Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Friday 20 January 2017**
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 meetings held on 14 November 2016 and of the special meeting held on 6 January 2017 (Pages 3 - 20)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. County Durham and Darlington Fire and Rescue Authority Integrated Risk Management Plan Action Plan 2017/18 Consultation - Report of Stuart Errington, Chief Fire Officer (Pages 21 - 38)
8. Dentistry Services at the Richardson Hospital, Barnard Castle - Update by Pauline Fletcher, Primary Care Commissioning Manager (Dental) NHS England, Cumbria and the North East (Pages 39 - 42)

   A copy of the briefing paper reported to the special Adults Wellbeing and Health Overview and Scrutiny Committee on Friday 6 January 2017 is attached.

9. Public Health Update - Report of Gill O'Neill, Interim Director of Public Health for County Durham, Adult and Health Services (Pages 43 - 66)
10. CAS Quarter 2 Forecast of Revenue and Capital Outturn 2016/17 - Report of Head of Finance (Financial Services), presented by Andrew Gilmore, Finance Manager (Pages 67 - 74)
11. 2016/17 Quarter 2 Performance Management Report - Report of the Director of Transformation and Partnerships, presented by Peter Appleton, Head of Quality and Service Strategy, Adult and Health Services (Pages 75 - 88)
12. Adults Wellbeing and Health Overview and Scrutiny Committee - Review of Suicide Rates and Mental Health and Wellbeing on County Durham - Verbal Update by the Principal Overview and Scrutiny Officer
13. 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
12 January 2017

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

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

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Monday 14 November 2016 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, J Blakey, P Brookes, S Forster, K Hopper, E Huntington, J Lindsay, M Nicholls, A Savory, P Stradling and O Temple

Co-opted Members:
Mrs R Hassoon

Also Present:
Councillor J Shuttleworth

1 Apologies

Apologies for absence were received from Councillors J Chaplow, P Crathorne, P Lawton, H Liddle, O Milburn, L Pounder, W Stelling and Mrs B Carr

2 Substitute Members

There were no substitute Members present.

3 Minutes

The Minutes of the meeting held on 3 October 2016 were agreed and signed by the Chairman as a correct record.

4 Declarations of Interest

There were no declarations of interest.

5 Media Issues

The Principal Overview and Scrutiny Officer provided the Committee with a presentation of the following press articles which related to the remit of the Adults, Wellbeing and Health Overview and Scrutiny Committee;

- North East Ambulance Service rated ‘Good’ by the CQC but told to improve some response times – Evening Chronicle 1/11/16

The North East’s ambulance service has been rated as ‘good’ by a health watchdog - but told to improve its response times to immediately life-threatening incidents.

A team of inspectors from the Care Quality Commission (CQC) found that the North East Ambulance Service NHS Foundation Trust (NEAS) provided services which were safe, effective, caring, responsive and well led.
A CQC report rated the service as “good” overall, and praised the trust for its “general culture of passion and enthusiasm”.
But NEAS was also told to make improvements in some areas, after data showed it was the joint worst performing ambulance service in the NHS for responses to “Red 1” - immediately life-threatening - calls

- Poor A&E performance has 'become the norm' for NHS trusts – MPs – Northern Echo 1/11/16

A new report from the Commons Health Committee warns the NHS could face a "substantially more difficult" winter this year than last, with increasing demand for services, trusts suffering due to too-few staff and a widespread inability to move out patients who are medically fit to be discharged.
Evidence submitted to the MPs' inquiry showed that A&E departments are now routinely missing the national target to deal with 95% of patients within four hours.
Major type 1 A&E departments - those that are located in hospitals - perform the worst, with only 87.9% of patients admitted, discharged or transferred within that timeframe in 2015/16.

- Health chiefs rule out Consett hospital sale – Northern Echo 31/10/16

Health chiefs have appeared to move to quash fears a community hospital will be sold to make way for more housing.
People who use Shotley Bridge Hospital, near Consett, voiced concern after the closure of the 16-bed inpatient ward at the hospital.
NHS bosses were accused of ‘hospital closure by stealth’ by North-West Durham MP Pat Glass, concerns echoed by councillors and campaigners.
More than 4,000 have signed an online petition to save the services.
A joint statement issued by NHS Property Services, NHS North Durham CCG and County Durham and Darlington NHS Foundation Trust said: “In response to queries about the potential disposal of the site for housing development, NHS Property Services Ltd can confirm that the site is not for sale.

- Report shows services need improvement – Northern Echo – 28/10/16

An NHS body has been rated one among the worst in the country for maternity and mental health services, latest statistics have shown.
NHS England has examined and graded the country’s 209 Clinical Commissioning Groups (CCGs) for the first time.
Its findings showed more than half of mental health services and almost three-quarters of maternity care services at local NHS groups needed improvement.
However, the Durham Dales, Easington and Sedgefield Clinical Commissioning Group fell into the Greatest Need for Improvement category for both services.
The figures showed that while it was rated similar to others in the neonatal mortality and stillbirths and women’s experience of maternity services category, it was among the lowest scoring for choices.
And in mental health provision, only 45.5 per cent of people who finished treatment were moving to recovery.

- Anger over GPs having to ask permission to refer patients to hospital – Evening Chronicle 20/10/16

Doctors have hit out at plans for a private company to review GPs referrals, raising concerns it will put patient safety at risk.
North Durham CCG has entered a new contract with private healthcare company About Healthcare which will charge £10 per letter to review GP's referrals before they are passed on to hospitals.
It is hoped that this will stop unnecessary appointments and save the NHS cash however the BMA has questioned the safety of decisions been taken by staff who haven't met the patient.
Patients with cardiology, gynaecology, dermatology and gastroenterology issues will be referred using the system but urgent cases and suspected cancer cases will not be subject to this additional layer of referral.

Councillor Forster asked if these proposals would be rolled out at every surgery as she was aware that this happens at her own. The Principal Overview and Scrutiny Officer explained that this had specifically been put in place by North Durham CCG and would cover all of the GP's in that area.
The Director of Primary Care, Partnerships and Engagement, DDES & North Durham CCGs, advised that this was not in operation in DDES however talks had been taking place with the clinicians in North Durham to advise how North Durham had approach it.
The Chairman suggested that a briefing be sent to Members once further information was known.

6 Any Items from Co-opted Members or Interested Parties

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

7 Durham Dales, Easington and Sedgefield CCG Accident and Emergency Ambulance Service Review - Post Implementation update

The Committee considered a Report of Director of the Transformation and Partnerships and presentation by representatives of DDES CCG and North East Ambulance Service that gave a post implementation update for the Durham Dales, Easington and Sedgefield CCG Accident and Emergency Ambulance Service Review (for copy see file of Minutes).

The Assistant Director of Communications and Engagement, NEAS gave a detailed presentation that included:-

- Our service in numbers – figures from April 2015 to March 2016
- A new journey operating environment – adapting to changing needs – a new Chief Executive and Board were in place
- Our Strategy 2015-20 – driving our purpose and direction
- Care Quality Commission – rated GOOD
- CQC inspection rating
- Chief Inspector of Hospitals Quote - "The North East Ambulance Service has a lot of to be proud of. We found a general culture of passion and enthusiasm at the trust and it was clear that everyone's first priority was the patient."
- Performance

- Incident and Call Volume
- Top Conditions
- Red Incident Volume – steady increase in the number of red calls.
- Impact of Increased Red Volume – deterioration in performance standards.
- Age Profile of A&E Attendances via ambulance – NEAS conveys more patients to A&E to the NHS than the England average.
- Hear & Treat, See & Treat, See & Convey Rates – number of calls increased. Investment made to control rooms and more clinicians available to assess. 280 staff had been trained.
- Arrivals and Handover Time
- Time lost to Handovers
- Workforce – currently recruiting and the vacancy gap was closing. Paramedics had 140 vacancies last year compared to 70 this year. It was hoped to achieve a full establishment by 2017. Most effective way was to grow our own and NEAS were working closely with the Universities of Sunderland and Teesside.
- Clinical Quality Indicators

• Durham Dales and Easington progress update
  - Staffing levels in Weardale and Teesdale – an increase in staffing levels in the Weardale and Teesdale areas with less overtime claimed.
  - Response times in Durham Dales – showed response times by minute from March 2015 to March 2016.
  - Service Improvements – invested heavily. Challenges included funding for 1st responders. First responders had been recruited. Worked with Durham Police and Durham and Darlington Fire & rescue. 2 advanced practitioners attend lower community calls in the Dales.

The Chairman invited representatives from the Rural Ambulance Monitoring Group to comment on the report. He referred to the information circulated to members from the group for information (for copy see file of Minutes).

Mrs Joy Urwin, Rural Ambulance Monitoring Group referred to the Independent Clinical Senate Review and said that the group felt no wiser from anything that had been said today. The group supported the work carried out by the paramedics and had respect for them. She said that it was accepted that NEAS were not supported by the NHS foundation trust. The group were no clearer in the data regarding response times and felt that Bishop Auckland was an urban area, not rural, and that Crook was a long way to parts of the Dales. The group felt strongly that it was recognised that defibrillators were put in place and funded by community fund raising and not NEAS, that they were not maintained by NEAS and that training had not been arranged by NEAS. The first responders were very welcomed but gave a false sense of security as did not work in all situations and emergencies. Rural in the title of the report did not reflect that it was about rural areas.

Mrs Urwin said that some issues within the report were worthy of merit but felt that some of the points did not address the core problems. The group felt that the performance remained poor. With regards to staff shortages it had been recognised that trainees were being utilised. On occasions two vehicles were being brought into the Dales to deal with cardiac patients. This was a drain on resources. The projected number of paramedics from the Dales had been unrealistic and the group felt that the rural areas were receiving

a downgraded service. People were waiting for ambulances longer than ever and the groups believed that the CCG were not holding NEAS to account for failing to deliver the provision. She asked how a 48% response time across the patch could be justified.

The Chairman said that discussions had taken place about rurality for the whole of Durham at the Joint Health Committee, including the percentage of fair access, the drop in response times and staffing. He confirmed that these issues had been taken up with NEAS.

Councillor Savory said that we all had a duty of care to residents in County Durham and the wait for an ambulance in Weardale was always a topic of conversation. She referred to a recent incident whereby an elderly gentleman had to wait over one and a half hours for an ambulance. She found this totally unacceptable and asked where the ambulances were located at that time.

Councillor Bell echoed those comments and said that he too had heard many stories about response times being poor. He referred to the additional resources DDES put into NEAS and asked if detailed data could be provided for each area to show service delivery. He emphasised that the Committee needed sight of local data so that points could be addressed. The Chairman that this should be looked at for the whole County.

The Assistant Director of Communications and Engagement made an apology about the ambulance incident and would provide a response once investigated. He said that this was not the type of service NEAS wanted to provide. He advised that locality data was published on their website each month and would circulate a weblink on performance data.

Councillor Bell said that this information should be included in the report and asked that NEAS come back to a future meeting with that locality data.

Referring to paragraph 4 of the NEAS report ‘The need to manage resources across wider areas has been impacted on by the increased pressure on services, resulting in a higher number of periods of clinical escalation where otherwise ring-fenced resources are allowed to be used across a wider geography to meet the needs of those most acutely unwell’, Councillor Temple asked if this meant that ambulances were pulled out of the Dales to treat emergencies at other parts of the County. He said that performance for the whole of DDES was poor and asked what would be done to improve the figures. He was concerned that the statistics that used to be available were no longer and therefore comparisons were not possible. He also raised concerns about the statement under system pressures within the report ‘This has greater significance for the DDES area due to the lack of acute hospital provision within the locality’. The threat to Darlington Memorial Hospital through the STP was very important to the residents of the Dales and the whole of DDES. He was concerned that if that capacity was removed then we would end up with more overcrowding at other hospitals.

Councillor Brookes agreed that the Committee needed more bespoke information and commented that the figures for August and September were unacceptable in terms of performance.

Councillor Shuttleworth felt that the bottom line was that the ambulance was hardly ever present in the Dales as would be somewhere else in the County on a call out.

The Chairman concluded that uniformity was required and would request that both the CCGs and the acute trust would be asked for their views and comment on the information shared by NEAS and the inspection report.

Resolved:

(i) That the comments made by the Committee were noted.

(ii) That NEAS be requested to come back to a future meeting of the Committee with a further report showing locality data.

(iii) That County Durham and Darlington NHS FT and the Durham CCGs be asked to comment on what they were doing to ensure that A& E Ambulance response times for R1 and 2 calls improved across County Durham, especially what steps are being implemented to reduce the unacceptable delays in patient handover from NEAS to CDD NHS FT at hospital A&E departments.

8 Proposals for Renal Services at University Hospital North Durham

The Committee received a presentation of the Director of Corporate Affairs, City Hospitals Sunderland NHS Foundation Trust about the proposals for Renal Services at University Hospital North Durham (for copy see file of Minutes).

The presentation highlighted:-

- An overview
- Background
- Challenges
- Durham Dialysis Unit
- Opportunities
- Solution
- Durham Treatment Centre
- Where – Belmont
- What would be included
- Washington Dialysis Centre
- What services
- Other features
- Transport
  - Dialysis
  - Urology Ops
- Transport
- Public Transport
- Timetable
- Benefits
- Next Steps

Councillor Forster was advised that most of the medical staff would not be based in Durham, and would travel to and from Sunderland. Permanent admin and clerical staff would be based at Durham. She was concerned that the new centre should have a

sufficient workforce and was informed that the same consultants and nursing staff would work from both centres and already had the expertise to run an efficient service.

Councillor Armstrong said that this was an exciting project and suggested that with regards to transport, Simon Day, Public Transport Network Manager was the best person to look into the queries about bus services and routes to the centre.

Councillor Blakey suggested that the Park and Ride Service may be able to be utilised.

Councillor Brookes welcomed the development and asked if patients in the East of the County could still use Sunderland. He was informed that yes there would still be patient choice available.

The Chairman congratulated City Hospitals Sunderland and wished them well with the developments. He advised that enquiries would be made with the Public Transport Network Manager together with Councillor Hovvels and Councillor Foster as Cabinet portfolio holders in relation to support with transport links.

The Chairman thanked the officers for their presentation.

Resolved:
That the presentation be noted.

9 Urgent and Emergency Care Network

The Committee considered a report of the Director of Transformation and Partnerships and presentation by the Urgent and Emergency Care Network Director and Transformation Lead, North East Commissioning Support regarding the Urgent and Emergency Care Network (for copy see file of Minutes).

The UEC Network Director gave a detailed presentation that highlighted the following:-

- The UEC Network & Our Approach
- Network Mandated Interventions
- Local A&E Delivery Board
- Model of Care
- Specific Projects
  - Integrated Urgent Care – Clinical Hub
  - Pilot 2016/17
  - Expected Outcomes
  - Digital Care
  - Directory of Services
  - Mobile Directory of Services
  - Delayed Transfer of Care
- Applying Best Practice
- Regional Approach
- Deliverables
- Additional Network Achievements and Plans
- Evaluation

Mrs Hassoon referred to the slide on 'deliverables' and asked if there was an assessor to do the work. She was advised that the Network did have assessors and that work needed to be streamlined to provide one service.

