Improves sleep
- ✓ Maintains healthy weight
- ✓ Manages stress
- ✓ Improves quality of life

Reduces your chance of:

- Type 2 diabetes **-40%**
- Cardiovascular disease **-35%**
- Falls, depression and dementia **-30%**
- Joint and back pain **-25%**
- Cancers (colon and breast) **-20%**

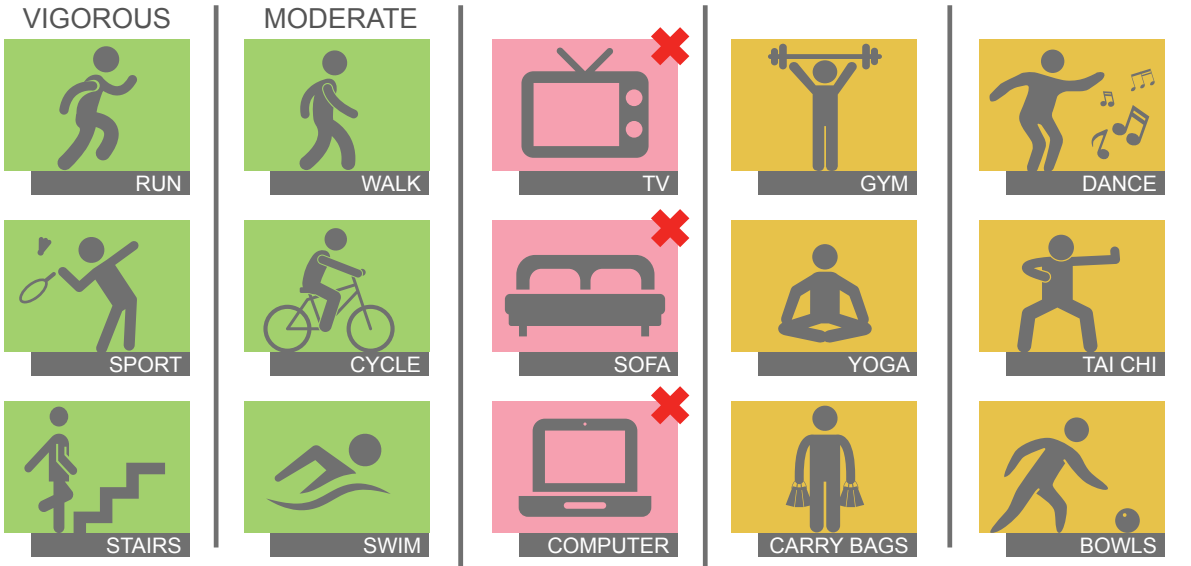
What should you do?

For a healthy heart and mind

To keep your muscles, bones and joints strong

To reduce your chance of falls

Be active | **Sit less** | **Build strength** | **Improve balance**



MINUTES PER WEEK

75 OR **150**

VIGOROUS INTENSITY (breathing fast difficulty talking)

MODERATE INTENSITY (increased breathing able to talk)

OR

A COMBINATION OF BOTH

Break up sitting time

2 days per week

Something is better than nothing.

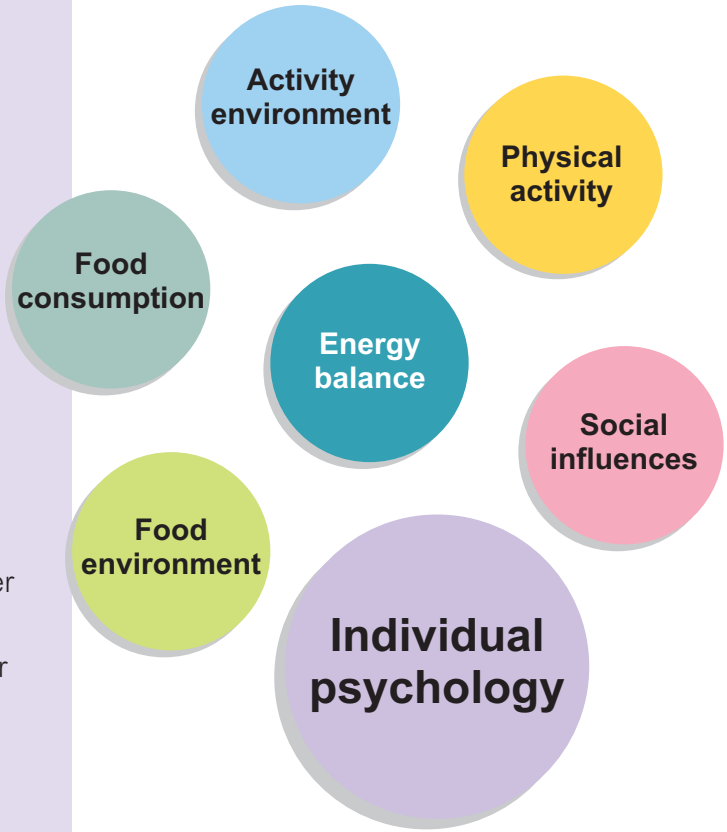
Start small and build up gradually: just 10 minutes at a time provides benefit.

MAKE A START TODAY: it's never too late!

Source: UK Chief Medical Officers' Guidelines 2011 Start Active, Stay Active: http:bit.ly/startactive

Spotlight on:

Individual psychology



Food intake

Research suggests the majority of adults and children have an understanding of what constitutes a healthy diet[34]. Eating lots of fruit and vegetables is the most frequently cited component whilst the reduction of sugar and fat also figures highly. The majority of adults consider healthy eating to be important and would like to improve their own eating habits and those of their children.

Yet the majority of adults do not eat the recommended minimum of five portions of fruit and vegetables per day and neither do the majority of children. Across all age and income groups, both men and women consume less than the recommended daily amount of fibre.

As the majority of people know what they should be eating for a healthy diet then we need to understand what factors are making it difficult to achieve this goal.

Stress

Long-term stress from a range of pressures, can affect eating behaviour in different ways. It is estimated that around 30% of people eat less than normal when stressed, but most individuals will eat more[35].

Individual psychology *describes a number of psychological attributes from stress to the demand for indulgence. It also covers aspects such as the level of children's control over their diet.*

Food labelling

Nutrition literacy is the term used to describe people's understanding of food, especially the complexity of food labelling. Whilst the 'traffic light system' is now present on a great deal of food packaging, this is not universal on all foods and may not be far reaching enough.

If individuals are to make informed choices about what they eat then any mechanism to make this as easy and accessible as possible should be promoted and welcomed. The traffic light system for food labelling is one example which could be rolled out to simplify choice for people.

Resilience

The choices we make are influenced – perhaps more than we realise – by the day-to-day pressures we face, the behaviour of those around us, the sort of neighbourhood we live in and the prevailing culture relating to food and physical activity. This unfortunately favours overconsumption and inactivity. Going against the 'norm' can be challenging for most people.

The County Durham school nursing service will deliver health improvement interventions as part of a schools planned and progressive curriculum. Resilience building work will support life skills including decision making, managing peer pressure and risk taking behaviours. The County Durham resilience programme is working with schools across the county to enable them to support and develop resilient children and young people.

Targeted weight management programmes

The Family Initiative Supporting Children's Health (FISCH) programme provided by Durham County Council, Leisureworks and County Durham and Darlington Foundation Trust is a weight management programme delivered mainly to primary school aged children, targeted at those with a BMI at or above the 91st centile.

The programme consists of a 10 week school based group intervention during curriculum time and pre/after school club sessions. In addition one to one family interventions for children with BMI at 95th centile or above are delivered. The programme aims to maintain the weight (body mass)/BMI of participants and promote behavioural change. (See description of BMI and centiles on page 6.)

A recent evaluation assessed the effectiveness of the programme and the impact on BMI trends.

It was found that,

- the school based intervention led to a reduction in both excess weight and obesity prevalence over a 12 month period. One case study school also showed a sustained reduction at 18 months;
- There was a 6% and 4% decline in prevalence of excess weight and obesity respectively across the participants included in the evaluation;
- A 40% increase in knowledge for proposed behavioural changes was achieved at 12 months; and
- The family intervention achieved a sustained reduction or stabilisation of BMI in over 90% of participants at 12 months.

The programme was effective in reducing excess weight and obesity prevalence among participants.

- We continue to strengthen and explore further partnership working with other agencies in order to increase coverage of this programme.
- The programme is being expanded to include five health trainers. This approach acknowledges the social complexity of obesity and the reality of the challenges facing families in County Durham. The health trainers will work closely with the whole family to help them achieve a healthy weight. This will be monitored after 12 months to establish the effectiveness of this approach.

Making Every Contact Count (MECC)

There are thousands of opportunities every day for frontline staff across a range of partner organisations to help tackle obesity and reduce health inequalities. Every contact with a resident should be seen as an opportunity to encourage healthier lifestyle choices.

MECC encourages conversations based on behaviour change approaches, empowering healthier lifestyle choices and exploring the wider social determinants that influence our health.

To make every contact count organisations should:

- Build a culture and operating environment that supports continuous health improvement around obesity through the contacts it has with individuals[36]. Insight from MECC initiatives across the country have shown that service users expect to be asked about their health[37].
- Create the culture in which MECC operates through vision and mission statements and through strong leadership.
- Offer staff a suitable environment and the skills and knowledge to deliver MECC.

The whole system should align itself towards the prevention of obesity. Providers of care should build the prevention of obesity and promotion of healthy living into their day-to-day business. Service commissioners could require providers to do this through contracts, payment, incentives and pathway design, and the priorities set for commissioners should reflect this responsibility[38].

The wellbeing for life service uses a 'strengths based' approach that acknowledges and builds upon the strengths, skills and capacities of people to live healthy lives alongside the assets within their local community. Part of the local approach is the delivery of MECC training to members of the community and front line partners, to help develop the skills needed for this approach.

Obesity has much in common with many of other public health challenges.

Wellbeing approaches

Obesity has much in common with many of other public health challenges. Many of the wider determinants of health that impact upon obesity, such as educational attainment and income, are the same for other areas of poor health. The social, infrastructural and environmental factors that impact on obesity are the same for many other public health issues. Current programmes in County Durham are taking a collective approach to tackling obesity, mindful that the evidence demonstrates a many pronged approach will have the greatest impact.

We know that people's lifestyles and the conditions in which they live and work act together to influence their health and wellbeing. Poor socio-economic circumstances can affect health and wellbeing throughout life, resulting in persistent and pervasive health inequalities. Behaviour change policy and practice must be addressed in a more integrated and holistic manner to have the greatest impact.

The evidence indicates that 70% of adults currently engage in two or more of the main unhealthy behaviours, and the situation is even more pronounced for those in lower socio-economic groups[39].
A holistic wellbeing approach provides support to people to live well by addressing the factors that influence their health. It also builds their capacity to be independent, resilient and maintain good health for themselves and those around them[40].

Many existing solutions focus on single issues, e.g., weight management, food and health etc. The wellbeing approach goes beyond looking at single-issue healthy lifestyle services and instead aims to take a whole-person and community approach to improving health[41].

What is a wellbeing service?

Wellbeing services provide support to people in order to improve their health and wellbeing. There are different national models for wellbeing services, however, they all share common features:

- Promote positive health that can empower individuals, enabling them to maintain and improve their own health and wellbeing.
- Where necessary services and programmes facilitate lifestyle adjustments e.g., healthy eating.
- The focus is on promoting quality of life not just length of life.
- Rather than considering just the specific issue, the service considers the whole person and issues impacted by the wider determinants of health such as lifestyle, social environment and living conditions as these may be preventing them from reaching their optimum health. If poverty is the fundamental issue, then the wellbeing for life service will provide meaningful guidance into the appropriate services.
- Wellbeing services take into consideration inequalities in health and actively seek out those individuals who do not usually benefit from mainstream health services.

County Durham's Wellbeing for Life Service

The Wellbeing for Life service adheres to the principles of a general wellbeing model as described above. More information about the Wellbeing for Life service in County Durham can be found at www.wellbeingforlife.net or contact 0800 8766887.

Spotlight on:

Social influences

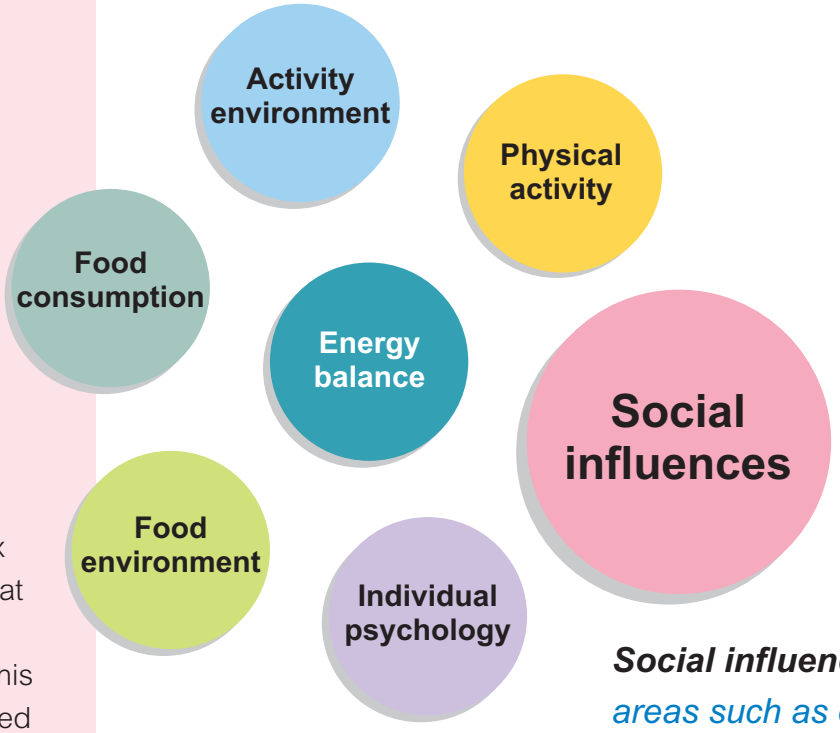
Who is obese?

Nationally most adults (around 65%) are overweight or obese[5]. It's not surprising that the average body mass index in the UK is now above that considered to be in the healthy range. Arguably this shift in the norm has altered people's perception of obesity. Innovative work by Newcastle University seeks to explore this issue and create approaches which can help parents to identify overweight and obesity outside of any specific measurement programme.

Food and culture

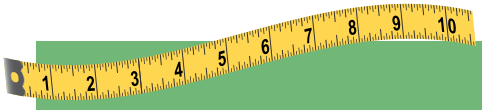
Food is an enjoyable part of life and plays an important part in many cultural celebrations from birthdays through to Christmas. However, many of these important occasions are becoming heavily linked with the consumption of unhealthy foodstuffs and alcohol, in ways no longer associated with the occasion itself.

Further information on the impact of alcohol on weight, is found on page 37.



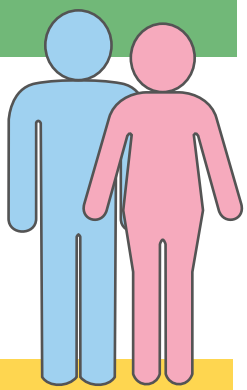
Social influences *cover areas such as education and the impact of the media. It also includes societal attitudes to overweight such as its acceptance or not.*

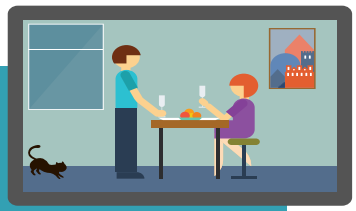
We may not see ourselves or our children as obese...



Adults tend to underestimate their own weight

Half of parents do not recognise their children are overweight or obese





The media tend to use images of extreme obesity to illustrate articles about obesity

GPs may underestimate their patients' BMI

If we do not recognise obesity we are less likely to prioritise tackling it

Source: After Public Health England

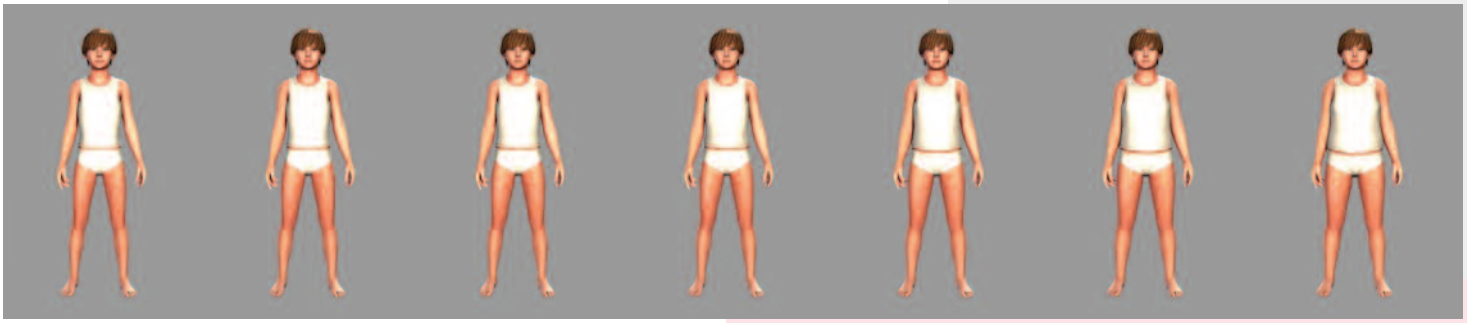
MapMe body image scales

Guest contribution from Professor Ashley Adamson and team at the Institute of Health & Society Newcastle University

Childhood obesity is an important public health problem worldwide and identifying effective preventive strategies remains a priority. Parents are central to the development of their child's health-related behaviours and play a key role in both the development and implementation of prevention strategies. However, many studies show that many of us do not recognise when a child is overweight compared with guidance on healthy body weights for children. For example, previous work in the North East showed that over two thirds of parents of overweight children described their child as being of 'normal weight' at seven years. In common with most people parents tend to use how their children look compared with others who may be more overweight, to identify their weight status. So this means that in the context of a high prevalence of childhood overweight, many of us rely on extreme cases as a reference point for our understanding of what 'overweight' means.

Addressing the difference between parents' perceptions and actual child weight status is important. If parents do not perceive their child as overweight they are unlikely to make appropriate changes to their child's lifestyle. However there is evidence that parents are more likely to make such changes if they perceive their child's weight as being a health problem. So increasing parents' knowledge of what an overweight child does look like, plus increasing their knowledge about the health consequences of childhood overweight is a strategy worth exploring.

Body image scales are visual images of body shapes ranging from underweight to obese (very overweight). These were developed using portable 3D body scanning technology to obtain body scans from 800 children (boys and girls aged 4-5 and 10-11 years). Parents and health professionals throughout the North East were consulted extensively and helped to develop the body image scales as a method to improve parents' ability to recognise overweight in children and to develop supporting information to increase parental knowledge of the consequences of childhood overweight. The results are being tested in a large trial with almost 3,000 families.



A study at Newcastle University funded by the Medical Research Council (MRC) - National Prevention Research Initiative has developed and tested visual tools (body image scales) designed to improve parents' ability to correctly assess their child's weight status as well to improve knowledge of the health consequences of childhood overweight.

Next steps

During 2016/2017 public health will be working with Newcastle University, wider health partners and Durham County Council's One Point Service to implement the 'body scans' project, to try and alter perceptions of excess weight and impact upon the prevalence of obesity of reception age children.

change 4 life

Eat well Move more Live longer

Change4Life is a national initiative that brings together a range of stakeholders

Change4Life

Change4Life is a national initiative that brings together a range of stakeholders with the shared aims to improve diets and levels of activity so reducing the threat to the individual's future health and wellbeing. The promotion of 'unhealthy' behaviour and foodstuffs is commonplace and it is important to have a recognisable brand to help our communities make healthier choices.

The goal of Change4Life is to help every family eat well, move more and live longer.

Change4Life seeks to change behaviour by providing support for families and individuals to make small but significant changes to their diets, activity levels and alcohol consumption.

In County Durham, Change4Life has expanded beyond the confines of traditional marketing, to be the public face of positive intervention around obesity. There are Change4Life branded cooking courses, sports clubs in schools, fun runs and events.

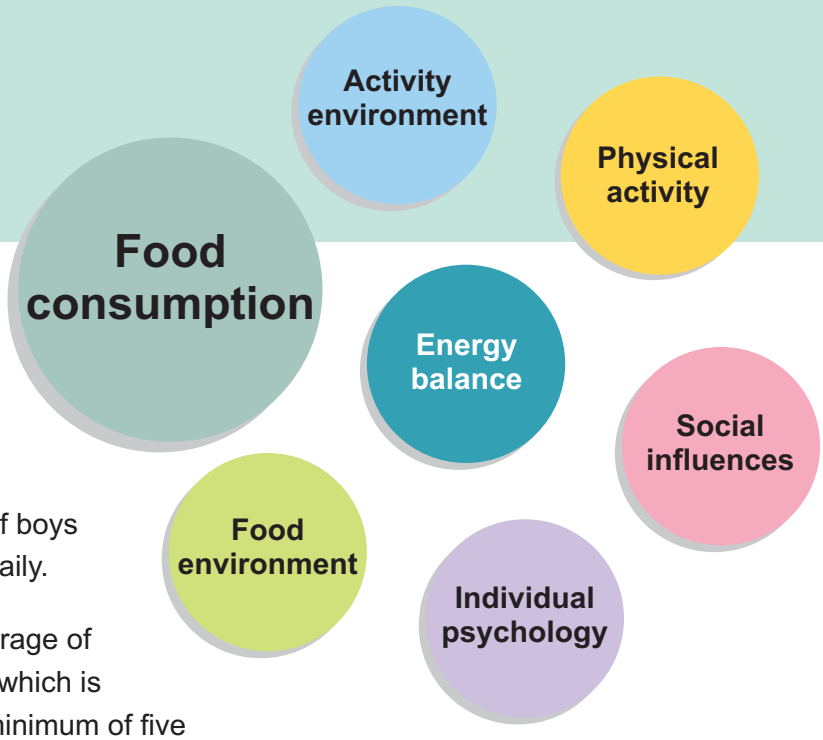
It has even been adopted by the local health check programme, Check4Life, which can help people make changes to their behaviour through one recognisable, consistently branded programme.

The Healthy Weight Strategic Framework for County Durham acknowledges the importance and power of Change4Life and recommends its adoption for all healthy weight initiatives across the county. National activity provides a significant platform for local initiatives to utilise as well as the free national programme that is full of useful tips and tools for our residents.

Too often campaigns used by the health community compete with each other for attention and recognition. In an often cluttered health environment, the collective use across County Durham of Change4Life, which is a recognised and trusted brand, could help to make the healthy choice easier for our communities.

Spotlight on:

Food consumption



Food consumption

Surveys show that nationally, the majority of children do not eat the recommended minimum of five portions of a variety of fruit and vegetables per day[25]. For children aged 11-18 years only 10.1% of boys and 7.5% of girls actually eat five portions daily.

Children aged 11-18 years consume an average of 2.9 portions of fruit and vegetables per day which is significantly lower than the recommended minimum of five portions.

For children aged 5-15 years, those aged 11-12 years consume the smallest number of portions of fruit and vegetables per day, 2.3 portions for boys and 2.8 portions for girls.

Children living in households with the highest incomes eat the most fruit and vegetables per day, 3.9 portions for girls and 3.5 portions for boys.

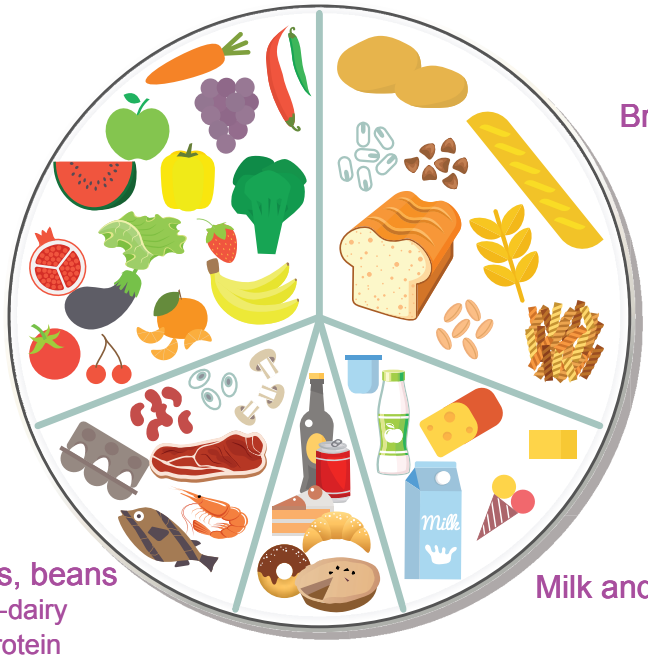
Food consumption *includes many characteristics of the food market and of food products, such as the nutritional quality of food and drink, the energy density of food, and portion size.*

Food intake

Use the eatwell plate to help you get the balance right. It shows how much of what you eat should come from each food group.