Councillor Forster commented that people were trained to go to A&E and she was concerned that the current 111 service did not work. She suggested that everyone in the service were re-trained and urged people to use the term assessment instead of triage.

Councillor Bell said that good work was being described but asked how this would fit at a regional level. He referred to rumours through the STP that Darlington hospital would close and asked how this would fit with that agenda. He was informed that changes were being made at an operational level and that work was ongoing with the STP. The Director of Primary Care, Partnerships and Engagement, DDES CCG explained that the Local Delivery Boards would look at regional systems and that the STP were looking at the future and anticipating the current demands. He advised that the current local delivery boards would align and feed into the STP.

Referring to digital care, Councillor Brookes asked how this would fit in with data protection and asked if there was a patient agreement for data sharing, and if the system was deliverable. The Director of Primary Care, Partnerships and Engagement explained that this process starts at the GP practice where patients would be able to opt in or out and if consent was given wherever the patient turned up in the system all information would be available. Bridging software would be used to combine and migrate the systems. Each practice had dealt with the issue differently but all practices were being asked to write to those patients who had opted out previously to explain the benefits of opting in.

The Chairman thanked the officers for their presentation.

Resolved:
That the report be received and that the comments of the Committee be noted.

10 Preventative Mental Health Review and Recommissioning

The Committee considered a report of the Strategic Commissioning Manager, Adults and Health Services that provided an overview of work ongoing and proposed recommendations on the future of community preventative mental health services, following a strategic review undertaken by Durham County Council (DCC) Children and Adult Services Commissioning and Public Health (for copy see file of Minutes).

The Strategic Commissioning Manager and Commissioning, Policy and Planning Officer gave a report that highlighted:-

- Background to the review
- Proposed future model – key elements
- Core aspects of what services were trying to do
- 5 key themes – need to be measurable
- Key outcomes – short & medium term
- Pathways – by range of providers & clear about where they join up

- Network – all services being asked to sign up to become part of the network

The Strategic Commissioning Manager highlighted the next steps of the review:-

- Engagement with key stakeholders (August–October 2016)
- Mapping current service provision and identifying areas for development (October-November 2016)
- Further work on outcomes and pathways required from the new service model including those identified in the Crisis Care Concordat work (November 2016)
- Commissioning decisions and service specification development (December 2016)
- Redesign and re-procurement (December 2016 onwards)
- New model to commence from April 2017(phased approach)

Councillor Forster referred to the length of time it takes to get appointments with therapists and counsellors and was advised that work was ongoing with the CCG as they commission this service. The Mental Health Partnership Board were aware of the time taken to receive therapy and had fed back to the CCGs that the response time and delays were significant and that people were left feeling more anxious and disappointed. The Strategic Commissioning Manager responded to Councillor Forster's comment that the system was not fair as he agreed that in some areas people had choice and in some areas people had none. With this new model people should be able to access the right help at the right time.

Councillor Brookes asked if this review was linked to the County Council's Transformational programme. The Strategic Commissioning Manager explained that it was as mental health was everybody's business and it was a collective responsibility. It was also linked to the transformation of the STP and close discussions with the CCG about where mental health sits were part of the development process.

The Director of Primary Care, Partnerships and Engagement, DDES CCG referred to counselling and agreed that there were improvements to be made. However, he stated that the counselling service in the Easington area was good as GP practices worked with TEWV.

The Strategic Commissioning Manager further explained that the TEWV arrangements were not in place for North Durham and a lot of feedback from GPs said that they needed access to be able to refer patients for help and support with mental health needs. He informed the Committee that the One Point Service offered support to children and families but not all schools had bought into the service.

Councillor Huntington referred to the counselling service and pointed out that in order to become qualified hours of voluntary work were required. This was a problem as people could not access the hours required and the service were losing potential employees. The Strategic Commissioning Manager said that there would be opportunities to discuss this moving forward. The Commissioning, Policy and Planning Officer further advised that this was linked to other health programmes ongoing. Community Parenting had commissioned a bereavement service for children and young people from funding from CAMHS and Parenting Support. This service would be available for a year with the option to extend.

The Chairman thanked the officers for their presentation.

Resolved:

(i) That the contents of the report and the proposed service model be noted.

(ii) That the further work required to inform future commissioning decisions and develop the model into detailed specifications for service redesign and/or reprocurement from December 2016 be noted.

(iii) That a further report during 2017 outlining progress and key implementation stages be received.

11 Any Other Business

The Principal Overview and Scrutiny Officer reminded members that the next meeting of the Suicide Prevention Working Group would take place on Monday 21 November 2016 at 10 a.m.

Councillor Bell asked for information about the dentistry services at Richardson Hospital. The Principal Overview and Scrutiny Officer said that he would circulate a briefing note that had been received from NHS England. Councillor Armstrong reminded members that Sue Jacques had been asked to provide a report at a future meeting.

Councillor Temple raised concerns that TEWV were not fulfilling what they said they would in terms of transport arrangements for the reconfigure of Organic Inpatient (Dementia) wards serving County Durham and Darlington. The Principal Overview and Scrutiny Officer reminded members that assurances had been given around the transport issues and had been advised that a mitigation plan would be in place to support patients and their families with transport needs. A letter would be sent to TEWV on behalf of the Chairman seeking post implementation feedback including the number of people who had been approached in terms of mitigation travel and accessing services at Auckland Park.

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Friday 6 January 2017 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Armstrong, R Bell, J Blakey, P Crathorne, K Hopper, E Huntington, J Lindsay, M Nicholls, L Pounder, P Stradling and O Temple

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

Also Present:
Councillor L Hovvels

1 Apologies

Apologies for absence were received from Councillors P Brookes, J Chaplow, S Forster, P Lawton, H Liddle, O Milburn, A Savory and W Stelling

2 Substitute Members

There were no substitute Members present.

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 Community Hospitals and Community Health provision

The Committee received a presentation from the Chief Executive of County Durham and Darlington NHS Foundation Trust (CDDFT) and the Chief Clinical Officer of Durham, Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) about an Integrated Community Hub Model (for copy see file of Minutes).

The Chief Executive of CDDFT advised that by introducing an integrated community hub model it would keep people well and that they would benefit from being at home. The model would be introduced in the next financial year and work was ongoing with GPs,

trusts and local authorities to ensure that wrap around services were available. She offered to provide Members with a list of services from each Community Hospital facility and who provided them. She went on to highlight the context within the presentation.

The Chief Clinical Officer, DDES CCG highlighted the following:-

- Integrated hub model – including wrap around services and single points of access

Councillor Temple was advised that SPA refers to Single Point of Access for GPs to access community nurses.

Councillor Huntington said that someone needs to have overall control and asked how this was decided and who it would be. The Chief Clinical Officer explained that it would depend upon the hub. The person in control could be a social worker, lead community nurse, practice nurse or a GP. The service wrapped around the patient and was very patient focused.

Referring to the SPA abbreviation, Councillor Nicholls said that this type of wording was confusing for people. The Chief Clinical Officer agreed that they could do better and confirmed that the main contact for a patient was with their GP. The Director of Integration, CDDFT advised Members that nothing was yet written in stone. The aim was to have a slicker and smoother system.

Mrs Hassoon asked if this would fit in with Specialist Community Providers and if one point of contact who would carry out a care plan and where would this work be picked up. The Director of Integration said that it would be the most appropriate professional. The Chief Clinical Officer advised that this would depend on the needs of the patient. There was a need to get teams working locally. He confirmed that there would be one assessment but that it would need to be more involved.

With reference to hubs, Councillor Bell asked where they would be and if transport and other issues had been addressed. The Chief Clinical Officer confirmed that this would include Barnard Castle as community nurses already work directly with GPs now.

The Chief Clinical Officer continued with the presentation, highlighting the following:-

- Community hub vision
- Out of Hospital Strategy
- Why we need to do it
- What will be different for our populations?
- What will be different for our workforce?

The Chief Executive, CDDFT concluded the presentation by explaining:-

- Community Hospitals
- Where are we now?

The Chairman thanked the officers for their presentation.

Councillor Crathorne agreed that it was better to get people home more quickly, especially older people and those with disabilities. She asked if the Trust were working with independent providers to ensure that appropriate care would be given at home. The Chief Executive, CDDFT advised that they do this and said that work was underway to look at what the community hospital could provide in terms of a care package, especially as the private sector was under stress. The Trust had also considered looking at providing geriatricians working within primary care. The Director of Integration added that they already had an Intermediate Care Service and that the CDDFT were working within an intermediate care capacity. She informed the Committee that by investing in enhanced intermediate care could prevent people needing longer term care. She also referred to the reablement service that could prevent re-admission into care.

Councillor Huntington agreed that the Community Hospital could provide crucial care however was concerned that there was never enough car parking provision. She also expressed concern about social workers and asked if we had enough staff, as she was also aware that there were not enough GPs. She further asked if people would receive the correct training as an important part of the success of the hub. She felt that reception staff needed further training around confidentiality. The Chief Clinical Officer said that the shortage of GPs was being addressed and the CCG were looking at how to make the offer more attractive. The hubs would ensure that appropriately trained staff were in post allowing the GPs to concentrate on the job they were best at.

The Chief Executive added that places in medical schools had increased however it would be 6-10 years before any professionals emerge from that arena. She said that they were trying to ensure that this was the place were people wanting to come and work and that they would be given an opportunity to carry out a portfolio of work, perhaps working in the community.

Councillor Huntington re-iterated her point about the lack of confidentiality in reception areas and that some staff require proper training. The Chief Clinical Officer advised that they did try to drive up the quality offered and asked Members to report any specific problems. With regards to the point about social workers the Chief Executive explained that social worker roles would be well defined and would be kept under review. As the early stages progressed this would be monitored and there may be a need to re-invest in community provision. The Director of Integration advised that there had been no indication to suggest that there was insufficient provision in this area. Social workers would work across more than one hub and would be based much closer to localities. She also touched on the voluntary sector, adding that social workers back in the community would align with the voluntary sector through the hubs.

With regards to parking, the Chief Executive explained that this would be looked into.

The Head of Planning and Performance Strategy said that we were all good at making things complicated and suggested that we should be simplifying systems. He believed that by doing this it would free up a lot of capacity and that by simplifying things it would alleviate a lot of stress, worry and waste currently in the system. He hoped that we did not lose the fact that the user/patient was at the centre.

Councillor Nicholls appreciated that this was a difficult task and said that the changes needed to be worthwhile. He added that it was important for the community to become involved.

Councillor Bell expressed concerns at the under-utilisation of community hospitals. He stressed that multiple NHS providers had pulled out and that there were empty wards at the Richardson hospital. He also commented that there were a number of care homes in the Barnard Castle area. The Chief Executive advised that the demand for services at the Richardson hospital reduced as Darlington CCG had commissioned care in the town. She added that it was important to offer an enhanced level of care and get the patient reabled and back into the community. The facility at Darlington only takes patients for a 2 week period and therefore Richardson hospital still receive patients from that facility. With regards to the care homes the Chief Clinical Officer advised that where they could not be sufficiently staffed then there would be an opportunity for people to attend the community hospitals that could offer some services. The Director of Integration added that there was a project plan and engagement plan in place that links with the leads in the CCGs and Patient Reference Groups. The Chief Clinical Officer added that this was also part of the engagement strategy for the STP.

Following a question from Councillor Temple regarding the closure of the inpatient ward at Shotley Bridge Hospital, the Chief Executive, CDD FT confirmed that it was anticipated that the necessary remedial works would be completed at the end of January 2017 and the inpatient ward would be expected to re-open in February 2017. Staff and patients had been temporarily moved whilst works were underway.

Mrs Hassoon asked how the multi-specialist assessments would be paid for if there was a funding shortage. The Chief Executive advised that there would be a more efficient way of doing things and a natural direction of travel. The Chief Clinical Officer said that 90% of healthcare was delivered in a community setting with only 10% of the funding. He said that there needed to be a shift in funding as changes took place.

Resolved:

(i) That the presentation be noted.
(ii) That information about the services provided at each Community hospital be circulated.

6 County Durham and Darlington NHS Foundation Trust - CQC Inspection Improvement Action Plan update

The Committee considered a Report of Director of the Transformation and Partnerships and presentation from the Chief Executive of County Durham and Darlington NHS Foundation Trust an update in respect of the Care Quality Commission (CQC) inspection improvement Action Plan of County Durham and Darlington NHS Foundation Trust (for copy see file of Minutes).

The Chief Executive gave a detailed presentation that highlighted:-

- CQC Assessment for Darlington, Durham and Community Hospitals
- Context of the findings – e.g. 80% of indicators were good
- Ratings Distribution

- The Services that required improvement/ Trust-wide areas
- A&E Urgent Care – key actions completed prior to receipt of report and subsequently
- End of Life – key actions completed prior to receipt of report and subsequently
- Medicine & NIV & Critical Care – key actions completed prior to receipt of report and subsequently
- The Acute Intervention Team
- The developed solution
- Training & integration
- What they will do?
- Record Keeping, Care Planning & Ward Management – key actions completed prior to receipt of report and subsequently
- Governance & Strategy
- Where we are now
- Remaining Actions
- Monitoring & Assurance Processes
- Quality Matters/ Care Quality Improvement Framework

The Chief Executive concluded that all actions identified were complete or near-complete and that the ambition remains to move from good to outstanding.

The Chairman thanked the Chief Executive for her presentation.

Councillor Armstrong asked when the CQC would be returning to carry out a further inspection and further asked if the Trust were confident that actions had been put into place. The Chief Executive advised that the Trust had asked the CQC to return but as they must give 100 days' notice of a visit it would not be early this year. The Trust were keen to go through the process again and believed that the CQC must be comfortable with that they were putting the actions into place. The Trust had carried out their own internal inspection and had arranged for an external partner to carry out an inspection.

The Chairman said that it was frustrating as the public should be able to have sight of a follow up report that gave the assurances that things had been put right. It would also give staff a pat on the back. He added that good news did not seem to be reported but that any problems within the system are slated by the media and no follow up reports are ever carried out to see what improvements had been made.

Councillor Nicholls congratulated the Chief Executive for an excellent presentation and said that the information should be sent to the media.

The Chief Executive said that she would circulate their Board report to Members so that they could see the good news stories.

Councillor Bell felt that the 2 year cycle of inspections was unsatisfactory as the positives should be reassuring the public. He said that he would continue to hold the Trust to account but fully supported the report.

The Chairman suggested that the Committee send a letter to the Trust to commend the progress made and to congratulate them on the direction of travel. The Committee fully endorsed the actions taken by the Trust.

Resolved:

(i) That the contents of the report and presentation be noted.

(ii) That the Committee commend and fully endorse the actions taken by the Trust to improve the quality and performance.

7 Dentistry Services at the Richardson Hospital, Barnard Castle

The Committee received a report from the Primary Care Commissioning Manager, NHS England – North, Cumbria and the North East that gave an update in respect of dentistry services at Richardson Hospital, Barnard Castle (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer informed Members that representatives from NHS England had advised that they were unable to attend the meeting. He reminded Members that the issue around dentistry was highlighted at the meeting on 14 November 2016. The organisation had been asked to provide an explanation for the removal of the service, including information on the number of affected patients, their location and the available alternative provision in the locality. The report highlighted the number of affected patients from the Bishop Auckland and Middleton in Teesdale areas when the mobile service ceased and they were transferred to Richardson Hospital. Numbers accessing dental services at the Richardson Hospital had declined over the last few years. Special needs patients were also seen at the Richardson Hospital and this service would not be affected.

Members were asked to refer to the map attached to the report that showed the level of take up, red indicating low take up and dark green indicating high take up. Take up in the Teesdale areas was very good in comparison to other areas within the North East.

The Principal Overview and Scrutiny Officer reported that the Castle Dene surgery in Barnard Castle had been actively recruiting new patients. Ongoing discussions were taking place and the move would be from the Richardson Hospital to seeking alternative provision. Members were asked to note the situation of the removal of the service.

Councillor Bell was seriously unhappy that there was an ongoing need for the service but that people had already been advised that the service would cease and that they would have to find alternative provision. He felt that no assurances had been given by NHS England. He referred to the background information within the report that showed that 200 patients in Teesdale and 80 people in Middleton in Teesdale had used the mobile service. Alternative provision had been put in place at the Richardson hospital. Most of the patients accessing the service came from Barnard Castle West. He attributed the falling numbers to the fact that people had already been told that the service would cease and therefore that had already found alternative provision. He went on to ask if there was enough capacity at other practices for all patients and stated that Crook and Shildon were not local areas, especially of people had to travel on public transport. Those people that were not mobile or that were elderly would suffer as a result. He said that his questions had not been answered, that the organisation had already stated its intention to withdraw the service and no assurance had been given that people would find alternative local

provision. He also found it unreasonable that no-one had attended the meeting today from NHS England.

Councillor Hopper said it would interesting to know about general access to general practices.

Councillor Huntington commented that an overarching manager should have been in control and advised people where to find alternative provision. She questioned why the organisation had been allowed to withdraw from the contract.

The Chairman suggested that a letter was sent to NHS England stating what the statutory overview and scrutiny process was and to explain that this Committee had discovered this piece of news from a local newspaper, via Councillor Bell. It had been a poor piece of work and they would be asked to attend a future meeting.

Councillor Bell expressed concern about transport links and felt that he had asked perfectly reasonable questions.

Councillor Temple said that it was not obvious from the report how many general patients had reduced. It was noted that the specialist service would remain but that these patients were included with the overall number of patients. He would like to know how many sessions had been cancelled not just the number of patients.

The Principal Overview and Scrutiny Officer referred to information in the report that stated 2 sessions per week had reduced to 2 sessions per fortnight. He suggested that as the Committee had a further meeting on 20 January 2017 he would make enquiries and ask for representation at that session.

Resolved:
That representatives from NHS England be invited to attend the meeting on 20 January 2017.

Adults Wellbeing and Health Overview and Scrutiny Committee

20 January 2017

Integrated Risk Management Plan (IRMP) Action Plan 2017/18 Consultation

Report of Stuart Errington, Chief Fire Officer, County Durham & Darlington Fire & Rescue Authority

Purpose of the Report

1. To provide the Adults Wellbeing and Health Overview and Scrutiny Committee with background to the Fire Authority's IRMP Action Plan consultation for 2017/18. The Committee will be provided with a presentation setting out details of the consultation and key issues for the Fire Authority going forward.

Background

2. The Fire and Rescue Service National Framework for England (published in July 2012 by the Department of Communities and local Government) places a statutory responsibility on all Fire and Rescue Authorities to produce an IRMP.

3. The IRMP must be publicly available (currently on the County Durham and Darlington Fire and Rescue Service website, attached at Appendix 2) and cover at least a three year timescale. The Framework requires that an IRMP must also:

    - Be regularly reviewed and reflect up to date risk information and evaluation of the outcomes of delivering our service;
    - Identify and assess all foreseeable fire and rescue related risks that could affect the community;
    - Have regard to existing analyses of risk to communities completed by partners such as Local and Regional Resilience Forums;
    - Reflect effective consultation during its development and at all review stages with representatives of all sections of the community and those who have a stake in the local area;
    - Demonstrate how prevention, protection and response activities will be best used to reduce the impact of risk on communities in a cost effective way;
    - Provide details of how Fire and Rescue Authorities deliver their objectives and meet the needs of communities through working with partners.

4. The IRMP will be equality impact assessed to ensure County Durham and Darlington Fire and Rescue Service's activities and proposals satisfy the requirements of equality legislation.

6. Following an extensive consultation programme the Authority approved the 3 Year Strategic Plan in February 2015 which covers the period 2015/16 – 2017/18 and incorporates the Authority's IRMP.

7. Although there is no requirement to consult on the full IRMP every year, the Authority must publish and consult on an annual IRMP action plan. The consultation document, attached as Appendix 2, is the basis of our consultation with staff, stakeholders and the public on the proposals we intend to progress in 2017/18 to ensure we continue to provide the appropriate level of service to our communities based on risk.

8. The consultation on the IRMP will include Area Action Partnerships, Parish and Town Councils, Service Personnel and Social Media as in previous years. The Authority is also holding a number of specific consultation events in the areas most impacted by the potential changes.

7. The consultation period commenced on 16 November and concludes on 08 February 2016. A copy of the consultation document is attached as Appendix A.

The 2015/16 – 2017/18 IRMP

8. The consultation document seeks the views on our proposals for change by posing the following three questions:

   1. **Based on the outcomes of the emergency medical response trial, should we continue this work with North East Ambulance Service provided it supports our core fire and rescue service strategic priorities?**

   2. **Would you support us in exploring further collaboration with health services in the future?**

   3. **Do you agree that we should share High Handenhold Fire Station with Durham Police?**

Recommendations

9. Members are requested to

   (i) Consider and note the content of the IRMP Action Plan consultation for 2017/18 which will be presented at the meeting.
   (ii) Provide feedback on the IRMP Action Plan for 2017/18.

Contact: **Keith Lazzari, Performance and Information Systems Manager**
County Durham & Darlington Fire and Rescue Authority
Tel: **0191 3755580** **E-mail: klazzari@ddfire.gov.uk**

Appendix 1: Implications

Appendix 2
Finance – None

Staffing – None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights – None

Consultation – Outcomes from this report and presentation will raise Members awareness of the Fire Authority's consultation on its Integrated Risk Management Plan Action Plan.

Procurement – None

Disability Issues – None

Legal Implications – None

Safest People, Safest Places

County Durham and Darlington
Fire and Rescue Authority

Integrated risk management plan consultation 2017-2018

County Durham and Darlington
Fire and Rescue Authority

Contents

Introduction	3
Our performance	4
The financial outlook	8
You said, we did	10
Consultation questions	11
How to take part in the consultation	14

County Durham and Darlington
Fire and Rescue Authority

Integrated risk management plan consultation 2017-2018

Introduction

Funding for your local fire and rescue service comes from two main sources: a government grant, providing approximately 35 per cent of the total; and precept payments from local taxpayers and non-domestic rate-payers in County Durham and Darlington, which make up the remaining 65 per cent.

For the past six years we have transformed the way we provide services to the community in response to a £6m cut in our funding from central government.

In 2016 the Fire Authority agreed to accept the government's offer of a four year funding settlement. This settlement still results in a reduction in government funding of 19 per cent in the medium term, forcing us to consider further proposals to reduce costs.

Before these decisions are made CDDFRS is consulting with people living and working in our area about three proposals which could affect spending and the way the service operates.

In this document, which is linked to our three year strategic plan 2015 to 2018, we have included some background information about the performance of the Service and the vital role we play.

Three consultation questions, including information relating to each one, are set out at the end of this document.

For details about how to respond to the questions as well as a link to the survey, please turn to page 14.

We would be very grateful if you could spare a few minutes to take part in our consultation by 20 February. The results will be published in March 2017.

This is your fire and rescue service, funded by you and operating to protect the community. Your help is important to us as we prepare to make future plans and decisions.

Councillor Michele Hodgson
Chair of the Combined Fire Authority

Stuart Errington
Chief fire officer

Our performance

As an emergency service CDDFRS is governed by legislation and national frameworks to ensure that we have the people, equipment and training in place to respond to a wide variety of incidents including:

- Fires of all types
- Road traffic collisions
- Specialist rescues such as those using lifting equipment for injured horses and large animals; rescuing people trapped at height or in confined spaces
- Bariatric rescues
- Wildfires
- Search and rescue operations on rivers, lakes and reservoirs using our swift water boats
- Flood response and incidents involving the pumping of water from homes and buildings
- Incidents involving chemicals and noxious gases.

The Service also has a statutory duty to prepare for incidents where major disruption affecting the people of County Durham and Darlington is likely to occur. These situations include:

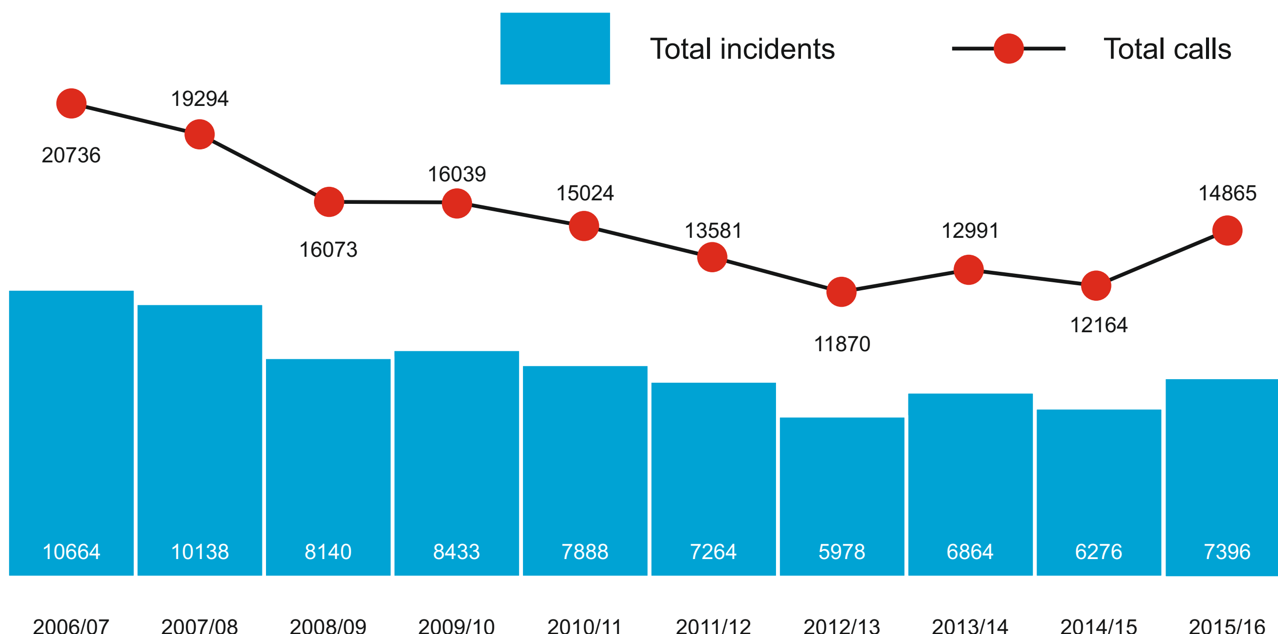
- Severe weather events, such as flash flooding or prolonged and heavy snowfall
- Network power losses
- Major incidents involving fuel and chemical spills
- Public health issues, for example a flu epidemic
- Animal incidents, such as foot and mouth disease.

Due to a comprehensive programme of prevention and protection work, as well as improvements in legislation, which reduce the risk of fire, the number of incidents attended by CDDFRS has decreased during the last ten years with the reduction reaching a plateau between 2012 and 2015.

Although the chart in figure one shows an 18% (1120) increase in incidents in 2015/16, 86% (962) of this increase has been due to the introduction of a trial involving our fire crews responding to life threatening medical emergencies in support of North East Ambulance Service.

This new Emergency Medical Response (EMR) incident type has increased our operational activity and has provided valuable lifesaving treatment to people with serious medical conditions such as heart attacks or respiratory arrest.

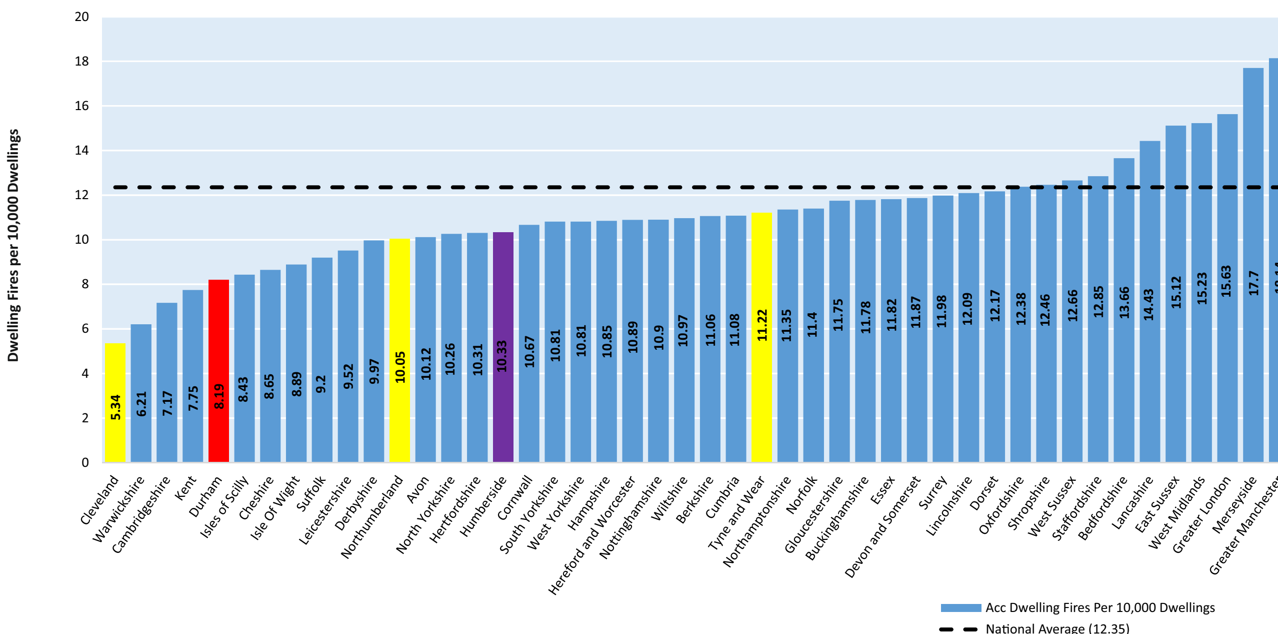
Figure one - Total calls and total incidents (2006/07 to 2015/16) - CDDFRS only



CDDFRS is one of the best performing services nationally for prevention work and it remains committed to reducing all incident types through working in partnership with other agencies, problem solving and introducing new initiatives which reduce risk in the community.