The eatwell plate

The eatwell plate highlights the different types of food that make up our diet, and shows the proportions we should eat in order to have a healthy, balanced diet.



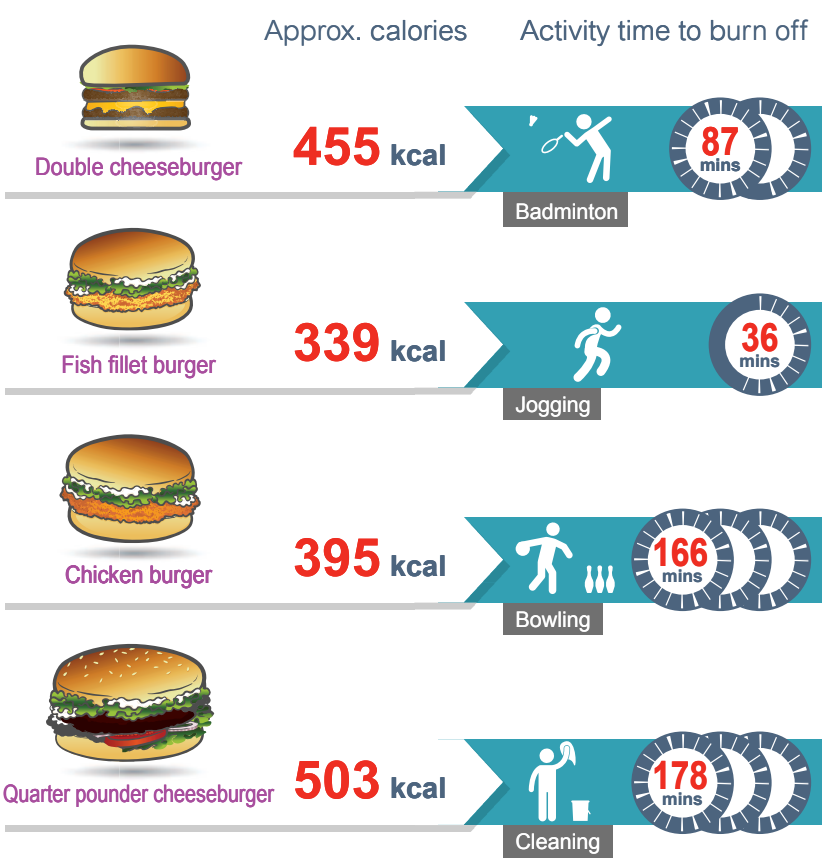
Source: Public Health England in association with the Welsh Government, the Scottish Government and the Food Standards Agency in Northern Ireland

Energy dense foods

The energy density of food and drink (the amount of energy per unit weight of food or beverage) has been identified as an important factor in weight control in both adults and children. **Foods high in fat tend to be energy dense** as dietary fat provides the greatest amount of energy per gram, whereas foods that contain a lot of water or are high in fibre tend to be less energy dense.

People with access to less energy dense foods have been shown to consume less energy overall (making it easier to maintain a healthy weight) and conversely evidence suggests that consumption of energy dense foods can lead to people eating food containing more energy than they need, before feeling full[42,43]. Indeed a recent review concluded that for adults "consuming a diet higher in energy density is associated with increased body weight, whereas consuming a diet that is relatively low in energy density improves weight loss and weight maintenance"[42].

There is also a relationship between the energy density of foods and cost, such that cheaper foods tend to be more energy dense[44,45]. Therefore attempts to eat a healthy diet based on lean meat, fish, fresh fruit and vegetables may represent an increased cost. Obesity itself has been shown to be socio-economically patterned with those from more deprived backgrounds being most at risk[24,25].



This observation may be at least in part due to efforts to manage food budgets[46,47].

Taste, often a consequence of added fats and sugars and convenience, may also predispose people towards food choices which include processed and pre-packaged foods[48]. However, when the economic picture is also considered it is possible to see how wider factors create the conditions that make it difficult not to over consume, leading to excess weight. This is often called the obesogenic environment.

Sugar

The recent report *Sugar Reduction: The evidence for action*[49] highlighted that consuming too much sugar in food and drinks can lead to weight gain and its related health problems.

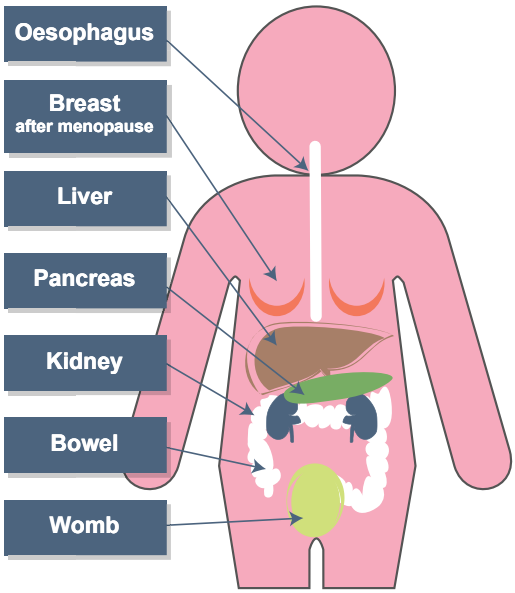
A high sugar diet
can lead to weight gain

A high sugar diet can lead to weight gain, which increases the risk of cancer

Overweight and obesity
can cause 10 types of cancer

1 IN 20
UK cancers are linked to weight

Being overweight may also cause gallbladder, aggressive prostate and ovarian cancer



Source: After Cancer Research UK

Key Facts on Sugar from Scientific Advisory Committee on Nutrition (SACN)[50]

SACN has recommended that:

the average population maximum intake of sugar should be halved:

it should not exceed 5% of total dietary energy.

The emerging breakfast drinks market, often labelled as convenience, contains products which contain as much as 25g of sugar per serving (6 teaspoons).

Currently sugar intakes for all population groups are above the recommended levels, contributing between 12 to 15% of total energy intake.

This is the first time Scientific Advisory Committee on Nutrition (SACN) has made a recommendation to minimise consumption of a specific food and its significance and importance must not be underestimated.

Consumption of sugar and sugar sweetened drinks in school age children is particularly high.

Sugar consumption also tends to be highest among our most disadvantaged communities who also experience higher prevalence of obesity and its health consequences.

A systematic review of the association between body weight and the intake of sugar-containing foods and beverages, commissioned by the World Health Organisation found that reducing sugar intake in adults without imposing any other food restriction led to a decrease in body weight[51].

Sugar intake

Nationally representative data on the carbohydrate intakes of the UK population drawn from the National Diet and Nutrition Survey (NDNS)[26] rolling programme highlights the sources of sugar as below:

Adults 19-64 years

Table sugar, biscuits, buns, cakes, pastries and puddings and soft drinks are the main sources of sugar.

Age 11-18 years

Soft drinks (excluding fruit juice) are the largest single source of sugar and on average those who consume them drink around 336ml per day. This is roughly equivalent to one can of a sugary drink daily.

On average soft drinks provide 29% of daily sugar intake for this age group. Table sugar and confectionery at 21% and fruit juice at 10% are also large contributors to the sugar intake of 11 to 18 year olds.

Age 4-10 years

For younger children soft drinks, biscuits, buns, cakes, pastries and puddings, breakfast cereals, confectionery and fruit juice are the major sources.

what's the maximum amount of sugar we can have?

A typical 8 year old shouldn't have more than 6 cubes of added sugar* per day [52]

Age	Recommended maximum added sugar intake	Sugar cubes†
4-6yrs	no more than 19g per day	5 cubes
7-10yrs	no more than 24g per day	6 cubes
From 11yrs	no more than 30g per day	7 cubes

The number of sugar cubes featured is based on total sugar in grams per portion/100g/pack divided by 4 grams (the weight of one 4g sugar cube). Images are a representation only.

Whilst it is not news that too much sugar is bad for us, the amount of it we eat, the impact on our health and the number of factors sustaining our consumption are certainly worth exploring. Sugar features in so much of what we eat and clearly is enjoyable but the newest evidence is very clear – we must reduce our intake quite drastically.

Public Health England state in very stark terms that "this is too serious a problem to be solved by relying only on individuals to change their behaviour in response to health education or to rely simply on food labelling. No single action will be effective in reducing sugar intakes"[49].

A broad programme of measures to affect the areas that influence our sugar consumption, reduce the sugar content of our food and drinks as well supporting people to make healthier choices would have significant impact across population health.

Whilst some of the report's recommendations might require Government interventions, many can be tackled in our communities through working together. We can bring about local change to reduce our unhealthy consumption of sugar.

Sugar swaps

Change4Life have recently created a sugar swap app available for smartphones. This app allows the user to scan the bar code on a food product and the app will display the number of cubes of sugar within the food or drink. It's a quick, easy and fun way to keep a check on sugar intake. Visit www.nhs.uk/change4life/Pages/change-for-life

What could be tackled at a local level in County Durham	What might require national action (which we could support)
Look at choices such as 'kids meals' in local retail venues i.e. providing water with a meal instead of a sugary drink. Work with retailers to bring about changes.	Tighter regulations and controls on catering provision.
Look at what is promoted in venues such as leisure centres and canteens i.e. branded fridges in retail environments with high fat and sugar snacks and drinks. Work with providers on healthy options.	Significantly reduce opportunities to market and advertise high sugar food and drink products to children and adults across all media including digital platforms and through sponsorship.
Adopt agreed standards for a range of food and drink related issues where these are available.	Legislation.
Look at any environment where food is sold i.e. staff canteens, visitor and tourist sites, cafes etc. and explore increasing healthy options with providers.	Nationally introduce a broad, structured and transparently monitored programme of gradual sugar reduction in everyday food and drink products, combined with reductions in portion size.
Support the call for a tax on sugar. Explore with local caterers and providers of food a local initiative to charge more for high sugar products with the increased margin being collected for charity.	Introduction of a price increase of a minimum of 10-20% on high sugar products through the use of a tax or levy such as on full sugar soft drinks, based on the emerging evidence of the impact of such measures in other countries.
Adopt, implement and monitor the government buying standards for food and catering services (GBSF) across the public sector, including national and local government and the NHS to ensure provision and sale of healthier food and drinks in hospitals, leisure centres, public sector environments and commissioned services.	
Ensure that accredited training in diet and health is routinely delivered to all of those who have opportunities to influence food choices in the catering, fitness and leisure sectors and others within local authorities.	
Continue to raise awareness of concerns around sugar levels in the diet to the public as well as health professionals, employers, the food industry etc. Encourage action to reduce intake and provide practical steps to help people lower their own and their family's sugar intake.	

Energy drinks

Energy drinks are non-alcoholic beverages promoted as a way to improve performance and relieve fatigue. They can contain high levels of caffeine and sugar as well as other ingredients with stimulant properties, such as guarana, taurine or herbal substances[53].

Due to the increasing popularity and their high caffeine and sugar content, consumption of energy drinks by children and young people is a growing concern for many. There are no clear recommendations for caffeine intake, although the Food Standards Agency recommends that it should only be consumed by children in 'moderation'. Anecdotal evidence suggests that young people who regularly consume energy drinks can become dependent on them and even moderate consumption may be detrimental[54,55,56]. Caffeine when consumed in larger doses, can cause anxiety, agitation, sleeplessness, gastrointestinal problems and arrhythmias[57].

Almost 29% of 11-18 year olds' sugar intake is through sugar sweetened beverages and is three times higher than is recommended. The reduction of these alone could lead to a decrease in sugar consumption for our next generation.

Much work has taken place to reduce sugary drinks in our schools across County Durham, with many schools prohibiting them on their premises. The journey to school and what a child eats before their first lesson is being explored elsewhere in the country.

Energy drinks are frequently high in sugar and there are health implications associated with excessive sugar intake, such as dental erosion, obesity and type 2 diabetes.

The HYPER! study found that young people in County Durham consume energy drinks before, during or after school and discussions with young people, parents and teachers imply that consumption is widespread[58].

There have been calls to restrict the sale of energy drinks to under-18s in recognition that childhood is a period of rapid growth and the final stages of brain development, when sleep and good nutrition are especially important[56].

It is likely that many people are simply unaware of the possible negative effects of energy drink consumption.

Raising awareness of these issues should help but elsewhere in the UK, organisations have begun to explore how they can tackle the availability of energy drinks.

The RRED (Responsible Retail of Energy Drinks) campaign in Edinburgh has successfully encouraged a number of local retailers to sign up to a voluntary code of practice restricting sales of energy drinks to children[59].

Alcohol and calories

Source: After www.12wbt.com

'Empty calories' in alcohol

On average, alcohol makes up 10% of the calorie intake among adults who drink. Drinking alcohol regularly can form a significant part of daily calorie consumption[60].