A high priority for the service is to reduce the risk from fire in the home and so, working in partnership, we introduced the Safer Homes initiative in 2014/15. This initiative resulted in fire and crime awareness training being delivered to more than 3000 frontline staff from partner agencies. These staff have access to homes through their daily work and can offer brief interventions or referrals where needed for more specialist support and advice. As a result we have reduced accidental fires in the home by a further 4.2% during 2015/16 making CDDFRS the fifth best performing service in the country, as illustrated in figure two below.

Figure two - Accidental dwelling fires Per 10,000 dwellings, by fire and rescue authority 2015/16 - CDDFRS fifth best performing service nationally



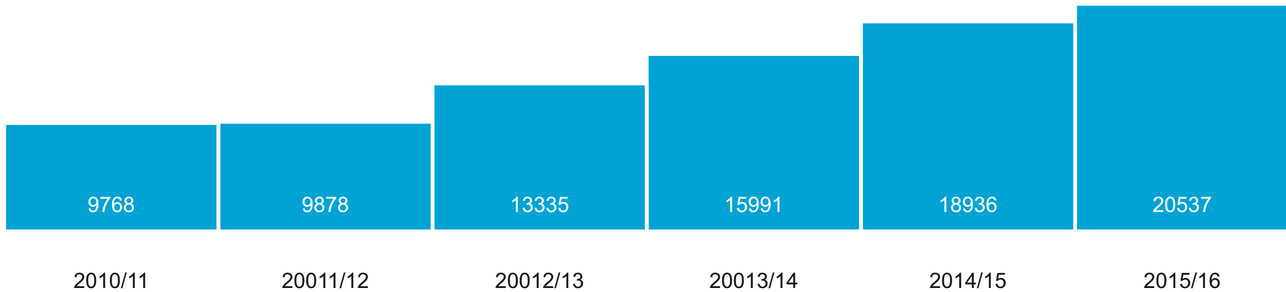
Service most similar to CDDFRS

North east fire and rescue services

County Durham and Darlington Fire and Rescue Service

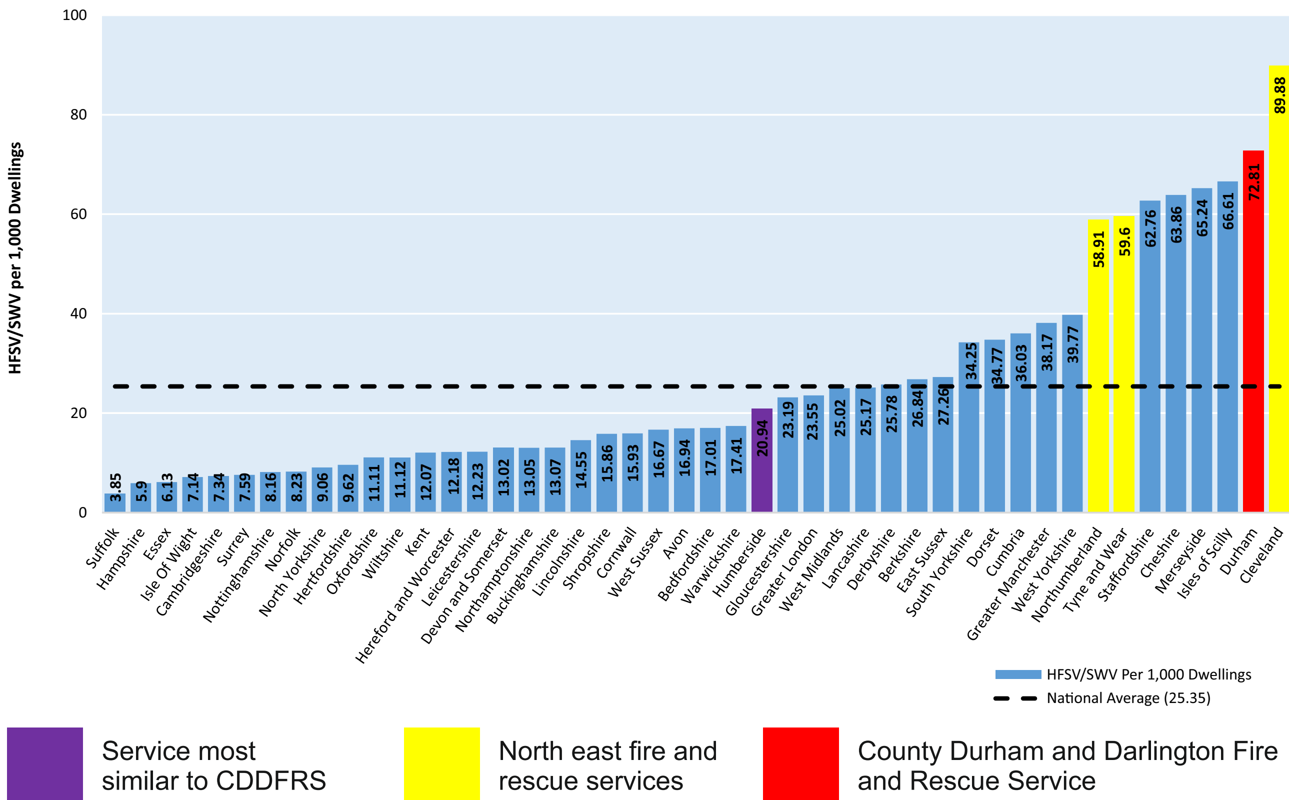
Further to this work we recognise that many people affected by accidental fires in the home have lifestyle factors linked to their personal health and wellbeing, such as smoking, drinking or mental health conditions. To help keep people safer in their homes we have been working with our partners and expanded our home fire safety check (HFSC) to include six key elements of health and wellbeing. These checks have been renamed safe and wellbeing visits (SWV) to reflect the increased benefits delivered in the assessment and advice. The graph in figure three shows the annual increase in delivery of HFSCs to more than 20,000 in 2015/16. However, due to the introduction of the extended SWV in February 2016, the overall number of HFSCs reduced slightly during 2016/17 to allow for the increased wellbeing element of the assessment.

Figure three - Home fire safety checks/safe and wellbeing visits (2010/11 - 2015/16) - CDDFRS only



Nationally CDDFRS is the second best performing Service in the country with regard to home fire safety checks/safe and wellbeing visits. Figure four shows the national comparison.

Figure four - Home fire safety visits/safe and wellbeing visits per 1,000 dwellings by fire and rescue authority 2015/16



National statistics show that CDDFRS is currently the best performing service in the country with regard to the number of fire safety audits carried out on non-domestic properties (see figure five). This achievement reflects the Service's extensive work with businesses and organisations to help keep people safe at work or when visiting a workplace such as a hotel or shop. CDDFRS does this by offering fire safety advice to businesses and conducting an audit programme on workplace fire safety risk assessments.

During 2015/16 there was a 16% decrease in the number of fires in non-domestic premises and a 5% reduction in false alarms caused by automatic fire detection apparatus when compared to the previous year. Figure six shows the increase in workplace fire safety audits during the same period.

Figure five – Fire safety audits per 1,000 non domestic premises by fire and rescue authority 2015/16

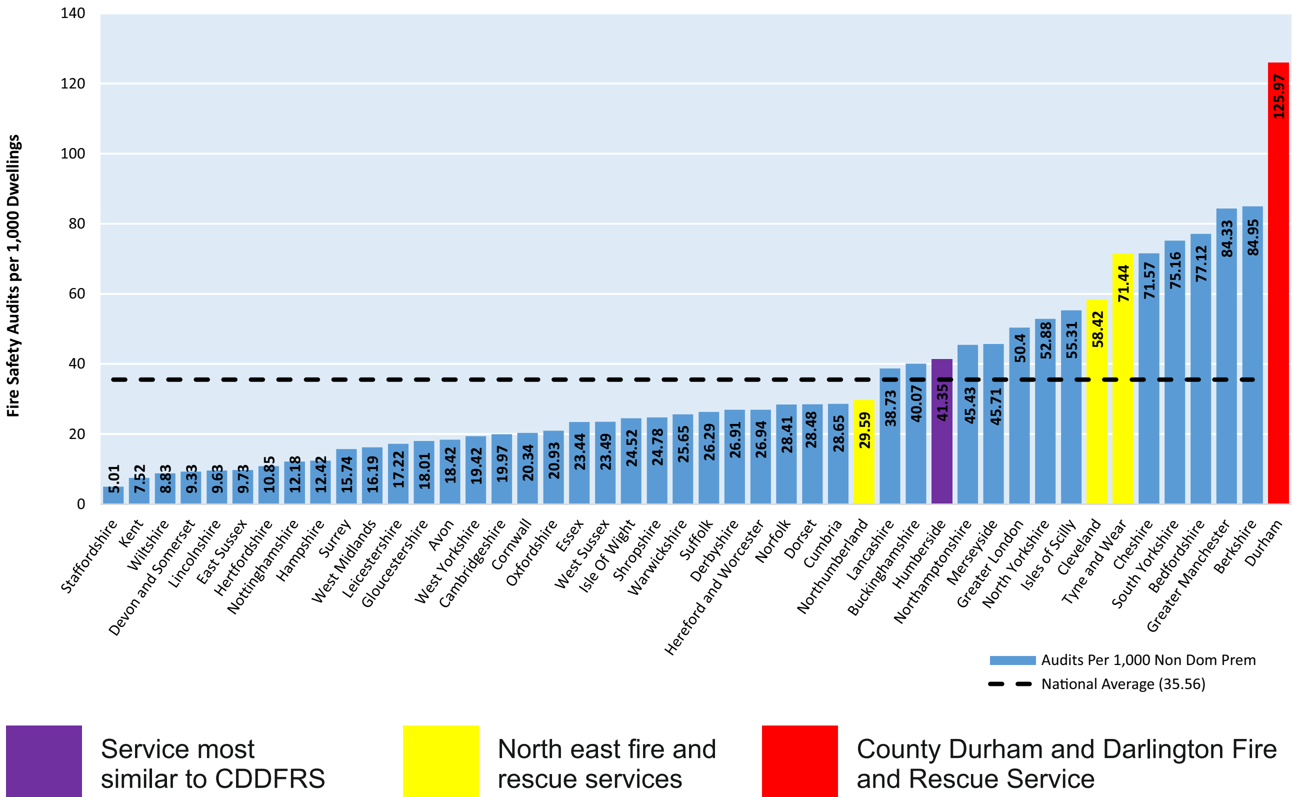
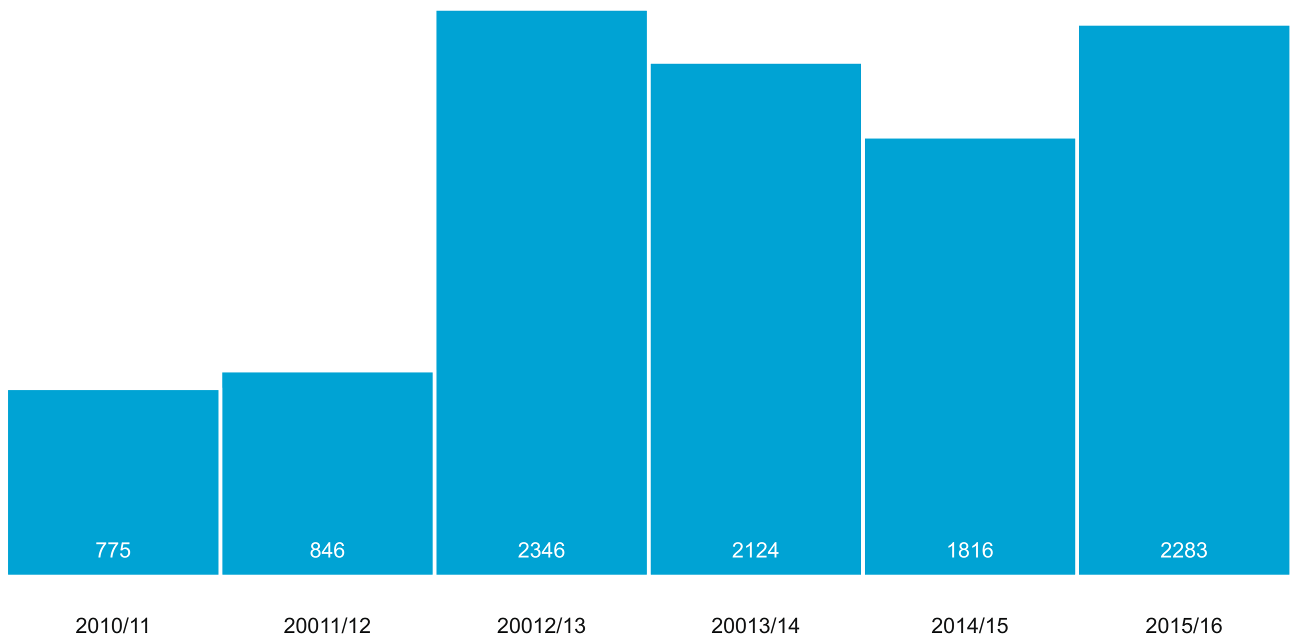


Figure six – Fire safety audits non domestic properties (2010/11 – 2015/16) CDDFRS only



The financial outlook

In the face of an ongoing reduction in government funding, we remain committed to protecting front line services to the public ensuring that there is no increase in risk and no change to emergency response standards.

This commitment is evident in our recruitment strategy, which is designed to put viable succession plans in place to ensure the future resilience of CDDFRS. There are currently four strands to the recruitment strategy:

- Retained (part-time) firefighters to whole-time (full-time) transfers;
- Firefighters transferring into CDDFRS from other Services;
- Recruitment from the general public; and
- New firefighter apprenticeships.

Our funding from central government has reduced by almost £6m since 2010. In spite of the challenging financial circumstances, we have been successful in achieving savings through our service transformation programme which has enabled us to balance the budget while at the same time protecting front line services.

The Fire Authority has agreed to accept the government's offer of a four year funding settlement covering the period 2016/17 to 2019/20, however this will still result in a significant reduction in government funding (19%) over the medium term. The medium term financial plan, set out in the table below, outlines our financial position over the next four years:

Medium term financial plan

	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
Net expenditure	**28.609**	**28.183**	**28.774**	**29.062**
Total government funding	10.945	9.676	9.134	8.884
Local non domestic rates	1.479	1.508	1.552	1.602
Council tax	15.861	16.254	16.646	17.047
Surplus on collection fund	0.324	0	0	0
Total funding	**28.609**	**27.438**	**27.332**	**27.533**
Shortfall	**0**	**-0.745**	**-1.442**	**-1.529**

As part of the medium term financial plan we have assumed that council tax increases by 1.9% each year; under current regulations this is the maximum increase permitted before a local referendum would be required to seek approval from residents.