According to Alcohol Concern, there is a lack of public awareness about the calorific content of alcoholic drinks and about how alcohol intake should be managed in order to maintain a healthy weight.

Alcoholic drinks lack most essential nutrients and vitamins, so if alcohol is providing many or most of the calories in the diet then there is a risk of nutritional deficiencies. Saving calories from food for alcohol i.e. drinking alcohol rather than eating to prevent putting on weight – sometimes termed 'drunkorexia' – should clearly be avoided.

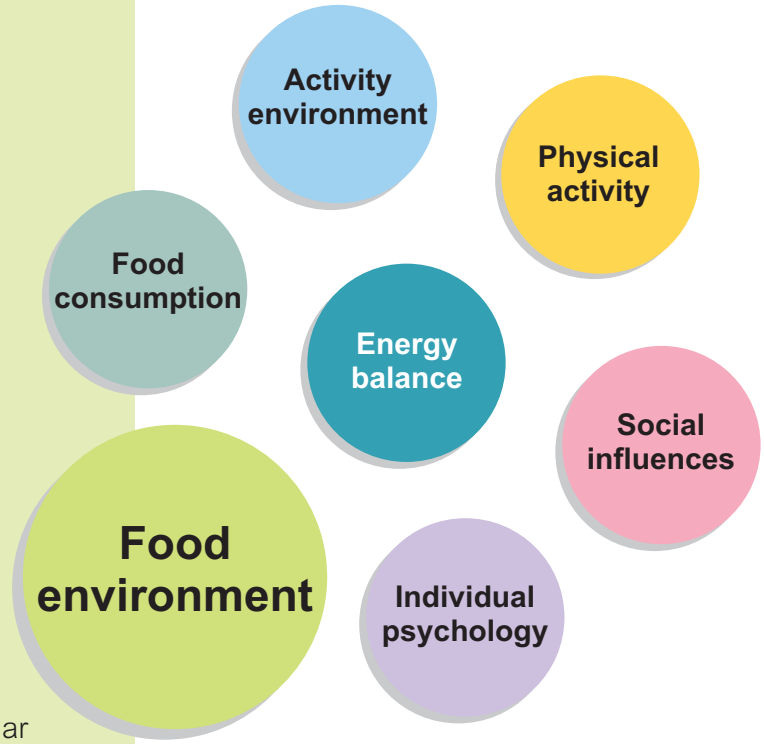
Many people forget to include alcoholic drinks when watching what they eat. It's easy for calories from alcohol to add up quickly and be unnoticed as they are being consumed as a liquid. To achieve and maintain a healthy weight it is far better to moderate alcohol intake.

Alcoholic drinks are made by fermenting and distilling natural starch and sugar. Calories from alcohol are 'empty calories', they have no nutritional value. Drinking alcohol also reduces the amount of fat the body burns for energy[61]. Whilst the body can store nutrients such as protein, carbohydrates and fat it cannot store alcohol. The body system needs to process the alcohol and doing so takes priority. Other processes that should be taking place including burning fat, are halted whilst the liver is processing alcohol.

Recent evidence of a strong link between obesity and liver cirrhosis in people with excess weight demonstrates the compounding effects of both obesity and alcohol, highlighting the need to look at the complexity of issues that impact upon levels of obesity[62].

Spotlight on:

Food environment



Food environment *includes the food industry and the pressure for profitability and the cost of ingredients. It also includes aspects reflecting the wider social and economic situation in the UK, such as purchasing power and societal pressure to consume.*

Takeaways

Reducing salt and saturated fat intakes for the population could reduce morbidity and mortality rates from cardiovascular disease. Sections of the population who regularly eat fast-food may be consuming substantially higher amounts of trans fats, industrially-produced trans fatty acids. Analysis by Public Health England shows a strong association between deprivation and the density of fast food outlets, with more deprived areas having a higher proportion of fast food outlets per head of population than others[63].

Durham County Council has powers to prevent new fast-food outlets being provided and street trading consents close to schools and other children's educational facilities.

Portion size

Research into portion sizes by the British Heart Foundation has suggested that when people are presented with more food, they eat more. Larger portion sizes tend to increase the total amount of food eaten over the day as people do not compensate by eating smaller portions at other times[64].

Whilst the British Heart Foundation is seeking national action, there exists the opportunity to make changes at a local level. Local workplaces that serve food can contribute by controlling portion sizes and providing relevant information to allow employees to understand their intake during meal and snack times.

Purchasing power

Research by Cambridge University showed that since 2002, healthier foods and beverages have consistently been more expensive than less healthy ones. In 2012, healthy foods were three times more expensive per calorie than less healthy ones. This trend is likely to make healthier diets less affordable over time, which may have implications for population health and social inequalities in health[65].

School Food Plan

The School Food Plan has the support of the Secretary of State for Education and of diverse organisations supporting head teachers to improve food in their schools. As part of the School Food Plan, a new set of standards for all food served in schools was launched by the Department for Education. These standards became mandatory in all maintained schools, new academies and free schools from January 2015.

Welcomed by the Save Our Standards Campaign, the new standards are designed to make it easier for school cooks to create imaginative, flexible and nutritious meals. Many schools in England have already started using the new standards and are really enthused by the possibilities. In some areas, improvements have been dramatic leading to more nutritious meals for children and young people.

Durham County Council is supporting schools in the education system locally to adopt the school food plan. For further information contact publichealth@durham.gov.uk

School growing clubs

County Durham has 44 school growing clubs that incorporate learning with the provision and consumption of healthier foods. The Growing Healthy Project works with a number of schools to use spare space to grow fruit, vegetables and herbs.

Children are also involved in creating recipes to try at home with the produce they have grown. This encourages their family to share in the healthy meal and potentially expand diet choices. Cooking on a budget can be challenging and may prevent parents from experimenting with new foods as they do not want any waste when money is tight.

School growing clubs can help to introduce children to healthier foods in an interactive and enjoyable way and 10 more clubs are planned for 2016/2017.

FACT:

Currently County Durham has a school meals uptake rate of approximately **64%** across primary schools.

84% of key stage one children access the free school meals offer.

The school food environment alone may not change the lunchtime culture. The support of local parents to ensure the success of this plan is essential if it is to have a lasting impact on the health of our children.

Growing Durham aims to support more people to grow food in their local community...

Sustainable food

Food Durham is the name for the County Durham Food Partnership that was launched in May 2014 and brought together organisations, individuals and groups involved or interested in sustainable food. The strategy has six main themes; supporting the local economy, environmental sustainability, health and wellbeing, resilient and active communities, education and skills and food fairness.

Two areas have been prioritised - research into how to make the local food supply chain more efficient and increasing opportunities for people to grow their own food. The former is a study to explore the efficiency of the local food supply chain for business to business trade. Achieving this will provide a more secure route to market for growers and producers wanting to sell for local consumption, give confidence of growth for new food producers and make it easier for local businesses to source locally produced food.

Growing Durham aims to support more people to grow food in their local community and it covers a range of options including people getting together to plant fruit trees on public land where anyone can pick them to starting a social enterprise.

The following are examples of local partners who are influencing the food environment.

Case study:

Durham University food procurement

Durham University have implemented a procurement strategy to ensure a sustainable source from local growers for fruit and vegetables. The university catering team worked with key local providers to identify a group of local growers of seasonal produce that were sourced within 25 miles of the university.

One provider has now become a hub for local producers identified by the university to supply bread, milk, yoghurt and free range eggs. The university now sources milk and yoghurt from locally based businesses.

There are many challenges to eating healthily and helping to ensure the sustainability of local producers can bring locally sourced food closer to our communities. If people are to eat healthier food such as fruit and vegetables then clearly they need to be able to access it. This is just one of many approaches to help achieve that.

Case study:

Durham County Council Sustainable Buying Standard

As part of Durham County Council's commitment to delivering its services in a sustainable manner, a sustainable buying standard for food contracts, for both direct food supplies and catering purposes was agreed in May 2015.
The standard provides the council with an opportunity to build into its vending machine re-procurement exercise, tighter nutritional standards for both hot and cold drinks.

Case study:

Durham County Council restriction of fast food takeaways

In England, there is considerable access to cheap, palatable, energy-dense food that may lack nutritional value. Evidence from high-income countries has shown that the level of fast food consumption is an independent predictor of obesity.

Food from takeaway outlets is often high in salt, fat and sugar making it difficult to make a healthy choice. Around 40% of the calories in meals and snacks eaten outside the home tend to come from fat. A health needs assessment undertaken in County Durham revealed a greater concentration of fast food takeaways in our more deprived neighbourhoods. Restricting the siting of new takeaways proposed within 400 metres of schools can help to address this.

The next step from individual project success would be to work with takeaway outlets and trading standards to improve the quality of the food offered in local communities to improve access to healthier options.

So what are we doing in County Durham?

We know that 'one-off' interventions may work in isolation for some individuals but are not having the necessary impact on levels of excess weight. The evidence is clear, we need to work as a system tackling overweight and obesity on all fronts. This section gives the reader some insight into what we have been doing. We need however to build on this work and be braver if we are to make a difference.

Partnerships

The Healthy Weight Alliance, accountable to the County Durham Health & Wellbeing Board, is County Durham's main partnership that is tackling the healthy weight agenda. The overarching purpose of the alliance is to develop and improve strategic partnerships that are committed to reducing the prevalence of obesity in County Durham.

The alliance developed the Healthy Weight Strategic Framework for County Durham. The aims and objectives are detailed below:

Aim

Develop and promote evidence based multi-agency working and strengthen local capacity and capability to achieve a sustained upward trend in healthy weight for children and adults in County Durham by 2020.

Objectives

- To develop a supportive built environment so that it is less inhibiting of healthy lifestyles such as walking, cycling and access to healthy food and nutrition;
- Provide information and practical support needed for individuals to make healthier choices;
- Provide effective programmes and services to help individuals and families achieve and maintain a healthy weight; and
- Develop a workforce which is competent, confident and effective in promoting healthy weight.

On the back of new evidence, publication and research, the Healthy Weight Strategic Framework will be refreshed and relaunched in 2016.

If you would to join the Healthy Weight Alliance please contact publichealth@durham.gov.uk

Diabetes in County Durham

In County Durham we have been piloting some innovative work to identify those most at risk of type 2 diabetes and work with them to reduce their risk.

Excess weight and having a large waist (94cm or 37 inches for men of White or Black ethnicity, 90cm or 35 inches for men of Asian ethnicity and 80cm or 31.5 inches for women) are risk factors for developing type 2 diabetes[66].

11.5 million people in the UK are at increased risk of type 2 diabetes and that number is rising every year. **What is startling is that 80% of type 2 diabetes is preventable.**

It is estimated that 3.9 million people in the UK have diabetes, with around **700 people being diagnosed each day**.

If nothing changes, by 2025 **five million people** in the UK may have diabetes[67].

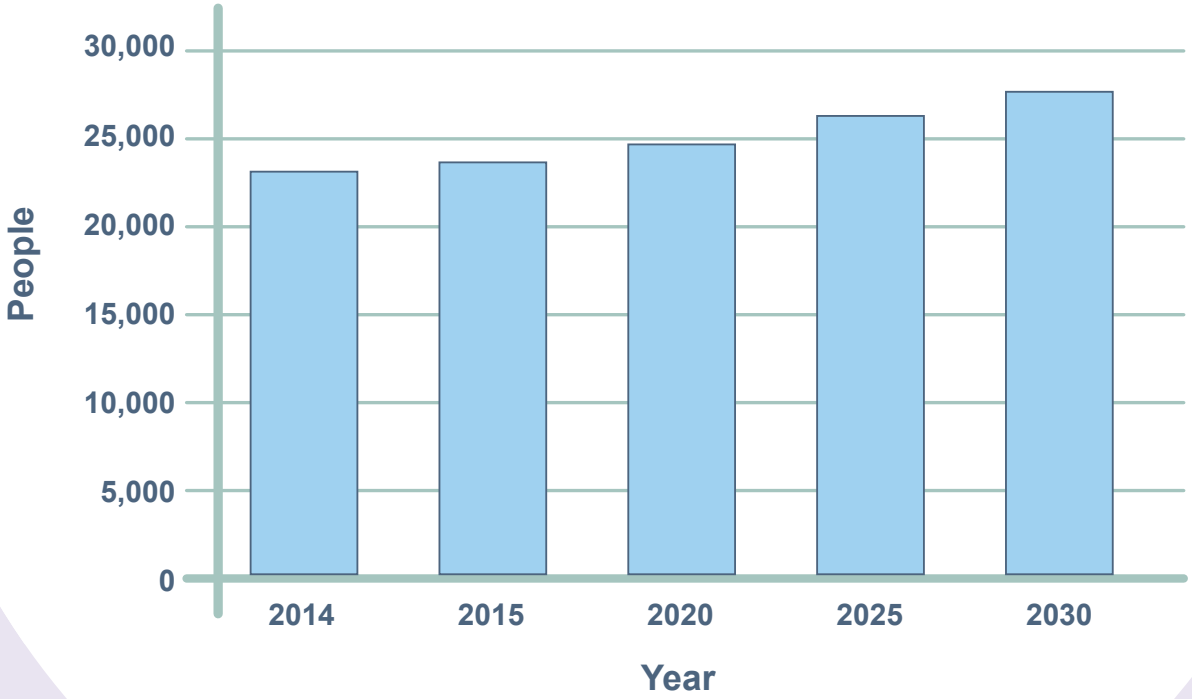
In **County Durham 23,743** are known to have diabetes now.