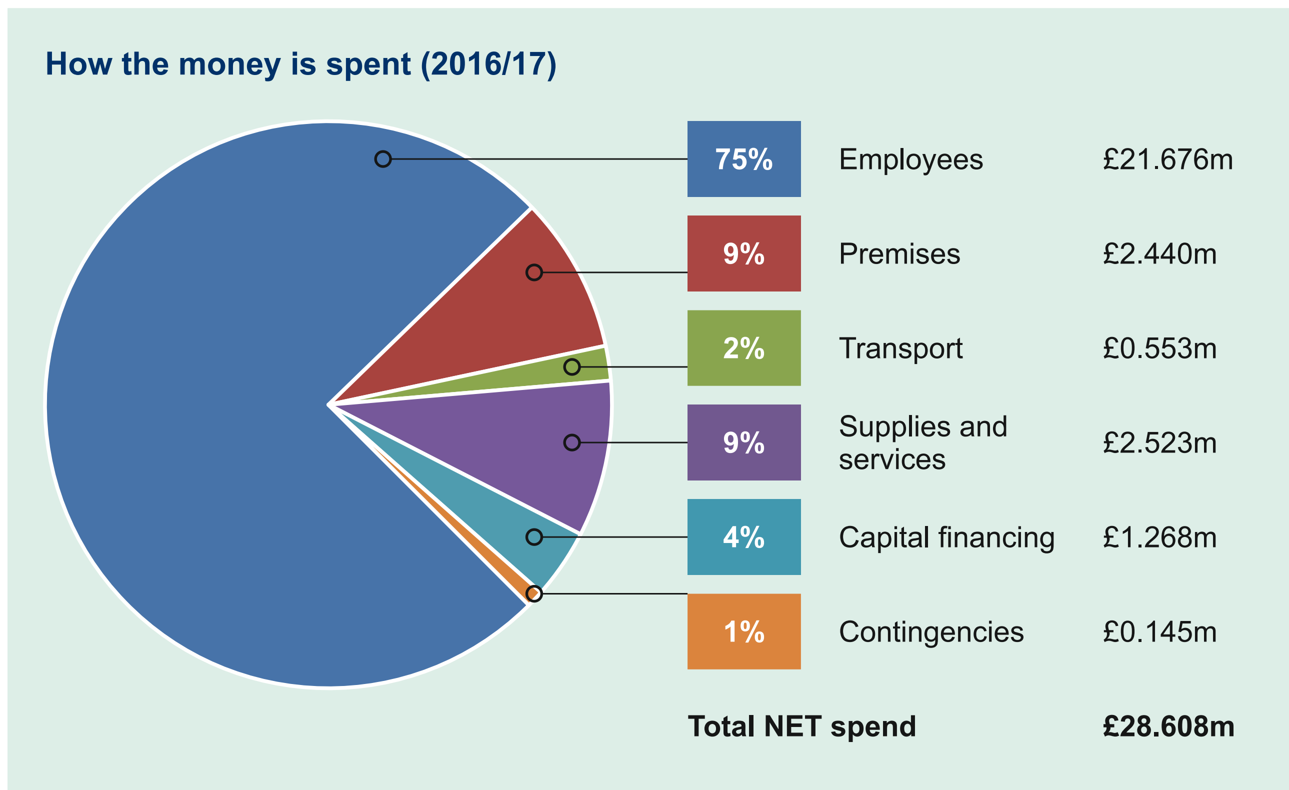
In order to balance the budget we still need to find a further £1.5m of savings. Having implemented the vast majority of cost savings available to us, to run a lean and efficient service, we are now looking at other measures which could help to generate income and/or reduce costs without affecting our frontline fire appliances, stations and community safety activities.

We have a strong track record of collaboration with partners, which has secured government funding to progress a number of high profile collaborative projects including:

- The building of the first quad station in the country in Barnard Castle which, when complete, will provide a joint facility for the fire, police, ambulance and mountain rescue services.
- A joint facility with Durham Police at our Belmont Training Centre for incident command training.
- The provision of community safety tri-responders in Stanhope where staff work for the fire, police and ambulance services according to demand.

Collaborative projects and schemes with other public sector organisations are a key consideration as reflected in our consultation questions. This approach also fits into the government's agenda to enable 'closer working between the emergency services'.

Based on our current finances, this is how the total (net) £28.608m of our funding is spent:



As a marker, households paying council tax at band D level pay £1.84 per week towards the fire and rescue service, a total of £95.76 per year.

You said, we did

In last year's IRMP consultation we asked for your opinions in relation to five aspects of our developing strategy. Here is an update on the work carried out in each of the five areas since gaining approval through the consultation process.

The strategic review of fire control has resulted in shift systems to provide more efficient cover within the fire control team. This review was conducted in cooperation with the fire control team and the Fire Brigades Union. The revised shift systems will come into operation in January 2017.

Extending the role of firefighters to assist public health services has resulted in the development of our safe and wellbeing visits. These visits involve the provision of information and advice and cover six key areas of health intervention services: dementia, slips trips and falls, smoking cessation, alcohol awareness, loneliness and isolation and winter warmth. Each of these factors are often directly involved in fire related incidents.

Expansion of the Emergency Medical Response (EMR) scheme. The EMR trial has been in operation across Consett, Seaham, Darlington and Stanhope. As of 31 October CDDFRS EMR crews had responded to 2684 incidents as part of the trial and lives have been saved. The trial was scheduled to end in June but thanks to interim funding from the Local Accident and Emergency Delivery Board it will now continue to the end of February 2017.

Exploring further collaboration through support services, our estates and fire stations. The service has established a Joint Strategic Collaboration Board together with Durham Constabulary and Durham Police and Crime Commissioner. The board has identified a range of areas where the possibility of collaboration could be explored. These areas include: use of buildings, back up support for command and control teams, shared IT networks and training.

Extending the Young Firefighters' Association (YFA) and Fire Cadets' schemes. In addition to the established groups running at Consett, Darlington, High Handenhold and Seaham Fire Stations, four new schemes have been added in the past year. Young people can now attend groups at Bishop Auckland, Crook, Durham and Spennymoor Fire Stations.

Pictured: Fire Cadets taking a break from demonstrating their skills to guests at Darlington Fire Station.

Consultation questions
Seeking your views on our future plans

1. Emergency medical response (EMR)

Based on the outcomes of the EMR trial, should we continue this work with North East Ambulance Service provided it supports our core fire and rescue service strategic priorities?

The EMR trial involves fire and rescue services across the region joining forces with North East Ambulance Service (NEAS) to respond to specific types of medical emergency where they can be at the scene before an ambulance arrives.

The trial began in January 2016 and, following an extension to the original six month scheme, it will now continue until the end of February 2017.

In the first six months of the EMR trial fire crews across the region attended a total of 2,904 incidents as a result of 999 calls: 1,811 in Durham and Darlington, 136 in Northumberland, 395 in Tyne and Wear and 562 in Cleveland.

In County Durham and Darlington, Consett, Darlington and Seaham Fire Stations have been taking part in this trial. Two tri-responders, who cover fire, police and ambulance service incidents can also respond to EMR calls from Stanhope Fire Station.

Suitably trained firefighters from these stations have been co-responding alongside the ambulance service to patients indentified by NEAS control operators as having potentially life threatening conditions.

The improved response to patients where CDDFRS crews have initiated life saving intervention prior to the arrival of an ambulance has clearly saved lives.

The Fire and Rescue Service does not receive core funding to provide response to medical emergencies, however it has been keen to work more collaboratively with the ambulance service in order to help save lives. The trial is currently part of a review of the terms and conditions of firefighters by the National Joint Council for Local Authority Fire and Rescue Services, looking at the current and future demands on the service and profession.

Any continuation of this collaboration would be dependent on a full consultation with fire service crews and the Fire Brigades Union as well as detailed discussions with NEAS.

Pictured: Nick Leeming (centre), who suffered a cardiac arrest, was attended by a crew from CDDFRS Darlington blue watch followed by North East Ambulance Service in an Emergency Medical Response rescue earlier this year.

2. Further collaboration with health services

Would you support us in exploring further collaboration with health services in the future?

Linked but separate to our emergency medical response (EMR) trial is the work that has been done this year as part of our new safe and wellbeing scheme.

Since 15 February 2016, County Durham and Darlington Fire and Rescue Service (CDDFRS) had carried out 12,420 Safe and Wellbeing Visits (SWVs) and made 1,621 referrals to partner agencies as of 31 October. The new visits form part of our community safety work and replace the home fire safety checks, which the Service had run successfully for the past ten years.

SWVs continue to include advice to drive down the incidents of fire in the home but they are also designed to provide information and practical help to improve health and quality of life through referrals to partner agencies, where appropriate. This could be preventing slips, trips and falls, which are a big risk for elderly people in their homes; providing details about access to schemes to heat homes or health initiatives such as flu jabs. We can also give information about smoking cessation and alcohol consumption and support those affected by dementia as well as loneliness and isolation.

We are working closely with local authorities, our partners in health, housing providers and organisations such as Age UK Darlington, Age UK County Durham, the Alzheimer's Society and the Royal British Legion, to provide the referrals and expertise, should people take up the initial offers of support and advice.

Our firefighters and community safety teams have taken part in training to equip them with the skills to carry out this new element of their roles.

3. Sharing High Handenhold Fire Station with Durham Police

Do you agree that we should share High Handenhold Fire Station with Durham Police?

Sharing fire stations with other emergency services allows CDDFRS to reduce costs, improve facilities and provide savings for both organisations. There are also a range of operational benefits to both organisations such as shared intelligence and joint training opportunities.

A similar arrangement has been in place in Newton Aycliffe for the past two years where Durham Police share the fire station with fire crews. This allowed the former police station near to the fire station to close, saving costs and freeing up land for sale. It has also helped to maintain a police presence in the area, fostered partnership working between both services and generated income for the fire service to go towards the running costs of the building.

What to do now / how to respond?

This consultation runs until **Monday 20 February** and we are keen to canvas as many views as possible. Please take part in our survey via the following address **www.smartsurvey.co.uk/s/consultation2017-18/**

Should you require a hard copy of the survey to complete and return to us please phone: 0845 3058383 or email **ServiceHQ@ddfire.gov.uk**

This publication is also available in other languages, large print and audio format on request.

More information about the work and performance of County Durham and Darlington Fire and Rescue Authority is available via the website **www.ddfire.gov.uk**

Agenda Item 8

NHS England

Adults, Wellbeing and Health Overview and Scrutiny Committee
6 January 2017

Dentistry Services at the Richardson Hospital, Barnard Castle

1. Purpose of Report

To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with an update in respect of dentistry services at Richardson Hospital, Barnard Castle.

2. Background

County Durham and Darlington NHS Foundation Trust (CDDFT) operated a limited mobile dental service in Middleton in Teesdale two sessions per week and in Bishop Auckland one session per week. Unfortunately in March 2014 the service ceased due to the vehicle no longer being fit for purpose and difficulties in recruiting staff. Prior to this the number of patients accessing the mobile service was in decline as shown below.

	Bishop Auckland Patient Numbers	Middleton In Teesdale Patient Numbers
2011-12	87	216
2012-13	52	206
2013-14	48	197

Alternative provision (two sessions per week) was put in place by CDDFT at Richardson Community Hospital for patients who previously accessed the mobile dental service. This has recently been reduced to two sessions per fortnight in line with demand. CDDFT have confirmed that there have been no complaints regarding any delays in treatment as a result of the recent change.

3. Dental Provision at Richardson Hospital

In addition to the general dental clinics, CDDFT also operate a dental service for patients with special needs from Richardson Hospital, operating a total of 4-6 clinical sessions per month for both specialist dental patients and patients who previously attended the mobile dental service.

The numbers accessing dental services at Richardson Hospital has reduced over the last two years as shown in the table overleaf.

	Richardson Hospital – patients numbers (figures include general dental access patients and patients with special needs)
2014-15	158
2015-16	128
2016-17*	58

* position as at end of Nov 2016

The table below provides a breakdown of patients by ward area:

Wards	2015-16	2016-17
Barnard Castle East	31	12
Barnard Castle West	89	39
Chester-le-Street East	1	
Chester-le-Street South	1	
Evenwood	2	5
Shipley	1	
Aycliffe North & Middridge		1
Sadberge & Middleton St George		1
(blank)	3	
Grand Total	128	58

4. General Dental Access and other provision in the surrounding area

NHS England is currently working with the local dental networks and Consultants in Dental Public Health to review general dental access provision across the whole of Cumbria and North East.

From the work undertaken to date, take up of NHS dental care within the Dales area is particularly good in comparison with other areas of Cumbria and the North East and indeed other parts of England, with 68.64% of the Dales population accessing NHS dental care.

The attached map shows access across the Durham Area, and highlights very good take up rates in the Upper Teesdale area over the last 2 years.

In addition to the dental provision at Richardson Hospital, nine other NHS dental practices operate in the area, including a practice in Barnard Castle that is actively recruiting new NHS patients. The table below provides details of the practices and the distances from Richardson Hospital.

Practice	Opening times	Distance from Richardson Hospital
Castle Dental Practice 39 Galgate, Barnard Castle, County Durham DL12 8EJ **Telephone: 01833 631140**		0.2
West Auckland Dental Practice, 26 Front Street, West Auckland, Bishop Auckland, County Durham DL14 9HW **Telephone: 01388 833899**		9.9

Oasis Dental Care, 69 Cockton Hill Road, Bishop Auckland, County Durham Dl14 6HS **Telephone: 01388 603164**		12.2
Ashby and Atkinson, 23-27 Main Street, Shildon, County Durham DL4 1DY **Telephone: 01388 775104**		12.3
Oasis Shildon, Limetree House, St. Johns Road, Shildon, County Durham DL4 1LU **Telephone: 01388 772678**		12.4
Market Place Dental. 6 Market Place, Bishop Auckland County Durham DL15 7NJ **Telephone: 01388 602029**		12.8
Mr Nayyar, 1 Mill Street, Crook, County Durham DL15 9BE **Telephone: 01388 762522**		12.8
Burgess and Hyder Group, Victoria Lane Health Centre, Victoria Lane, Coundon, Bishop Auckland, DL14 8NP **Telephone: 01388 660372**		14.1
Burgess and Hyder Group, Stanhope Health Centre, Dales Street, Stanhope, Bishop Auckland DL13 2XD **Telephone: 01388 529945**		14.2

In view of the reducing patient numbers accessing the general dental service clinics at Richardson Hospital and the alternative provision available for patients as outlined above, discussions are currently taking place with CDDFT regarding the future viability of the general dental service provision. There would be clear benefits to patients in transferring to the alternative general dental practices in terms of extended access times and availability of dentists.

In the event that a decision is taken to cease the general dental access clinics at the hospital, NHS England will work with CDDFT to ensure that patients are signposted into alternative local NHS provision.

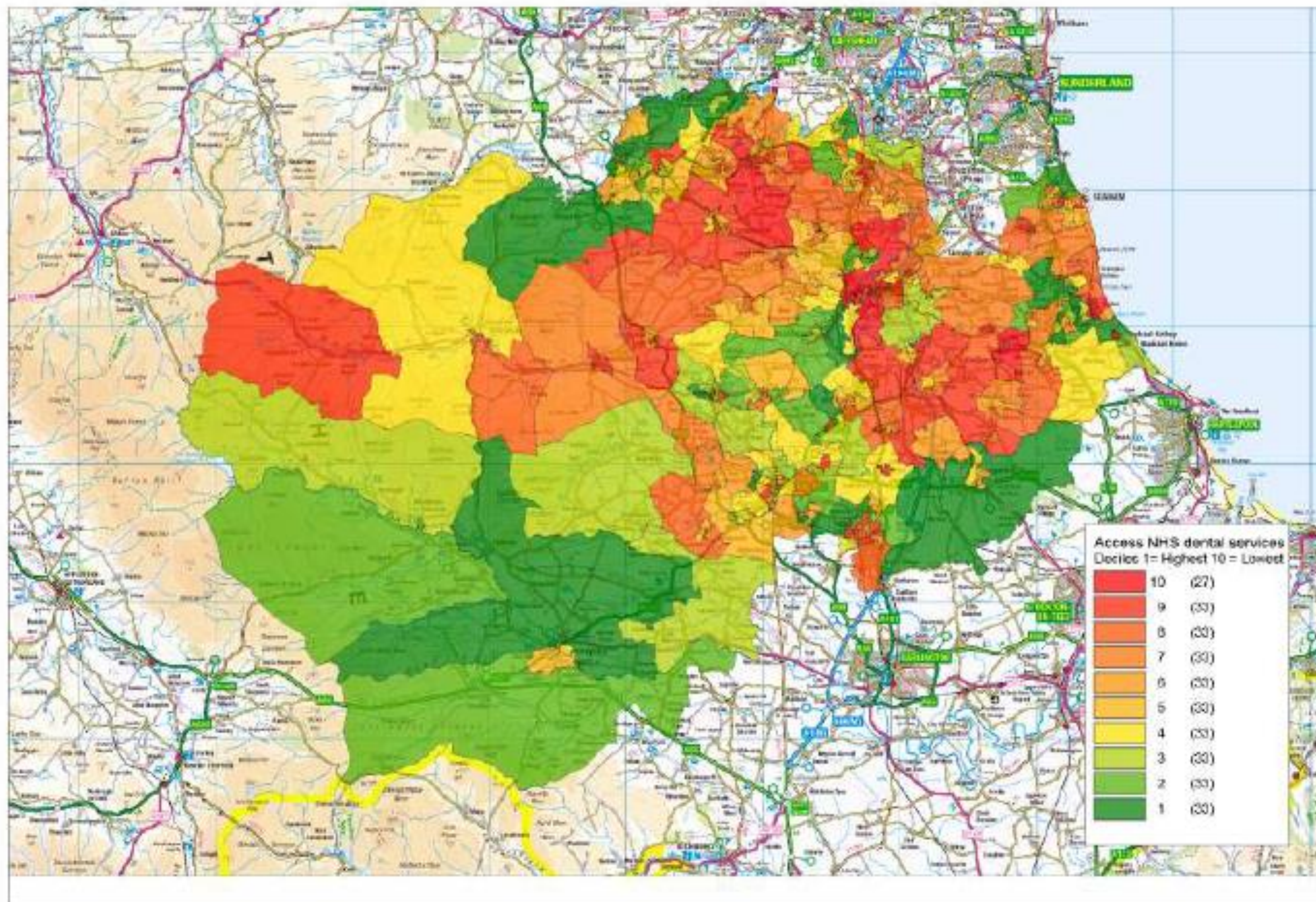
For the avoidance of doubt, there are no plans to change the current provision at Richardson Hospital of dental services for patients with special needs.

4. Recommendation

The Adults Wellbeing and Health Overview and Scrutiny Committee are asked to note the contents of this report and the on-going discussions with CDDFT with regard to the general dental service provision at Richardson Hospital.

Contact for further information:
Pauline Fletcher, Primary Care Commissioning Manager, NHS England – North, Cumbria and the North East
E-mail: Pauline.fletcher2@nhs.net

Map showing take up rates by Lower Super Output Areas (n = 324) in County Durham described in deciles 1 = best 10 = worst



Adults Wellbeing and Health
Overview and Scrutiny Committee

20 January 2017

Public Health Update

Report of Gill O'Neill, Interim Director of Public Health

Purpose of the report

1 This report provides an update on national, regional and local public health developments. In particular, it will highlight to AWH OSC the last 12 months work undertaken by the Durham County Council's public health team and areas for priority going forward.

Background

2 Public health has been in Durham County Council for almost four years. The impetus behind the transfer from the NHS was to transform the approach to improving the health of the population by a re-focus on tackling the social determinants of health as evidenced by the Marmot Review and to work more closely with communities. Tackling the social determinants of health includes improving the life chances for children, reducing income inequality, creating good employment and housing conditions, improving the social environment in which people live and work and helping people to live healthier lives.

Statutory duties

3 As a statutory appointment within the local authority the Director of Public Health (DPH) has statutory delivery requirements and mandated functions for which the public health ring fenced grant must be spent. This is as prescribed in the Health and Social Care Act 2012. The statutory duties of the DPH include:

- Taking appropriate steps to improve the health of their population. This duty complements much of the local authority's existing core business and its strategic responsibility for stewardship of place.
- Supporting local political leaders in their ambitions to improve local health.
- Contribute fully to rigorous and well-informed joint strategic needs assessments and joint health and wellbeing strategies
- Working with wider partners to foster joint commissioning arrangements (where appropriate) and to inform wider strategies, for example around adult social care, children's services, transport, housing and leisure
- Providing officers and elected members with appropriate advice, based on a rigorous appreciation of patterns of local health need, what works and potential returns on public health investment
- Providing advice to partners more broadly
- Being the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and concerns around access to health services

- Working through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health
- Having a particular focus on ensuring disadvantaged groups receive the attention they need, with the aim of reducing health inequalities
- Commissioning clinical services such as sexual health and drug and alcohol services the DPH will need to ensure that providers have appropriate clinical governance arrangements in place that are equivalent to NHS standards

Mandated functions

4 The work of the public health team is focused on delivering the stipulated mandated functions, as well as high priority discretionary services which are deemed most relevant to reduce health inequalities. The mandated functions include:

A. **Sexual health services** which include prevention and treatment of sexually transmitted infections and contraception
B. **NHS health checks** for 40 – 74 year olds. This is a programme designed to identify those in the population at risk of developing cardiovascular disease
C. **National child measurement programme** (NCMP) part of obesity prevention
D. **Five universal visits to families with children under the age of five** as part of the healthy child programme (as of October 2015)
E. **Support and advice to CCGs*** to commission equitable and evidence based health services to the local population which increase health outcomes and reduce inequalities
F. **Health protection**** – through the DPH holding the system to account and being the senior health advocate for the local population and protecting the health of residents

Health care public health (mandated function E*)

5 The DPH has responsibility, and funding within the grant, to provide a core offer of public health advice and support to the NHS locally. National guidance stipulates that there should be 1 whole time equivalent senior public health specialist / consultant per 250,000 population supporting the CCGs. This support arrangement provides an opportunity for local authorities to build and maintain close links with clinical commissioners and complements the close working relationship required for the health and wellbeing board. A separate public health work plan for the CCGs has been developed and is being delivered.

6 The public health service should have the staff resource to be able to offer:

- Expert advice to ensure that joint strategic needs assessments reflect the needs of the whole population
- Support the development of commissioning strategies that meet the needs of vulnerable groups
- Support the development of evidence-based care pathways and service specifications by CCGs
- Contribute advice on evidence-based prioritisation policies and individual funding requests
- Health needs assessments and health equity audits as required
- Provide other specialist public health advice as required by NHS commissioners

Health protection (mandated function F)**

7 The Secretary of State has the core duty to protect the health of the population. The DPH has a critical role at the local level in ensuring that all the relevant organisations have plans in place to protect the population against a range of threats such as major incidents, biological and radiological hazards and infectious diseases.

8 This will link to, but be different from, their statutory responsibility for public health aspects of planning for emergencies within local authorities. Most health protection incidents are contained locally and managed by Public Health England with assurance being sought from the DPH. The DPH will be the lead for the local authority at strategic coordinating groups (SCG) for major events such as pandemic flu.

9 The DPH and Consultants in Public Health should therefore:

- Provide strategic challenge to health protection plans/arrangements produced by partner organisations
- Scrutinise and as necessary challenge performance
- If necessary, escalate any concerns to the local health resilience partnership (LHRP)
- Receive information on all local health protection incidents and outbreaks and take any necessary action, working in concert with Public Health England and the NHS. This may include, for example, chairing an outbreak control committee, or chairing a look back exercise in response to a sudden untoward incident
- Contribute to the work of the LHRP, possibly as lead DPH for the region;
- Provide the public health input into the local authority emergency plans.

Public Health ring fenced grant

10 The public health grant allocation is ring fenced to commission, provide and discharge the statutory public health functions and achieve the public health outcomes agreed through the joint health and wellbeing strategy and national public health outcomes framework (see appendix two for PH outcomes framework and appendix 4 for the 2016 County Durham Health profile). The grant has been subject to a £4.3 million cut in 2016/17. This means that, as it stands, the grant in County Durham is £51,246 million.

The budget reductions for 2016/17 have been achieved through a re-prioritisation of spending. The following principles were considered when determining how to reduce the budget:

- Mandated / statutory responsibilities within the Local Authority
- Health needs of the local population and the inequality gap
- National research evidence and Public Health England's recommendations for priorities of spend
- Overlay of current proportion of spend in budget compared to the three factors listed above.

The majority of public health spend relates to commissioned services and medium term contracts with third party providers. This limits the flexibility/opportunity to react in the time scales that would be required to reduce expenditure in line with the reduced level of public health grant in 2016-17. In order to optimise service delivery and re-prioritise the service provision that can potentially be delivered within the reduced financial envelope, public health management team intend to phase in the saving over 2016/17 and 2017/18, facilitated by the use of public health earmarked reserves. The proposed re-prioritisation will deliver £4.3M reduction in spend by the close of 2017/18, using £3.6 million reserves.

Funding will be reduced from the following areas:

- Drugs and alcohol services
- Sexual health services
- NHS Health Checks
- Stop smoking service and NRT (Nicotine Replacement Therapy)

Public health has a commissioning review programme to manage the reductions to the public health grant. This includes completion of equality impact assessments and risks assessments as well as robust consultation where required. There are specific project plans in place for all of the planned reductions. Individual communication strategies and consultations are being managed as part of due processes.

National discussion is taking place currently to consider what the public health grant allocation will include from 2018/19 and whether it should be drawn from local business rates.

National picture

Public Health England

11 PHE is a national agency commissioned by the Department of Health to provide direction and advisory support to the public health system. PHE local centres provide the functions related to health protection and work closely with Directors of Public Health and environmental health services. In addition, they provide specialist advice on health care public health and health intelligence. Working with local authorities through local public health teams, they offer advice and guidance and aim to, where appropriate, suggest ways to operate at scale.

12 Through evidence reviews and engagement with public health professionals PHE has identified seven priorities for the next four years which are laid out in their strategic plan ‘Better outcomes by 2020’.

- Tackling obesity – prevention through whole systems
- Reducing smoking – tobacco control, stopping children from starting to smoke and stopping smoking during pregnancy. Changing social norms by making smoking history
- Reducing harmful alcohol consumption – reducing alcohol related admissions
- Every child to have the best start in life – resilience building, parenting programmes, early years provision, addressing poverty

- Reducing the risk of dementia – its incidence and prevalence in 65 – 74 year olds – lifestyle related changes as well as supporting those to live with Dementia and care for people with Dementia
- Tackling the growth in antimicrobial resistance
- Achieving a year in year decline in Tuberculosis

NHS England

13 NHS England has five area teams working to support local system delivery. County Durham sits within the sub-regional area consisting of Cumbria and the North East of England. NHS England commission population health screening and immunisation programmes. The Director of Public Health requires assurance of the effective delivery of these services to protect the health of the local residents. Inequalities can exist within County Durham as well as when compared to the England average or North East. It is therefore vital that local area data is received from NHS England to consider the uptake of screening and immunisation programmes.

Screening and immunisation programmes include:

- Cancer screening
- Bowel, breast, cervical

Non cancer screening programmes

- Diabetic retinopathy, Abdominal Aortic Aneurism (AAA), antenatal and new-born

Immunisation schedule

- Childhood and adolescent programme, flu, pneumococcal,

Overall County Durham performs well in immunisations and screening programmes. A separate report will be presented on the health protection functions of PHE and NHS England's performance on screening and immunisation delivery in November 2016.

Regional picture

NHS Five year forward view and Clinical Commissioning groups: Role of public health

14 To enable the implementation of the NHS five year forward view Sustainable and Transformation Plans (STPs) are being established based on patient flow foot prints. County Durham is part of two STP footprints. North of Tyne and Wear STP which covers: North County Durham, Sunderland, Gateshead, South Tyneside, Newcastle and Northumberland. The second STP is County Durham, Darlington, Tees, Richmond, Hambleton and Whitby STP.

15 The main drivers behind the STPs are better quality and more cost efficient health services, incorporating modern ways of working and a focus on prevention / early intervention. It is essential that public health has a strong voice in the prevention and early intervention element of both STPs.

16 The tool to drive the STPs through is known as the 'Better Health Programme' (BHP). There are two component parts to BHP. The review and reconfiguration of hospitals and specialist treatment centres is one element. The second element is the 'not in hospital' care. The 'not in hospital' model is focused on the integration of health and social care and how, through the appropriate skill mix of professionals and by working with communities, residents can stay out of hospital and be well within the community. Public health has a key role to play in both elements of the BHP to reduce variation in care and promote self-care in communities.

17 Through the *health care public health* remit public health will be providing advice and guidance to CCGs about the re-design of services such as maternity care. Public health must also ensure locally commissioned services such as Health Visiting and the Wellbeing for Life programme are included and built upon in local communities.

North East Combined Authority (NECA) and link with public health

18 Whilst the North East Combined Authority at its meeting on 6th September voted against plans to move forward with public consultation on the deal, there has been much work completed to date on regional partnerships which remains relevant. Over the last 12 months public health staff have been involved in all work streams across NECA which has provided a significant platform to influence plans ensuring health is considered in all strategic thinking and planning.