If no action is taken to slow the increase **27,472** will have developed the disease by 2030.

Source: www.pansi.org.uk data

Excess weight is a consequence of unhealthy diets that are high in calories coupled with increasing sedentary lifestyles. Steps can be taken to make a positive change and reduce the risk of developing diabetes. In addition to the modifiable risk factors of weight and waist size there are a number of other factors that may increase the likelihood of developing the condition, these include being over 40 or over 25, if of Black or Asian ethnicity, having a close family member with type 2 diabetes (parent, brother or sister), being south Asian or Afro-Caribbean, having polycystic ovary syndrome, having previously had gestational diabetes or having impaired fasting glycaemia or impaired glucose tolerance. Since it is not possible to change most of these characteristics people in these groups should pay particular attention to maintaining a healthy weight[66].

Over 18s predicted to have Type 1 or Type 2 diabetes in County Durham



Source: pansi

National diabetes prevention programme

County Durham is hoping to be part of the first wave NHS National Diabetes Prevention Programme. The programme was announced in the NHS Five Year Forward View, which set out an ambition for England to be the first country to implement a national evidence-based diabetes prevention programme, modelled on proven UK and international models and linked, where appropriate, to the new NHS Health Check.

The NHS National Diabetes Prevention Programme aims to deliver at a large scale, services which identify people with non-diabetic hyperglycaemia who are therefore at high risk of developing type 2 diabetes. The programme will offer them a behavioural intervention to lower their risk of type 2 diabetes.

The programme has been progressed locally by a partnership between Durham County Council, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and North Durham Clinical Commissioning Group.

Check4Life

During 2014, a new approach to the delivery of Health Checks in County Durham, Check4Life was developed. As well as providing an opportunity to help people achieve and maintain a healthy weight, be physically active, eat healthily, stop smoking and cut down alcohol consumption. Check4Life also establishes each individual's risk of heart disease and diabetes. This information is then used to signpost at risk people into the relevant programme. For further information on Check4Life visit www.impact.cdd.nhs.uk

Area Action Partnerships (AAP)

Durham County Council's 14 Area Action Partnerships cover all areas of the county. They deliver local services and give local people and organisations the opportunity to influence how services are provided. The AAPs ensure that the services provided by a range of organisations, including the town and parish councils, health and voluntary and community sector to meet the needs of local communities. Area Action Partnerships support local communities in tackling their obesity challenges by helping to secure funding for local sports clubs or creating and maintaining places for children to play such as skate parks and play areas. They also contribute towards the healthy eating agenda through supporting allotment programmes, kitchen facilities in community venues or working with partners to deliver healthy eating courses in the community.

Children's centres

A network of children's centres across the county provide support on health, education and social issues to families but is specifically focused on supporting those families in most need. Many children's centres run initiatives around healthy eating and encourage activity through play and learn sessions.

Healthy Child Programme

The World Health Organisation concluded that breastfeeding appears to provide some level of protection against childhood overweight and obesity. Together with other targeted nutritional interventions, breastfeeding can be an important component of strategies to reduce the risk of overweight and obesity in children. The healthy child programme delivered through health visitors includes universal visits to all families. During these visits advice and guidance for families about infant and child nutrition is provided at the appropriate time.

Obesity and oral health

Eating too much sugar is a risk factor both for obesity and oral health. The Scientific Advisory Committee on Nutrition concluded that higher consumption of sugar is associated with a greater risk of dental caries[50].

Dental caries impacts significantly on the quality of life of young children. Poor oral health can affect an individual's ability to eat, speak, smile and socialise normally[68, 69]. Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2013-14[70].

There is a strong relationship between deprivation and both obesity and dental caries in children. Data from the National Child Measurement Programme shows an almost linear relationship between obesity prevalence in children and the Index of Multiple Deprivation 2010 (IMD) decile for the area where they live. Please refer to pages 16 and 17 of the report for more information.

Because deprivation and high intakes of sugar are known risk factors for dental caries and for obesity[71,72,73], it is likely that interventions that reduce these common risk factors have the potential to impact both conditions.

Interventions that impact the social determinants of health and create supportive food environments are recommended as part of a common approach to health improvement[74]. Certain approaches may actually benefit more than one agenda and as such it is important that cross cutting initiatives are co-ordinated strategically and operationally across County Durham. Good oral health such as tooth brushing and regular visits to the dentist are clearly vital but reducing the amount of sugar in food and drink will also help maintain good oral health.

An oral health strategy is currently being developed for County Durham and it is expected to also impact on levels of obesity across County Durham due to the focus on sugar reduction.

Obesity and oral health are clearly linked and a concerted effort to reduce sugar intake will have multiple benefits to the health of our communities.

Dental caries impacts significantly on the quality of life of young children.

Whole systems approaches

There is broad agreement that tackling obesity requires a focus on multiple projects, at multiple levels, in multiple settings and for many groups of people and programmes. Expecting behaviour change by solely focusing on the individual is unlikely to be successful[75].

The evidence is clear that a whole systems approach is the most effective way to tackle obesity. We need to work across many professional disciplines and sectors to really make a difference.

Previous universal approaches to tackling obesity have often taken place in isolation or been a collection of individual interventions that have failed to mobilise and engage the entire system. Whole systems approaches release the potential for creative solutions which already exist within the system and need to be surfaced.

Our obesity challenge in County Durham needs people from across this complex system to bring their knowledge and specific expertise together as peers in a shared purpose. We need to work together to tackle obesity, generating healthy outcomes and doing so in a way that builds our community capacity that fosters resilience and sustainability.

Durham County Council has been identified as one of four local authorities across England to work with Leeds Beckett University for the next three years on approaches to tackle obesity. The purpose of the project is to understand how partners in County Durham can work together to reduce obesity and to halt the upward increase. This is a fantastic opportunity and success will rely on everyone playing their part.

A systems approach in County Durham

Some exciting work has already started. A group that represents the wider community and wants to tackle obesity has been brought together in the Four Together Area Action Partnership (AAP) area. Through a collective approach, the group is exploring the potential for creative solutions, drawing on the knowledge, experience and information already in the community. The initial group includes voluntary sector leaders, public health and physical activity professionals, elected members, teachers, primary care staff and children's services.

The challenge is to try and tackle the complex and integrated issue of obesity in children as a whole system, working together with a common goal.

A community of practice where people come together to share the work they are doing and generate ideas about future solutions is being progressed. The community of practice is linking together currently unconnected people and projects and opening the possibility of developing initiatives that are more integrated and coordinated.

Everyone in this community is welcome and all are encouraged to become involved with what will be a long term programme to improve the health of our children in County Durham. Anyone interested in joining this group in the Four Together AAP area that covers Ferryhill, Chilton, West Cornforth and Bishop Middleham, please contact publichealth@durham.gov.uk

So what next?

This is the million dollar question! I really hope this report has been able to show the complexity and challenge we face to tackle obesity in County Durham and I hope it will spur us all into greater action. I know there are already many initiatives and activities taking place across County Durham and being progressed by a whole range of partners. Can we do more? Can we work together as a system? I hope so.

You will already have ideas about actions you can take and the following recommendations will hopefully build on these. These are not the only actions and you may have some great ideas. Come along and join the Healthy Weight Alliance, share your experiences and learn from others. To find out more please contact publichealth@durham.gov.uk

Remember, this is everyone's business!

Recommendations

Elected members

Elected members have an influential role and could:

- Support the inclusion of changes that impact on obesity in appropriate strategies and plans. These plans may not always be directly about obesity but may still have an impact.
- Consider lobbying government over issues such as a sugar tax, or advertising restrictions on unhealthy foods and drinks aimed at children.
- Think about championing a healthy diet and a more active lifestyle in your community. Does the local neighbourhood make it easy for everyone to be active? Are there plenty of places for children to play?

Employers

Initiatives aimed at our workplaces may help to create a healthy and productive workforce. Employers could:

- Promote physical activity in the workplace especially those aimed at every day activity e.g., use stairs not lifts.
- How healthy is your canteen? Is having a healthy choice enough or should the majority of the food provision be healthy? Do you promote healthy options?
- Is water readily available to drink? Are unhealthy drinks heavily promoted?
- Do all policies consider the impact upon the health of your workforce, customers or your community?
- Review your vending machine procurement.

Workplace canteens

- Consider using the Government Buying Standard for Food and Catering, to improve quality and sustainability.
- How appropriate are the food portion sizes?
- Could you reduce the sugar content in the food and drinks you serve?
- How healthy or appropriate are your vending machines? Do they provide healthy alternatives?
- Is nutritional information available so that your colleagues can make informed choices about what they eat or drink?
- Can you promote healthier choices or initiatives such as the Change4Life sugar smart or snack swap initiatives?

Health professionals

All health professionals have a role in helping their patients to improve their health related behaviour.

- Midwives, GPs, health visitors, school nurses and their teams should provide information and advice to pregnant women and parents of young children about nutrition and physical activity for the whole family.
- Consider closer working with the public health team to explore all opportunities to tackle obesity.
- Health professionals should look at every contact with a patient as a health promoting opportunity and use this opportunity to provide guidance around healthier lifestyles and specifically around obesity.

Takeaways, cafes and local shops

There is no reason why this sector cannot consider healthier options.

- Consider healthy catering standards and provide food labelling.
- Could you join with your local community in their efforts to make the healthy choice easier?
- Promote healthy options in partnership with local schools or workplaces.
- Contact the public health team to explore opportunities to provide greater choice to your customers.

Child care settings

All settings where children spend time such as schools, child-care settings, children's sports facilities and events should have healthy food environments.

- Ensure only healthy foods, beverages and snacks are consumed on the premises. Use water not juice.
- Champion being physically active and explore all opportunities for active play and learning.
- Use Change4Life and capitalise on the national approach to tackling obesity.
- Involve parents and the wider community in healthy eating projects.

Social care and carers

- Provide clear guidance and support to carers and service users around healthier nutrition.
- Ensure that staff have basic and current nutrition training.
- Promote all opportunities to be active.

Planning

Planners have an important role in creating an environment that makes the healthy behaviour easier.

- New developments should create opportunities for physical activity.
- Ensure there are always opportunities for active travel such as cycling and walking routes.
- Explore how regulations and byelaws may help to make the healthy choice the easiest choice?

Procurement

Procurement often influences and determines the choices people make.

- All establishments that provide food should consider healthy and sustainable food procurement.
- Consider the impact of policies that inadvertently promote unhealthy choices and make the healthy option difficult.

Area Action Partnerships, parents and communities

There are many examples of communities that are making a real effort to improve health and wellbeing.

- Consider what you could champion in your local area.
- Could allotments or green places be used as a community garden to share skills and produce?
- Could you support your local school or community organisation in their efforts to make their environment healthier?
- Join Change4Life, the fun and friendly way to make the healthy choice.
- Work with local retailers to promote healthy options.
- Organised community events can promote healthier choices and options.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

4 July 2016

Quarter Four 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 2015/16 financial year.

Background

2. The council has delivered £153.2 million of financial savings since the beginning of austerity and these savings are forecast to exceed £258 million by 2019/20. Despite this, demand for some of our key services has increased over the year such as looked after children cases, freedom of information requests received and processing of benefit change of circumstances. However, it is encouraging to note that there have been some reductions in demand placed on some of our services. The number of incidents of fly-tipping being reported has continued to reduce although more incidents were reported at quarter four. Fewer new benefit claims required processing and face-to-face customer contacts and telephone calls received are reducing as people are contacting us in other ways such as email and through the web. Other reductions have been observed with fewer people rehoused and overall planning applications have reduced.

3. Against this backdrop of reducing resources and changing demand it is critical that the council continues to actively manage performance and ensure that the impact on the public of the difficult decisions we have had to make is minimised.