19 Health and social care (HSC) commission. The largest contribution from public health is on the HSC commission. Prevention and early intervention is a theme that overlaps with the two STPs discussed earlier. Public health is advocating for a higher proportion of spend to be allocated to prevention based activity. Due North says - *The health sector can still do much more to champion action on health inequalities; facilitating and influencing action across all sectors to increase numbers of people seeking help in primary care. Integrating support across agencies for the full range of problems that are driving them to seek help (e.g. employment support, debt, welfare advice, housing), will reduce pressure on GPs and enable early intervention to prevent the exacerbation of problems, reducing poverty among people with chronic illness and reducing children's exposure to poverty, and its consequences. For example by creating or expanding upon services in primary care which consider debt and housing advice and support to access disability-related benefits can impact on health outcomes for those with chronic illness.*

20 Increasing the spend on prevention is about the proportion of total spend across the health and social care system and not only about the public health grant allocation. If secondary prevention is to gain traction then health services must invest. One example of this could be the treatment of nicotine addiction and the financial benefit gained by the NHS with reduced spend on CVD, cancer and respiratory pathways. Local authority public health teams will continue to focus on tobacco control measures and making smoking history. Through this systems approach health inequalities will reduce and the NHS will be able to re-invest funding elsewhere from what is released from the current spend on smoking related ill health.

Local picture

21 The work of the DCC public health team is wide ranging and over the last three and a half years has endeavoured to reach out to work with as many stakeholders and communities as possible. The public health team structure can be found in appendix three. The Health and Wellbeing Board, Safe Durham Partnership and Children and Families Partnership are heavily reliant upon the leadership and delivery of the Public Health team to achieve strategic objectives. Much of the local delivery works in close partnership with the AAPs.

22 The remainder of the report provides some highlights of the local delivery over the last 12 months.

Early years and children's public health

0 – 19 service (health visiting and school nursing): Transformation
(Health and Wellbeing Board, Children and Families Partnership, LSCB)

23 Professor Michael Marmot emphasised the importance of investing in 'the best start in life' for the maximum gain in the future. During 2015/16 the health visiting 0 – 5 function moved across from NHS England to local authority control. This provided an opportunity to commission an integrated 0 – 19 service which includes the two mandated functions of the universal visits within the healthy child programme and the NCMP. Following extensive engagement and consultation with children, young people, parents, carers, schools and wider stakeholders a new service specification was designed. A comprehensive procurement process was undertaken to secure the best provider for the new 0 – 19 service.

24 In April 2016 Harrogate and District Foundation Trust (HDFT) were awarded the contract. Through a transformation programme staff numbers were maintained in County Durham and service delivery has altered to be much more focused on mental health and emotional wellbeing. In particular the school nursing service is making significant changes to be more visible for young people, more accessible through a variety of mechanisms such as text messaging and community as well as school based drop-ins. In addition to this a standard core offer for health improvement is being delivered within schools and a more bespoke / enhanced offer for special schools and children educated outside of mainstream. During the academic year 2016/17 these changes will be coming to fruition under the new brand 'Growing healthy'.

25 A vulnerable parent pathway has been designed for more targeted intervention for those families with risk factors such as domestic abuse, mental ill health, drug and alcohol use. All pregnant teenagers will be assessed through the vulnerable parent pathway to determine level of support. The vulnerable parent pathway is also designed to tackle root causes of ill health and family problems. Strong links are being made with housing and welfare colleagues to address poverty.

Children's wellbeing: Innovation and partnership
(Children and Families Partnership, LSCB early help sub group)

26 A rethink on how to deliver support to families to enhance the work on the best start in life was progressed in close partnership with children's services, education and

voluntary and community sector (VCS). A resilience pathway has been created through a:

- Community Parenting Programme which consists of trained, quality assured and supported volunteers to work with families who are pregnant or have a child under the age of five. This programme has dual benefits for both the volunteers to progress on a skills pathway and develop confidence and competence as well as the clear benefits to the families being supported by the volunteers. During the last 12 months 26 volunteers have been recruited and trained, five of which have progressed into employment and training.
- Durham resilience in schools programme. This programme is gaining real momentum in schools. The whole school approach to building resilience enables schools to consider how they could improve their environment and culture to embrace the concept of how the wellbeing of a child impacts directly on how well they achieve academically.
- Longer term outcomes for this programme are focused on the closing of the gap in attainment between children on free school meals, a reduction in absenteeism and an improvement in behaviour. All of which will improve the health outcomes of our future working age adults.

Stop smoking service and tobacco control: Reducing impact on health
(Health and Wellbeing Board, Children and Families Partnership, Safe Durham Partnership)

27 The single most modifiable risk factor for ill health is for people not to start to smoke or to stop as soon as possible. A new stop smoking provider has been secured over the last 12 months. Solutions for Health is already working to increase the 4 week smoking quit rate in County Durham. Smoking at time of delivery continues to be a major priority and significant work has been undertaken with the regional 'Baby Clear' programme. Percentage of women quitting through this service has increased from 43% in 2012 to 60% in 2015/16. 18.1% of women still smoke at time of delivery so there is still much work to do.

28 Smoke free play parks has gained national interest and local media coverage. The most recent population survey demonstrated that 99% of those surveyed were in favour of the voluntary code to make play parks smoke free. This area of work is about changing social norms so smoking is not accepted in public spaces and visible to children and young people. This work was sponsored by the Health and Wellbeing Board.

29 Electronic cigarette use is continuing to increase and be the main form of quitting tobacco for adults. Whilst PHE have suggested stop smoking services should be 'vaping friendly' as the evidence to date demonstrates it is significantly less harmful than tobacco, there should be caution about any unknown long term risks. There is a clear message that public health teams should be making sure young people don't start to vape and become addicted to nicotine. Latest smoking prevalence for County Durham shows a 3.2% decrease since 2012.

30 On 9th March 2016 (No Smoking Day) the Tees Esk Wear Valley (TEWV) Foundation Trust implemented their smoke free policy. The policy covers service users, staff, visitors and contractors are no longer able to smoke tobacco on any Trust premises. However the policy is much wider than a smoke free site provision, it is a policy that recognises that much needs to be done to address the high smoking rates and lower life expectancy amongst those living with mental health

problems. The Trust recognise they have a duty of care to their service users and by going smoke free aims to significantly increase both the physical and mental health of service users. The policy does not allow staff members to accompany or support a service user to smoke at any time, and includes nicotine management and smoking cessation support for service users.

31 Pathways have been developed to support the identification of a smoker and provide nicotine abstinent support on admission. A total of 1,479 staff have been trained in smoking cessation brief intervention and a further 187 staff trained as champions on wards to give nicotine management support and provide NRT (nicotine replacement therapy) e.g., patches etc. within 30 minutes of admission. A high proportion of the training has been delivered by the Durham County Council commissioned stop smoking service team. Links have also been made with all community stop smoking services to enable referral of patients to their nearest stop smoking service on discharge, to enable patients to continue their smoke free journey.

Mental health: Review and good practice
(Health and Wellbeing Board, Mental Health Partnership)

32 There is ongoing work to review the commissioned services focused on mental health. The intention is to ensure there is a seamless connection with the Wellbeing for Life programme, adult social care, mental health services and community involvement through AAPs and VCS. The emphasis is to be on mental health promotion and resilience going forward. Working on improving the mental health of the population will reduce the need for mental health treatment services.

33 The County Durham Crees (men's sheds) have undergone a local evaluation delivered through a co-produced piece of work with Teesside University. The Crees are designed to support socially isolated individuals who may be deemed to be at greater risk of suicide. Whilst there remains a focus on men, the Crees model has been expanded to include socially isolated young people and women. By bringing people together through a volunteer led infrastructure the Crees are as autonomous within the community as possible. The County Durham Crees have had national recognition for good practice.

34 Since the 2014 DPH annual report focusing on social isolation there has been a significant amount of activity driven by the AAPs in local communities. Funding has been invested in befriending schemes and inter-generational projects; all designed to connect people back into their communities and reduce isolation.

Preventing suicide is a high priority and the public health team are working with partners to develop a stand-alone suicide prevention plan for County Durham

Wellbeing for Life: Effective implementation and roll out
(Health and Wellbeing Board)

35 The Well Being for Life service is commissioned by public health and delivered by Durham County Council Culture and Sport, County Durham and Darlington Foundation Trust, Leisureworks, Durham Community Action and Pioneering Care Partnership. Taking a community asset based approach, the Wellbeing for Life service is operating in the 30% most deprived areas as well as providing outreach support to individuals and communities with specific needs outside of these

geographical boundaries. The service provides ‘one to one’ support, group activities, volunteering opportunities and community development approaches.

36 Over the last 12 months the wellbeing for life service has had a specific drive to promote LOCATE, the DCC information website. There has also been significant success with the more targeted elements of the service working closely with AAP colleagues. In South Moor and Quaking Houses as of October 2016 222 clients have engaged with the service and 98% of them demonstrated improvements in confidence, wellbeing and self-esteem.

37 The key performance indicators for the service have been exceeded in most cases, with those engaged with the service reporting improvements in their sense of wellbeing and being more engaged in their local community. This includes:

- From April 2015 to the end March 2016, 78 community-based group intervention programmes, in response to expressed community need were delivered, including friendship groups, walking, seated exercise and physical activity across the Wellbeing for Life target areas. A total of 715 participants benefited from these groups.
- From April 2015 to the end of August 2016, 2815 people received a ‘one to one’ wellbeing intervention. Two in five had sought help for multiple reasons, while one in five wanted help with weight loss or weight maintenance
- 209 volunteering opportunities have been created including 15 participants going into employment.

38 One of the main outcomes of the wellbeing for life programme is to reduce social isolation and work to enable people to connect with others in their communities. An independent evaluation is being completed by Durham University and will be published by February 2017.

39 The second phase of the Wellbeing for Life approach is to move beyond the specific commissioned service and engage social housing providers. The housing and health group has been established and is focusing on two main areas to begin with:

- Tackling fuel poverty and links to managing long term conditions
- Making every contact count (MECC) training for housing staff to deliver brief intervention messages and sign post to relevant health providers

This second phase of wellbeing for life has a primary aim of tackling the impacts of poverty. Further work is planned to have joint strategic aims that bring housing and health closer together.

Fuel poverty / Warmer Homes: Social determinants of health
(Health and Wellbeing Board)

40 The Warm and Healthy Homes programme is a joint programme between public health and the housing regeneration team part of economic development and housing in DCC. It aims to reduce fuel poverty and improve health and wellbeing.

41 The programme has become more embedded with health and social care this year with 193 referrals made by health practitioners, social care staff and partner organisations. In particular working with both CCGs’ who now have information on their websites. Information has also been disseminated to DDES CCG Patient

Reference Groups and links with the Dales Federation have been made with a view to exploring how the scheme can be targeted utilising Care Connectors. The project is embedded into the Health and Wellbeing and Affordable Warmth Strategies and performance managed via the respective systems.

42 Both in terms of patient disease profile and age range, the intervention is reaching the priority groups identified by the project. The project has also brought additionality, including external funding of £100K awarded from the Department of Energy and Climate Change Health Booster fund.

Fire and Rescue: safe and wellbeing visits: Partnership working
(Safe Durham Partnership, Health and Wellbeing Board)

43 Public health have worked collaboratively with County Durham and Darlington Fire and Rescue Service (FRS) to implement safe and wellbeing visits (S&WBV) across the county. The idea of Making Every Contact Count (MECC) is based on the 3 As' – Ask, Advise, Assist, and can include one or more of the following; giving individuals information, directing them where to go for further help, raising awareness of risks and providing encouragement and support for change.

44 The safe and wellbeing visits use a MECC approach and focuses on a number of health issues such as alcohol, smoking, dementia, social isolation, winter warmth and slips, trips and falls. These are health issues identified in the Joint Strategic Needs Assessment and Health and Well Being Strategy. Public health worked with the FRS to:

- Design a framework document for the programme
- Co-design the safe and wellbeing visits through consultation with partner agencies
- Support the delivery of training and development for MECC and topic based modules.
- Advise on systems and processes to ensure relevant data is provided to partners when a referral is made via the appropriate pathway.
- Commissioned an external evaluation from Teesside University to evaluate the medium to longer term impact of the intervention.

45 Between 15th Feb (when the visits were first introduced) and 31st August a total of 9,255 visits were carried out. 3,506 people agreed to answer the lifestyle related questions. 1352 referrals were made to partner agencies. The highest numbers of referrals made were regarding loneliness and isolation which is a key issue for communities in County Durham.

MacMillan: Joining the dots: Innovation and investment
(Health and Wellbeing Board)

46 Due to the history of strong partnership working between the former PCT and MacMillan, as well as work with the local authority over the years, MacMillan approached DCC to be an early adopter of a new social model of managing cancer. As we progress to consider cancer as a long term condition due to much improved survival rates, we need to consider how patients and carers live with and beyond cancer. There has been a £1 million investment into Durham to develop the joining the dots programme. Led by public health, Joining the Dots will consider new ways of working across the system to bring together health, social care, employers and

the VCS to work to best effect for patients and carers. Implementation of this programme will be September 2017.

20 MPH: Policy change
(Health and Wellbeing Board, Safe Durham Partnership)

47 The 'Slow to 20 for Safer Streets' is an important initiative that is being rolled out across a number of communities throughout the county over the next two years and will help ensure our children are happier and safer as well as better environments for walking and cycling, improvements to health and calmer and quieter streets. Public health were instrumental in working with colleagues in Neighbourhood services to bring a proposal to Cabinet in 2014 that approved a programme of 20mph limits across 33 schools with higher accident rates. The 'Slow to 20mph for Safer Streets' campaign was developed to support the programme and has met with local success. This programme is being extended to other schools after the first phase of 33 schools is complete. The programme is being evaluated by Durham University and public health. Following the roll out of the slow to 20 programme many elected members have chosen to back the scheme to enable expansion into their own constituent areas.

Drugs and alcohol: Service delivery and tackling trade through licencing
(Safe Durham Partnership)

48 The provision of effective substance misuse services in County Durham makes a significant contribution to tackling health inequalities, increasing life expectancy, improving the health and well-being of families and reducing crime and disorder in local communities.

49 The integrated Drug and Alcohol Service is beginning to show signs of improvement in relation to numbers of successful treatment completions and Blood Borne Virus (BBV's) testing and vaccination rates. Due to the public health grant reductions a new service is currently being designed and will focus on community outreach and recovery in the community.

50 The Alcohol Harm Reduction Group saw County Durham innovatively partnering with Gateshead Council to undertake a mock licensing hearing to support Public Health England's need for evidence to help advocate for a new national public health objective. If successful this will go some way to help to reduce the cumulative impact of alcohol harm across all local communities in County Durham.