4. The report sets out an overview of performance and progress for the Altogether Healthier theme. Key performance indicator progress is reported against two indicator types which comprise of:

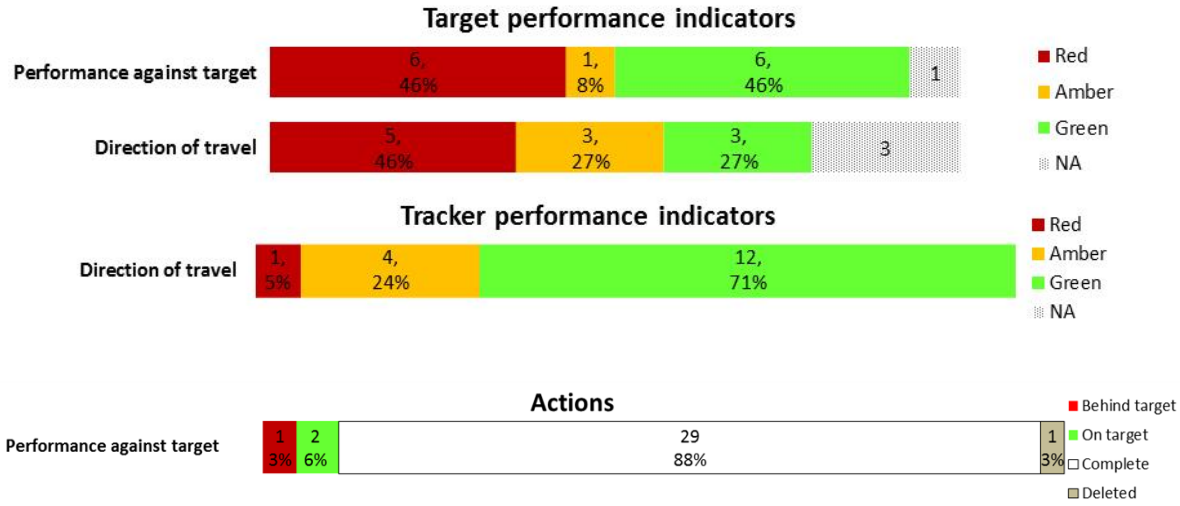
    a. Key target indicators – targets are set for indicators where improvements can be measured regularly and where improvement can be actively influenced by the council and its partners (see Appendix 3, table 1); and
    b. Key tracker indicators – performance will be tracked but no targets are set for indicators which are long-term and/or which the council and its partners only partially influence (see Appendix 3, table 2).

5. The corporate performance indicator guide provides 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.

6. For next year's reports work has been carried out by officers and members on developing the proposed indicator set and targets (see Appendix 4) to ensure that our performance management efforts continue to stay focused on the right areas. The suggestions raised by members of overview and scrutiny committees are appended to the report, including officer feedback and action that has been taken (see Appendix 5).

7. Members have recently raised specific issues of traffic lighting of performance indicators. We have therefore amended our traffic lighting system and introduced a 2% tolerance on direction of travel similar to that applied to variance from target. Detail of the change is outlined in Appendix 2.

Altogether Healthier: Overview



Council Performance

8. Key achievements this quarter include:

   a. Between April and December 2015, the Stop Smoking Service supported 1,973 people to quit smoking (2,091 per 100,000 smoking population). This is above the quarterly target of 1,852 (1,748 per 100,000) and is on track to achieve the 2015/16 target set to aim to treat a minimum of 6% of the smoking population, which equates to 2,774 quitters in 2015/16 (2,939 per 100,000).

   b. At 31 March 2016, 92.6% of adult social care users were in receipt of self-directed support (including direct payments). This is exceeding the target of 90% and all latest benchmarking data.

   c. During 2015, 2,122 people received a reablement service following their discharge from hospital. Of these, 1,850 (87.2%) remained living independently in their own home 91 days after their discharge. This is exceeding the target of 85.7% and all latest benchmarking data.

   d. Between April 2015 and February 2016, 91.6% of service users (1,294 of 1,412) reported that the help and support they receive has made their quality of life better. This is a slight decrease from 92.6% in 2014/15 but is achieving the target of 90%.

   e. Tracker indicators show reductions in delayed transfers of care. In the eleven snapshot days between April 2015 and February 2016, 212 people were reported as being delayed during their discharge from hospital, resulting in a rate of 4.6 per 100,000 population. This is significantly better than the rate of 7.7 per 100,000 over 2014/15 and the 2014/15 national rate of 11.1. Only 51 delays were attributable to adult social care (either partially or entirely), resulting in a rate of 1.1 per 100,000 population. This is better than the rate of 1.5 over 2014/15 and the national rate of 3.7.

   f. Progress has been made with the following Council Plan actions:

i. As part of the implementation of the Affordable Warmth Strategy Action Plan, which aims to address the impact of fuel poverty and target people who have a health condition, we have delivered briefing programmes for 156 health and social care staff in 2015/16 and managed 193 referrals from health and social care professionals during the same period.

ii. The stop smoking service, to reduce tobacco related ill health, has been modernised and is now in place. The contract went out to tender in October 2015 and was awarded to solutions4Health who commenced the contract in April 2016.

iii. The Better Care Fund Plan 2015/2016 has been fully implemented with partners to improve integration of health and social care services in County Durham, with a focus on the seven national key work programmes. It remains one of the significant drivers in the delivery of transformational change in the integration of health and social care services.

9. The key performance improvement issues for this theme from data released this quarter are:

a. Between April and December 2015, 5% of the eligible population (8,230 of 163,780) have received a health check. This is below the target of 6%, slightly below performance in 2014/15 (5.3%) and worse than the regional (5.6%) and national averages (6.5%). A targeted approach to health checks toward those at a higher risk of cardiovascular disease (CVD) was implemented in County Durham. Public Health have been working closely with GP Practices to implement health check contracts. The majority of County Durham GP practices are now signed up (61 of 71) and 58 have had the call and recall IT software installed. This will enable GPs to identify those at risk of CVD and target invitations towards these patients. Incentives continue to be offered for each health check undertaken (£35 for those identified as at high risk of CVD and £25 for those not). Latest data show signs that this is having an impact, with 186 health checks undertaken on those at high-risk of CVD between January and March 2016.

b. Data for October to December 2015 show that 18% of mothers (248 of 1,381) were smoking at the time of delivery. Performance is achieving the annual target (18.2%) and is an improvement on the same period in 2014 (18.3%). In County Durham, the rate was 14% in North Durham Clinical Commissioning Group (CCG) and 21.2% in Durham Dales, Easington and Sedgefield CCG. Whilst the rate is improving, it remains worse than the England average of 10.6% and the North East CCG average of 16.7%.

The number of pregnant women setting a quit date with the Stop Smoking Service has continued to rise since the implementation in 2013 of the babyClear pathway, the North East's regional approach to reducing maternal smoking rates. Between April and December 2015, this rose to 63% (114 of 181 women setting a quit date) compared to 55% (76 of 138) in the same period in 2014 and 46% in England.

Solutions4Health were commissioned as County Durham’s new Stop Smoking Service from 1 April 2016. They will continue to work closely with

maternity services ensuring the babyClear pathway continues and midwives refer pregnant smokers to the new service and aim to continue to decrease smoking at the time of delivery in County Durham.

c. Provisional data identify 767 older people admitted to permanent care during 2015/16, which equates to a rate of 736.3 per 100,000 population aged 65 and over. This has not achieved the Better Care Fund target of 710.4 per 100,000 population, but represents a reduction from 2014/15 (804.2). The number of residential/nursing beds purchased reduced by 2% from 946,730 in 2014/15 to 928,413 in 2015/16. Robust panels continue to operate to ensure that only those who can no longer be properly cared for within their own home are admitted to permanent care.

d. Successful completions from drug and alcohol treatment have deteriorated further:

   i. The number of people in alcohol treatment in 2015/16 was 1,069, of whom 255 successfully completed. This equates to a 23.9% successful completion rate, below the target of 39.5%. It is also lower than 2014/15 (38%) and latest national performance (39.2% (2015/16)).

   ii. The number of people in drug treatment for opiate use between October 2014 and September 2015 was 1,459 of whom 88 successfully completed, i.e. they did not re-present between October 2015 and March 2016. This equates to a 6% successful completion rate, which is below the annual target of 9.4%, performance from the same period in the previous year (7.1%) and national performance for the equivalent period (6.8%).

   iii. The number of people in drug treatment for non-opiate use between October 2014 and September 2015 was 631, of whom 208 successfully completed, i.e. they did not re-present between October 2015 and March 2016. This equates to a 33% successful completion rate, which is below the annual target of 41.7%, performance from the same period in the previous year (40.1%) and national performance for the equivalent period (37.3%).

   Public Health and Commissioning are closely monitoring the service and have implemented a performance plan with Lifeline (service provider), which is monitored on a monthly basis. Actions within the plan include:

   - Developing specific, intensive recovery programmes to reduce time in treatment for non-opiate clients and investigating current prescribing methods to develop programmes for reduction for long-term opiate clients.

   - Improving pathways to the treatment service to increase referrals, including hospital and criminal justice pathways.

   - Increasing the identification of clients lost to follow-up treatment and enhancing performance management of caseloads.

- Procuring a new IT database and undertaking a data cleanse to ensure data quality.

e. Tracker indicators show:

i. Data for October to December 2015 show that 396 of 1,388 mothers were breastfeeding at six to eight weeks from birth. This equates to 28.5% which is a slight increase from 27.7% between October and December 2014 and is in line with the rate of 28.4% (April to June 2015) for the Durham, Darlington and Tees area team. It is however significantly worse than the England rate for April to June 2015 (45.2%).

ii. Latest data from the Public Health Outcomes Framework for 2014/15 show recorded diabetes prevalence of 7% in the population aged 17 and over in County Durham who are registered with GP practices which is a marginal increase from 6.9% in 2013/14. The national and North East averages are 6.4% and 6.7% respectively.

iii. Latest data for 2011-14 show that in County Durham there were 16.8% more deaths (an additional 849) in winter months than non-winter months, which was a decrease from 19% (944 more deaths) for 2010-13. This fall is in line with the national and regional trend although County Durham's rate is higher than the England (15.6%) and North East (13.4%) averages.

iv. Life expectancy has improved slightly and mortality rates have improved (with the exception of liver disease) although levels remain worse than for England:

- For males being born in County Durham, life expectancy has increased by 2.8 years in the last decade. The rise in County Durham is slightly less than that seen nationally (three years) and regionally (3.1) over the same period. The latest data (2012-14) show that male life expectancy stands at 79.5 for England, 78 for the North East and 78.1 for County Durham. For females being born in County Durham, life expectancy has increased by 2.1 years in the last decade. The rise in County Durham is consistent with that seen regionally (2.1 years) over the same period but is slightly lower than the national improvement (2.3). The latest data (2012-14) show that female life expectancy stands at 83.2 for England, 81.7 for the North East and 81.4 for County Durham.

- The premature mortality rate for cancer in County Durham for 2012-14 was 168.6 per 100,000. This was a slight increase from 166.6 for 2011-13. The increase equates to 60 deaths over the three year period. The County Durham rate is similar to the North East (167.9) and significantly worse than England (141.5). There has however been a 10% fall in premature cancer mortality in the last decade.

- The premature mortality rate for cardiovascular disease in County Durham for 2012-14 was 81.7 per 100,000. This was a

decrease from 88.3 for 2011-13 and is better than the North East rate (85.9) however worse than England (75.7). There has been a 49% fall in premature cardiovascular mortality in the last decade.

- The premature mortality rate for liver disease in County Durham for 2012-14 was 20.1 per 100,000. This was a decrease from the 2011-13 rate of 21.9. The County Durham rate is better than the North East (23.0) but significantly worse than England (17.8). Premature mortality from liver disease has however risen by 14% since 2002-04.

- The premature mortality rate for respiratory disease in County Durham for 2012-14 was 41.8 per 100,000, which is a decrease from the 2011-13 rate of 43.4. The County Durham rate is similar to the North East (41.2) and significantly worse than England (32.6) rates. There has been a 20% reduction in premature respiratory disease mortality in the last decade.

f. The Council Plan action to review the culture and sport offer within Bishop Auckland in response to both the Auckland Castle development and educational sector sports provision ambitions has been delayed from March 2016 until July 2016. The original timescale was optimistic given demands generated by service restructure and delivery transformation in 2015/16.

g. There is also one proposed deletion in relation to implementing with partners the Healthy Weight Strategic Framework to improve support to children and adults so that they can have a healthier lifestyle. The Healthy Weight Alliance has agreed that a Health Equity Audit (HEA) will no longer be undertaken. Other tools will be utilised to identify healthy weight provision, which are promoted by the National Obesity Pilot which Public Health are participating in. The HEA will be replaced by the sector led improvement self-assessment framework followed by a process of peer review.

10. There are no key risks which require any mitigating action in delivering the objectives of this theme.

Recommendation and Reasons

11. That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising there from.

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Appendix 1: Implications
Appendix 2: Key to symbols used in the report
Appendix 3: Summary of key performance indicators
Appendix 4: Corporate indicator set and 3 year targets
Appendix 5: Performance indicator challenge - Member comments/queries

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 Performance Indicators (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

Our traffic lighting system has been amended this quarter, introducing a 2% tolerance to variance from previous performance and comparator groups, similar to that applied to variance from target. Detail of the change is outlined in the table below:

Performance Indicators:

Previous traffic light system		**Current (amended) traffic light system**			
Variation from previous performance and comparator benchmarking groups		***Variation from previous performance and comparator benchmarking groups***		***Variation from target***	
Better than comparable period / comparator group	**Green**	Same or better than comparable period / comparator group	**Green**	Meeting/Exceeding target	**Green**
Same as comparable period / comparator group	**Amber**	Worse than comparable period / comparator group (within 2% tolerance)	**Amber**	Worse than target (within 2% tolerance)	**Amber**
Worse than comparable period / comparator group	**Red**	Worse than comparable period / comparator group (greater than 2%)	**Red**	Worse than target (outside of 2% tolerance)	**Red**

Where the traffic light system appears in this report, they have been applied to the most recently available information.

Nearest Neighbour Benchmarking:

The nearest neighbour model was developed by the Chartered Institute of Public Finance and Accountancy (CIPFA), one of the professional accountancy bodies in the UK. CIPFA has produced a list of 15 local authorities which Durham is statistically close to when you look at a number of characteristics. The 15 authorities that are in the nearest statistical neighbours group for Durham using the CIPFA model are: Barnsley, Wakefield, Doncaster, Rotherham, Wigan, Kirklees, St Helens, Calderdale, Dudley, Northumberland, Tameside, Sheffield, Gateshead, Stockton-on-Tees and Stoke-on-Trent.

We also use other neighbour groups to compare our performance. More detail of these can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

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

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											
23	CASAH2	Percentage of eligible people who receive an NHS health check	5.0	Apr - Dec 2015	6.0	**RED**	5.3	**RED**	6.5 **RED**	5.6* **RED**	Apr - Dec 2015
24	CASAH3	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period	61.2	As at Mar 2015	Not set	NA	New indicator	NA	57.1 **GREEN**	59.4* **GREEN**	As at Mar 2015
25	CASAH10	Percentage of women eligible for breast screening who were screened adequately within a specified period	77.8	As at Mar 2015	70.0	**GREEN**	77.9	**AMBER**	75.4 **GREEN**	77.1* **GREEN**	As at Mar 2015
26	CASAH4	Percentage of women eligible for cervical screening who were screened adequately within a specified period	77.6	As at Mar 2015	80.0	**RED**	78.0	**AMBER**	75.7 **GREEN**	73.5* **GREEN**	As at Mar 2015
27	CASAS23	Percentage of successful completions of those in alcohol treatment **(Also in Altogether Safer)**	23.9	2015/16	39.5	**RED**	38.0	**RED**	39.2 **RED**		2015/16
28	CASAS7	Percentage of successful completions of those in drug treatment - opiates **(Also in Altogether Safer)**	6.0	Oct 2014 - Sep 2015 (re-presentations to Mar 2016)	9.4	**RED**	7.1	**RED**	6.8 **RED**		Oct 2014 - Sep 2015 (re-presentations to Mar 2016)

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
29	CASAS8	Percentage of successful completions of those in drug treatment - non-opiates **(Also in Altogether Safer)**	33.0	Oct 2014 - Sep 2015 (re-presentations to Mar 2016)	41.7	RED	40.1	RED	37.3 RED		Oct 2014 - Sep 2015 (re-presentations to Mar 2016)
30	CASCYP8	Percentage of mothers smoking at time of delivery **(Also in Altogether Better for Children and Young People)**	18.0	Oct - Dec 2015	18.2	GREEN	18.3	GREEN	10.6 RED	16.7* RED	Oct - Dec 2015
31	CASAH1	Four week smoking quitters per 100,000 smoking population	2,091	Apr - Dec 2015	1,852	GREEN	New definition	NA [2]			
32	CASAH11	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	736.3	2015/16 (provisional)	710.4	RED	804.2	GREEN	668.8 RED	835.8* GREEN	2014/15
33	CASAH12	Percentage of adult social care service users that receive self-directed support such as a direct payment or personal budget	92.6	As at Mar 2016	90.0	GREEN	New definition	NA [2]	83.7 GREEN	82.9** GREEN	2014/15
34	CASAH13	Percentage of service users reporting that the help and support they receive has made their quality of life better	91.6	Apr 2015 - Feb 2016	90.0	GREEN	92.6	AMBER	91.9 AMBER	93.4* AMBER	2014/15

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
35	CASAH14	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	87.2	2015	85.7	GREEN	89.6	RED	82.1 GREEN	85.2** GREEN	2014/15
36	CASAH24	Percentage of people who use services who have as much social contact as they want with people they like	49.2	2015/16 (provisional)	50.0	AMBER	48.7	GREEN	44.8 GREEN	47.6* GREEN	2014/15

[2] 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	CASCYP 18	Percentage of children aged 4 to 5 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	23.0	2014/15 ac yr	23.8	GREEN	23.8	GREEN	21.9 RED	23.7* GREEN	2014/15 ac yr
137	CASCYP 19	Percentage of children aged 10 to 11 years classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	36.6	2014/15 ac yr	36.1	AMBER	36.1	AMBER	33.2 RED	35.9* AMBER	2014/15 ac yr
138	CASCYP 25	Prevalence of breastfeeding at 6 to 8 weeks from birth **(Also in Altogether Better for Children and Young People)**	28.5	Oct - Dec 2015	29.6	RED	27.7	GREEN	45.2 RED	28.4* GREEN	Apr - Jun 2015 (NE - Durham, Darlington and Tees area team)
139	CASAH 18	Male life expectancy at birth (years)	78.1	2012-14	78.0	GREEN	78.0	GREEN	79.5 AMBER	78* GREEN	2012-14
140	CASAH 19	Female life expectancy at birth (years)	81.4	2012-14	81.3	GREEN	81.3	GREEN	83.2 RED	81.7* AMBER	2012-14
141	CASAH6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population [3]	81.7	2012-14	88.3	GREEN	88.3	GREEN	75.7 RED	85.9* GREEN	2012-14

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
142	CASAH7	Under 75 mortality rate from cancer per 100,000 population	168.6	2012-14	166.6	AMBER	166.6	AMBER	141.5 RED	167.9* AMBER	2012-14
143	CASAH9	Under 75 mortality rate from respiratory disease per 100,000 population	41.8	2012-14	43.4	GREEN	43.4	GREEN	32.6 RED	41.2* AMBER	2012-14
144	CASAH8	Under 75 mortality rate from liver disease per 100,000 population	20.1	2012-14	21.9	GREEN	21.9	GREEN	17.8 RED	23* GREEN	2012-14
145	CASAH 23	Percentage of registered GP patients aged 17 and over with a diagnosis of diabetes	7.0	2014/15	6.9	AMBER	6.9	AMBER	6.4 RED	6.7* RED	2014/15
146	CASAH 20	Excess winter deaths (%) (3 year pooled)	16.8	2011-14	19.0	GREEN	19.0	GREEN	15.6 RED	13.4* RED	2011-14
147	CASAH 22	Estimated smoking prevalence of persons aged 18 and over	20.6	2014	22.7	GREEN	22.7	GREEN	18 RED	19.9* RED	2014
148	CASAH 25	Number of residential/nursing care bed days for people aged 65 and over commissioned by Durham County Council	232,638	Jan - Mar 2016	233,777	GREEN	229,737	AMBER			
149	CASAH 20i	Delayed transfers of care from hospital per 100,000 population	4.6	Apr 2015 - Feb 2016	4.4	RED	7.7	GREEN	11.1 GREEN	7.4* GREEN	2014/15
150	CASAH 20ii	Delayed transfers of care from hospital, which are attributable to adult social care, per 100,000 population	1.1	Apr 2015 - Feb 2016	1.1	GREEN	1.5	GREEN	3.7 GREEN	1.6* GREEN	2014/15

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
151	CASAH 21	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population **(Also in Altogether Safer)**	13.3	2012-14	13.4	GREEN	13.4	GREEN	8.9 RED	11* RED	2012-14
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	25.0	Sep 2013 - Sep 2015	24.9	GREEN	26.0	RED			

[3] Data 12 months earlier amended (final published data)/refreshed

Appendix 4: Proposed 2016/17 Corporate Indicator set and 3 year targets

Indicator Type	PI ref	PI Description	Service	Frequency	Performance		2015/16 Target	Proposed targets			National Comparison
					2014/15	2015/16 Q3		2016/17	2017/18	2018/19	
Altogether Healthier											
Tracker	CAS CYP18	Percentage of children aged 4 to 5 classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	CAS	Annual Q3	23.8 (2013/14)	23 (2014/15)					21.9 (2014/15 ac yr)
Tracker	CAS CYP19	Percentage of children aged 10 to 11 classified as overweight or obese **(Also in Altogether Better for Children and Young People)**	CAS	Annual Q3	36.1 (2013/14)	36.6 (2014/15)					33.2 (2014/15 ac yr)
Target	CAS AH2	Percentage of eligible people who receive an NHS health check	CAS	Quarterly	7.4	3.5 (Q2)	8	8	8	Not yet set	9.6 (2014/15)
Tracker	CAS AH18	Male life expectancy at birth (years)	CAS	Annual Q3	77.9 (2010-12)	78 (2011-13)					79.4 (2011-13)
Tracker	CAS AH19	Female life expectancy at birth (years)	CAS	Annual Q3	81.5 (2010-12)	81.3 (2011-13)					83.1 (2011-13)
Target	CAS AH3	Percentage of people eligible for bowel cancer screening who were screened adequately within a specified period	CAS	Quarterly	New indicator	61.2 (2014/15)		60	60	60	57.1 (2014/15)

Indicator Type	PI ref	PI Description	Service	Frequency	Performance		2015/16 Target	Proposed targets			National Comparison
					2014/15	2015/16 Q3		2016/17	2017/18	2018/19	
Target	CAS AH10	Percentage of women eligible for breast screening who were screened adequately within a specified period	CAS	Annual Q3	77.9 (2013/14)	77.8 (2014/15)	70	70	70	70	75.4 (2014/15)
Target	CAS AH4	Percentage of women eligible for cervical screening who were screened adequately within a specified period	CAS	Annual Q3	78 (2013/14)	77.6 (2014/15)	80	80	80	80	75.7 (2014/15)
Tracker	CAS AH6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population	CAS	Annual Q4	91.3 (2010-12)	88.8 (2011-13)					78.2 (2011-13)
Tracker	CAS AH7	Under 75 mortality rate from cancer per 100,000 population	CAS	Annual Q4	164.2 (2010-12)	166.6 (2011-13)					144.4 (2011-13)
Tracker	CAS AH9	Under 75 mortality rate from respiratory diseases per 100,000 population	CAS	Annual Q4	40.1 (2010-12)	43.4 (2011-13)					33.2 (2011-13)
Tracker	CAS AH8	Under 75 mortality rate from liver disease per 100,000 population	CAS	Annual Q4	21.7 (2010-12)	21.9 (2011-13)					17.9 (2011-13)
Target	CAS AS23	Percentage of successful completions of those in alcohol treatment **(Also in Altogether Safer)**	CAS	Quarterly	38	26.9 (Q2)	39.5	Top quartile	Not yet set	Not yet set	39.3 (2015)

Indicator Type	PI ref	PI Description	Service	Frequency	Performance		2015/16 Target	Proposed targets			National Comparison
					2014/15	2015/16 Q3		2016/17	2017/18	2018/19	
Target	CAS AS7	Percentage of successful completions of those in drug treatment - opiates **(Also in Altogether Safer)**	CAS	Quarterly	7.1	6.5 (Q2)	9.4	Top quartile	Not yet set	Not yet set	7 (Jul 2014 – Jun 2015)
Target	CAS AS8	Percentage of successful completions of those in drug treatment - non opiates **(Also in Altogether Safer)**	CAS	Quarterly	40.1	41 (Q2)	41.7	Top quartile	Not yet set	Not yet set	37.7 (Jul 2014 – Jun 2015)
Tracker	CASAH 23	Percentage of registered GP patients aged 17 and over with a diagnosis of diabetes	CAS	Annual Q4	6.8 (2012/13)	6.9 (2013/14)					6.2 (2013/14)
Tracker	CAS AH20	Excess winter deaths (%) (3 year pooled)	CAS	Annual Q4	16.8 (2009-12)	19 (2010-13)					17.4 (2010-13)
Target	CAS CYP8	Percentage of mothers smoking at time of delivery **(Also in Altogether Better for Children and Young People)**	CAS	Quarterly	19	18.1 (Q2)	18.2	17.2	Not yet set	Not yet set	10.6 (Oct – Dec 2015)
Tracker	CAS AH22	Estimated smoking prevalence of persons aged 18 and over	CAS	Annual Q3	22.7 (2013)	20.6 (2014)					18 (2014)
Target	CAS AH1	Four week smoking quitters per 100,000 smoking population	CAS	Quarterly	New definition	1353 (Q2)	2,939	2,449 (2,331 quitters)	Not yet set	Not yet set	
Target	CAS AH11	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or	CAS	Quarterly	804.2 per 100,000	578.9 (604 admissions)	710.4	790 admissions	Not yet set	Not yet set	668.8 per 100,000 (2014/15)

Indicator Type	PI ref	PI Description	Service	Frequency	Performance		2015/16 Target	Proposed targets			National Comparison
					2014/15	2015/16 Q3		2016/17	2017/18	2018/19	
		nursing care									
Tracker	CASAH 25	Number of residential/nursing care bed days for people aged 65 and over commissioned by Durham County Council	CAS	Quarterly	946,730	695,775					
Target	CAS AH12	Percentage of adult social care service users that receive self-directed support such as a direct payment or personal budget	CAS	Quarterly	New definition	90.1	90	90	90	90	83.7 (2014/15)
Tracker	CAS AH13	Percentage of service users reporting that the help and support they receive has made their quality of life better	CAS	Quarterly	92.6	91.4	90				91.9 (2014/15 national survey)
Target	CAS AH14	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	CAS	Quarterly	89.9	87.7	85.7	86	Not yet set	Not yet set	82.1 (2014/15)
Tracker	CAS AH20i	Delayed transfers of care from hospital per 100,000 population	CAS	Quarterly	7.7	4.4					11.1 (2014/15)

Indicator Type	PI ref	PI Description	Service	Frequency	Performance		2015/16 Target	Proposed targets			National Comparison
					2014/15	2015/16 Q3		2016/17	2017/18	2018/19	
Tracker	CAS AH20ii	Delayed transfers of care from hospital, which are fully or partly attributable to adult social care, per 100,000 population	CAS	Quarterly	1.5	1.1					3.7 (2014/15)
Tracker	CAS AH24	Percentage of people who use services who have as much social contact as they want with people they like	CAS	Annual Q1 provisional Q2 confirmed	51 (2013/14)	48.7 (2014/15)	50				44.8 (2014/15 National Survey)
Tracker	CASAH 21	Suicide rate (deaths from suicide and injury of undetermined intent) per 100,000 population **(Also in Altogether Safer)**	CAS	Annual Q3	13.4 (2011-13)	13.3 (2012-14)					8.9 (2012-14)
Tracker	CASCYP 26	Young people aged 10-24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10-24 years) **(Also in Altogether Better for Children and Young People)**	CAS	Annual Q4	504.8 (2010/11-2012/13)	489.4 (2011/12-2013/14)					367.3 (2011/12 – 2013/14)
Tracker	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 3 days a week (Active People Survey)	NS	6 monthly	26	25					

Council and Service Plan 2016-19
Performance Indicator Challenge – Member comments/queries

Indicator	Member comment/query	Service feedback	Committee where raised
3 cancer screening PIs (CAS AH 3,4,10)	Proposed that these be retained	Agreed to put indicators back into corporate set	Adults, Wellbeing and Health Overview and Scrutiny

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Adults Wellbeing and Health Overview and Scrutiny Committee

4 July 2016

Review of the Committee's Work Programme 2016-17

Report of Lorraine O'Donnell, Assistant Chief Executive

Purpose of the Report

1. To provide for Members consideration an updated work programme for the Adults Wellbeing and Health Overview and Scrutiny Committee for 2016 - 17.

Background

2. At its meeting on 8 April 2016, the Adults Wellbeing and Health Overview and Scrutiny Committee considered the actions identified within the Council Plan 2015 – 2018 for the Altogether Healthier priority theme and agreed to refresh its work programme to include a number of these actions. In addition, topics have been identified that are in line with the Cabinet's Forward Plan of Key Decisions, the Sustainable Community Strategy, forthcoming Government Legislation, outcomes form Quarterly Performance reports and other plans and strategies accordingly.

Detail

3. In accordance with this decision, a work programme for 2016 – 2017 has been prepared and is attached at Appendix 2.

4. The Committee has also considered potential topics for a piece of in-depth scrutiny review activity and have suggested looking at Suicide Rates in County Durham and Mental Health and Wellbeing.

Recommendation

5. Members of the Committee are asked to agree the new work programme and that Suicide rates and Mental Health and Wellbeing be the Committee's agreed review topic for the coming year.

Background Papers

Council Plan 2016 – 2019
AWH OSC Report 8 April 2016 – Council Plan 2016-19 – Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee

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Appendix 1: Implications

Finance – The Council Plan sets out the corporate priorities of the Council for the next 3 years. The Medium Term Financial Plan aligns revenue and capital investment to priorities within the Council Plan.

Staffing – None

Risk - None

Equality and Diversity - None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – None

Procurement – None

Disability Discrimination Act – None

Legal Implications – None

OVERVIEW AND SCRUTINY WORK PROGRAMME 2016 TO 2017

OVERVIEW AND SCRUTINY WORK PROGRAMME 2016 TO 2017 **Adults, Well-being and Health OSC** **Lead Officer**: Stephen Gwillym **IPG contact**: Peter Appleton	**Note:** **O/S Review** - A systematic 6 monthly review of progress against recommendations/Action Plan **Scrutiny/Working Group** – In depth Review **Overview/progress** – information on an issue; opportunity to comment, shape, influence, progress with a scrutiny review **Performance** – ongoing monitoring (quarterly) performance reports/budgets

Committee	**When**	**Who**	**Outcome**	**Comment**
Adults' Social Care and Public Health				
O/S Review				
Suicide Rates and Mental Health and Wellbeing in County Durham	September 2016 to March 2017	Public Health/NHS Partners	To undertake a Review into Suicide Rates in County Durham and Mental Wellbeing	Scrutiny Review

Overview/Progress				
Health and Wellbeing Board – Annual Report and Performance Update	3 October 2016	Cllr Lucy Hovvels/Peter Appleton	To provide members with an update of the ley delivery plan actions against the JHWS	Member Update
Safeguarding Adults Annual Report	20 January 2017	Lee Alexander	Update on Annual Report	Member Update
Director of Public Health Report	4 July 2016	DPH	Update on Public Health priorities arising from DPH Annual Report	Member Update
Joint Health and Wellbeing Strategy/JSNA Refresh	20 January 2017	Peter Appleton	To engage members in the refresh process for the Health and Wellbeing Strategy and JSNA	Member Information and comment
Winter Resilience	3 October 2016 3 March 2017	Stewart Findley	To engage members in discussions around winter resilience arrangements/preparations	Member Information and comment
Adult Care Transformation and Integration with Health Services	14 November 2016	Paul Copeland	Progress against the implementation of Adult Social Care services Transformation and their integration with Health services	Member Update
Development of an Oral Health Strategy for County Durham	3 October 2016	Director of Public Health	To inform members of the development of an Oral Health Strategy for County Durham	Member Information and Comment
Public Health Update	20 January 2017	Director of Public Health	To update members on the latest developments in respect of Public Health	Member Update
Review of Public Mental Health Strategy – Consultation	14 November 2016	Catherine Richardson, Public Health	To update members on the review of the Public Mental Health Strategy	Member Update

Performance and Budget Reporting				
Performance	Performance Quarterly update Reports 2015/16 Q4 Outturn – 4 July 2016 2016/17 Q1 – 3 October 2016 2016/17 Q2 – 20 January 2017 2016/17Q3 – 10 April 2017	P. Appleton/K. Forster	Members using performance management information to inform the Work Programme and possible Review Activity	Summary information to members
Budget Outturn	2015/16 Q4 Outturn – 3 October 2016 2016/17 Q1 – 3 October 2016 2016/17 Q2 – 20 January 2017	Andrew Gilmore	Quarterly update key issues	Summary information to members

	2016/17 Q3 – 10 April 2016			

2. NHS commissioners (North Durham CCG; DDES CCG and NHS England Regional Team) and provider organisations	When	Who	Outcome	Comment
NHS Service change - Updates to AWHOSC				
Accident and Emergency Ambulance Service Review – Durham Dales, Easington and Sedgefield CCG	14 November 2016	NEAS/DDES CCG	Members appraised of the post implementation of the review of Accident and Emergency Ambulance Service provision in Durham Dales	Continued engagement of members and Community into Accident and Emergency Ambulance Service
Review of Inpatient Dementia Wards serving County Durham and Darlington – Tees Esk and Wear Valleys NHS FT	3 March 2017	TEWV/North Durham and DDES CCGs	Members appraised of the post implementation of the review of Inpatient Dementia Wards serving County Durham and Darlington	Continued engagement of members and Community into Inpatient Dementia Wards serving County Durham and Darlington
Statutory Health Scrutiny Consultations				
Durham Dales Easington and Sedgefield CCG – Review of Urgent Care Services	1 September 2016	DDES CCG	Members are informed of the Consultation and Engagement feedback arising from the Review of Urgent Care Services. The AWHOSC comment on proposed recommendations for change by DDES CCG	Member engagement and Comment

Overview/Progress				
Quality Accounts 2015/16 – Monitoring Updates	14 November 2016	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Monitoring Updates on 2015/16 Quality Accounts Priorities	Member Update
County Durham and Darlington NHS Foundation Trust – Clinical Strategy	TBC	CDD NHS FT	AWH OSC Engagement in the development of the emerging Clinical Strategy and any associated consultation proposals	Member information and comment
Quality Accounts 2016/17 – Preparation of Overview and Scrutiny Input and Commentary	10 April 2017	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Process of shaping and OSC commentary on 2016/17 Quality Accounts	For Member Information and comment

Overview/Progress				
Clinical Commissioning Groups – Clear and Credible Plans	TBC	North Durham and DDES CCGs	Overview of CCG Commissioning Plans and Relationship building with CCG Progress of CCGs in delivering against their CCP Priorities	For Member Information and comment
Care Quality Inspection Reports:- • North East Ambulance Service	TBC	NEAS Foundation Trust Reps	To provide members with key learning from CQC Inspection Reports	For member Information
Care Quality Commission Inspection Action Plans for :- County Durham and Darlington NHS FT Tees Esk and Wear Valleys NHS FT North Tees and Hartlepool NHS FT	 3 October 2016 3 October 2016 TBC	 CDD FT Reps TEWV Reps NT&H Reps	To update members on the progress made by NHS FTs against their CQC Inspection Action Plans	For member information
Care Quality Commission five year strategy	4 July 2016	CQC Regional Lead	To provide members with an overview of the CQC's recently published 5 Year strategy.	For member Information
County Durham HealthWatch Annual Report	1 September 2016	HealthWatch Reps	To update members of the development of County Durham HealthWatch	For member Information
NHS England Five Year Forward View – Implications for County Durham (To include the Sustainability and Transformation Plan)	TBC	Michael Houghton North Durham CCG and Sarah Burns DDES CCCG	To update members on the implications of NHS England's Five Year Forward View	For Member Information

Overview/Progress				
Urgent and Emergency Care Vanguard	1 September 2016	NHS England and CCGs	To update Members on the Urgent and Emergency Care Vanguard and the implications for Health and Social Care in County Durham	For member information
Primary Care Strategy	3 October 2016	North Durham and DDES CCGs	To update members with the development of the Primary Care Strategy and to discuss the role of GPs in Primary Care	For members information and comment

Other – Regional				
Better Health Programme – Joint Health OSC	11 November 2016	Better Health Programme Board Representatives	Member update on Better Health Programme and the work of the Joint Health OSC	For member information and Comment
Regional Joint Health OSC – Update	3 October 2016 3 March 2017	Principal OSO	Member update on the work of the Regional Joint Health OSC	For member information and comment
North East Combined Authority – Health and Social Care Integration and Commissioning	TBC	Principal OSO	Member update on the NECA Health and Social Care Integration and Commissioning project	For members information