51 The partnership between public health, Durham County Council's Trading Standards and Consumer Protection departments and the Alcohol Harm Reduction Unit based in Durham Constabulary continues to provide a comprehensive approach to managing the Licensing Act (2003) at a local level. This enables the activity of the 1724 on and off-sale licensed premises (April-June, 2016) to be effectively monitored, helping to reduce the cumulative impact of alcohol within our local communities. The positive outcomes for utilising this innovative approach results in the prevention of crime and disorder, increasing public safety, the prevention of public nuisance and the protection of children from harm.

Domestic abuse and sexual violence: Re-designing service

(Safe Durham Partnership, Health and Wellbeing Board, Children and Families Partnership)

52 A review of domestic abuse and sexual violence services across County Durham was completed which informed the service review of the public health contract held by Harbour Support Services. This enabled an informed re-modelling of the service taking into consideration the reductions in the funding available going forward. The contract was awarded to Harbour Support Services with additional funding sourced and secured from children's services, doubling the value of the contract, to provide specialist workers within social work led teams provided alongside the specialist domestic abuse service. This will ensure no duplication of provision, better value for money and an improved service for victims and families.

53 Part of the Harbour contract is to deliver "Operation Encompass" which is a programme designed to provide schools with information about a domestic abuse incident that has taken place and witnessed by one of their pupils. The police will phone the school following the incident and share the alert. This will enable to school to support the pupil and have a greater appreciation of why the pupil may not be behaving or performing as usual. Operation Encompass has been financially supported by members budgets led by Cllr Joy Allen. This is a strong example of multiple members coming together to back a priority which impacts on the public's health.

54 A service to reduce Lesbian, Gay, Bisexual and Transgender (LGBT) health inequalities by promoting education around providing better access, better range of services, and more integrated services has also been commissioned which commenced in April 2016. The service, provided by DISC will deliver a collaborative and innovative partnership, working across a wide range of agencies including primary & secondary care, local authority, education and voluntary agencies for Durham County Council raising awareness about a variety of issues around the wider determinants of health, domestic abuse, homophobic bullying and hate crime.

Sexual health and teenage pregnancy: Reducing inequalities

(Health and Wellbeing Board, Children and Families Partnership)

55 Public health has a statutory duty to commission sexual health services to treat and prevent sexually transmitted infections (STIs). During the last 12 months an integrated sexual health service has been delivered by County Durham and Darlington Foundation Trust (CDDFT) and bespoke work with LGBT&Q via DISC.

56 Regionally sexually transmitted infections (STIs) have increased in line with national trends. However, rates in County Durham, which are lower than region rates in the first place, have largely remained steady or have fallen. Public health commissioned services have played an important role in this trend.

57 County Durham continues to have a low prevalence of HIV. For over a decade, the most common probable route of infection for new HIV diagnosis in the North East has been heterosexual sex. However, we are now seeing a greater percentage of new diagnosis attributed to sex between men. Public health commissions community-based sexual health and HIV prevention services with LGBT communities through a contract with DISC.

58 Teenage pregnancy rates have gone down progressively over the last 14 years which is good news. The current (2014) rate is 28.5 per 1,000 females aged 15-17 which amounts to 243 individuals. This has fallen from a rate of 48.8 in the year 2,000 (435 individuals). There is further work to do to narrow the gap between County Durham and the national average. A rapid health needs assessment (HNA) for teenage pregnancy has been completed. This focused on preventing pregnancies, supporting teenagers who were pregnant and teenage parents. The outcomes of the HNA have informed the refreshed teenage pregnancy action plan which has been ratified by the Health and Wellbeing board.

59 There is a much greater emphasis on building the resilience of our young people, improving the relationship and sexual health education delivered within schools, better integration of support for those young people more likely to become teenage parents such as those in the looked after system or criminal justice system. There is also further work to be done on contraception services and take up of long acting reversible contraception options such as implants and depo injections.

60 During the last 12 months a very successful teenage parent support programme has been delivered through partnership working and is being maintained through the European investment of Durham Works. The programme has been oversubscribed by teenage parents who are normally reticent to engage. The programmes evaluation has demonstrated an increase in confidence, social skills and the young people gaining qualifications such as Duke of Edinburgh award.

Obesity: Whole systems approach – A national pilot
(Health and Wellbeing Board)

61 During 2015/16 work commenced on thinking differently about tackling obesity rates as population statistics remain stubborn in spite of a multitude of activity happening across County Durham. Work commenced in the Four Towns AAP area on a pilot whole systems approach to obesity. The approach aimed to include a variety of local stakeholders to understand obesity through their eyes. During the months of work in partnership with national experts on whole systems thinking it became clear that as a community obesity and weight did not resonate as a topic or a priority with the population.

62 A huge amount of obesity related activity was already happening in the Four Towns area and yet this work may not have been as connected as it could be or working towards a shared goal. Work is ongoing through schools and community groups to better connect the system such as certain schools applying for funding to create after school play rooms, or develop school allotments. This initial local pilot work, as well as the work being undertaken by the wider healthy weight alliance, was sufficient evidence for DCC public health team to submit a bid to become a national pilot working with PHE and Leeds Beckett University on whole systems thinking. During the last 12 months the DPH annual report has been a call to action on obesity.

63 DCC is leading by example to tackle obesity by changing the County Hall canteen and wider catering offer to emphasise the healthier alternatives. Vending machines in civic sites are being changed to include healthier options and to have brand advertising removed from outside of the machines. DCC has participated twice in the Step Jockey initiative to get people moving more and using the stairs.

64 Working collaboratively with Culture and Sport the newly formed Physical Activity Leadership Group have agreed to include the national child measurement programme (NCMP) childhood weight measures as part of their success criteria. This is in addition to standard metrics for demonstrating an increase in physical activity.

65 Further work is ongoing to influence planning and the impact the County Durham Plan can have on health outcomes including obesity.

Oral Health: Strategy development
(Health and Wellbeing Board)

66 The most recent oral health survey of five year olds highlights the health inequalities which exit within County Durham. Of those surveyed within the wards Woodhouse close has 61% of five year olds with decayed, missing or filled teeth. This is compared to Chester le Street South which has 6% of children with decayed, missing or filled teeth. In light of this health intelligence and the publication of the NICE guidance for oral health promotion, the DCC public health team are leading on the development of an oral health strategy and action plan. This strategy is to be ratified by the Health and Wellbeing Board in January 2017.

Better health at work award: Regional programme demonstrating local success

67 The North East Better Health at Work Award recognises the efforts and achievements of local businesses in addressing health and wellbeing within the workplace. The award scheme is available to all organisations regardless of size, location or type of business and supports them to move forward in a structured and supportive way. For those employers who have not considered promoting health at work, taking part in the award helps them reap the rewards of encouraging a healthier workforce and better business productivity.

68 Public health commissions and provides strategic advice and support to the co-ordination of the local award programme. There are four levels of the Award, Bronze, Silver, Gold and Continuing Excellence, with appropriate criteria at each stage to build into an Award Portfolio which is assessed annually. This allows organisations to move through a level each year.

69 The accreditation process follows a calendar which means that many assessments take place during spring. The initial contract required the providers to work with 45 organisations currently 58 are actively involved in the award.

- 11 Businesses working towards Bronze
- 16 Businesses working towards Silver (includes 2 multi-site businesses)
- 7 Businesses working towards Gold
- 24 Businesses working towards Continuing Excellence

Public Health Pharmacy: health embedded in communities

70 The Public Health Pharmacist works across DCC and community pharmacies to support a wide range of initiatives including the publishing of the pharmaceutical needs assessment, the development of Healthy Living Pharmacies programme and advice on pharmacy and medicines to public health, commissioning, social care and education.

71 The pharmaceutical needs assessment (PNA) is a statutory responsibility of the Director of Public Health and determines whether there are sufficient pharmacies distributed across the population. The Health and Wellbeing Board endorses the PNA and requires regular updates on the progress made against recommendations. The Health and Wellbeing board are also made aware of any pharmacy closures or requests for new businesses to be established as these changes alter the distribution in local communities. The last PNA was completed in 2014 and concluded that County Durham has above the national average supply of community pharmacies with good overall access to pharmaceutical services. This is an opportunity to allow more patient choice and links strongly into the belief of self-care and managing illness closer to home.

Healthy Living Pharmacy (HLP) programme

72 The aim of the healthy living pharmacy programme is for the pharmacy to become involved with the local community in order to improve the health and wellbeing of that community. HLPs are largely driven by the pharmacy staff who train to become healthy living champions. There are three levels to the HLP programme: levels 1, 2 and 3 which follow a national framework. Public health currently supports the HLP programme through the employment of part time public health pharmacist and funding for resources in the pharmacies to run health campaigns. Currently there are 54 pharmacies engaged in the HLP programme at various levels. This equates to 40% of pharmacies across County Durham. The programme is very well received by both the pharmacies and the local communities. Examples of successful areas of work include stop smoking advice and support, alcohol brief interventions, weight management advice and support, flu vaccination promotion and most recently an oral health promotion campaign running.

Gypsy Roma Traveller (GRT) Communities: Targeting vulnerable groups
(Health and Wellbeing Board)

73 Work has continued to address the sizable health gap between our GRT communities and the general population. The public health team has commissioned two health trainers and a specialist Health Visitor to work with the communities. There is ongoing work with the local community to develop accessible health related information. The work of the GRT health project is showing early signs of success and is being evaluated by a national expert, who is due to feedback outcomes in spring 2017. This will coincide with the delivery of a regional conference sharing the good practice which has developed across County Durham in work with our GRT communities. This will mainly focus on the health related work but will also include the range of other excellent GRT services provided locally through DCC.

Health checks and Diabetes prevention: mandated function and national example of good practice
(Health and Wellbeing Board)

74 The NHS Health Check is a free health MOT for adults aged 40-74 who do not have a pre-existing condition. It is one of the mandated public health functions in the Health and Social Care Act 2012. Not only does it check circulatory and vascular health but also informs patients of their risk of developing vascular disease. Health Checks are also used to establish risk of diabetes. In County Durham there is a more targeted approach to Health Checks. This more targeted approach was endorsed by the Health and Wellbeing board and is a way to ensure those invited

for a check are more likely to need the support to reduce their risk of CVD. The Health Check service is currently under review and a new programme will be operating through GP Federations from April 2017.

75 County Durham was a demonstrator site for the National Diabetes Prevention Programme and as such has contributed significantly to the development of the national programme. As part of this an intensive lifestyle programme, linked to local Health Checks, was established to help those identified as being at risk of developing diabetes to reduce their risk. As well as feeding local learning into national, the results of this programme have been discussed at regional, national and international conferences. Going forward County Durham, in part due to its previous experience, was chosen as a First Wave Site for the new national programme. The provider is now in place and is beginning to accept referrals. Whilst this is now a national process with local leadership provided by CCGs the public health team continues to provide advice through regular meetings with CCG representatives and the national provider.

CCG core offer and health care public health: mandated function with NHS partners

76 The public health team continue to provide extensive support which is agreed through a CCG health care public health work plan. There is comprehensive work carried out on NHS value based commissioning policies for treatments that fall outside of NICE guidance, are not being utilised as cost effectively as possible and are causing unnecessary variation in treatment and care. Public health advice is also given for individual funding request (IFR) panels. A recent example of a policy update includes changes to the patient pathway for varicose veins and what is available through NHS funded treatment. IVF treatment would be another example where County Durham and the North East are seen as an example of best practice for adherence to NICE guidance. The public health team is an important part of the system, which also includes several CCGs, which reviews and writes such evidence based clinical policies.

77 Patient pathway reviews and service re-design contributes to the work load of the public health team. The skills of the Public Health Consultants and health intelligence team enable the patterns of disease to be mapped (epidemiology) and then to benchmark local pathways to international, national and regional comparators. This work supports service re-design to encourage the NHS to commence pathways starting from prevention and progress to treatment and maintenance or recovery. The public health team are working to encourage greater link up between the NHS and people based services into place based thinking and community development. The Sustainable Transformation Plans (STPs) work highlighted earlier is part of this thinking.

Health intelligence and academic public health: Core work - Adding to the evidence base

78 The health intelligence team lead on the health data aspects of the DCC integrated needs assessment (INA). The INA is intended to be the central repository for key population statistics to inform county wide strategies and lead to informed commissioning of services. If there is a gap in health intelligence then further specific tools are used by the public health team to bridge that gap. Examples include health needs assessments, health equity audits, health impact assessments

and more general health profiles for certain population groups or diseases. Examples of work completed over the last 12 months include:

Health Needs Assessments (HNA)

79 A health needs assessment is used to review and provide a baseline of the current needs of a population including whether there is a mismatch between what is needed and what is currently provided, that can include service provision. A health needs assessment is a much more in depth analysis compared the integrated needs assessment factsheets being provided to fulfil the important function of the JSNA.

80 A teenage pregnancy HNA has been completed which has informed the refreshed action plan and commissioning intentions.

81 A HNA of the Youth Offending services is almost complete and will inform future commissioning intentions.

Health Equity Audits (HEA)

82 A HEA is a tool that can be used to reduce health inequalities within a population. A HEA identifies and measures health inequalities within a population so that services or other resources can be fairly redistributed relative to the health needs of different group or areas.

83 The 2014 Health Equity Audit of County Durham NHS Stop Smoking Services highlighted that the gap between people in the more deprived areas setting a quit date and going onto quit has reduced compared to 2007, therefore reducing inequalities. This demonstrates good strategic planning and effective delivery.

84 The cancer HEA from 2014 is currently being refreshed. The previous HEA found increasing early deaths in female lung cancer in both CCG areas and male bowel cancer in North Durham.

85 A breastfeeding HEA has begun. The profile, highlighting the inequality gap, was completed in July 2016. Currently the recommendations and actions for where and what we should work on for the next two years are being disseminated. A follow up analysis in 2018 will complete the HEA cycle to determine if inequalities have narrowed.

Health Impact Assessment (HIA)

86 A HIA can be used to assess policies programmes or projects and is intended to help make decisions by predicting the health consequences if a proposal is implemented, both good or bad. It may examine the overall population and the particular impact on discrete groups within that population. Work is underway to support the County Durham Plan.

Health profiles

87 In 2015 Early Years Profiles were created at children's centre cluster level. They contained a mix of both local and national data and were designed to help commissioners and providers to assess their priorities. Rather than comparing against England averages, which does not consider the specific social or economic nature of the County, the profiles benchmarked against similar local authorities. Benchmarking in this way gives local context, enabling a more detailed look at whether local people's health is better, worse or similar to like authorities and to consider how other areas achieve the higher levels

Co-production evaluation programme: Skills development

88 The Durham Evaluation project is a co-production piece of work involving collaboration between Teesside University and the public health team on the evaluation of new and existing public health services. Public health initiatives tend to be complex and context specific and it is imperative that these initiatives are evaluated to prove effectiveness. It is an opportunity for public health to test new and innovative ways of working and add to the evidence base. Collaboration with university partners allows robust and timely assessment of initiatives and provides a real world evidence base upon which to make decisions.

89 Previous evaluations have included: Alcohol Hospital Liaison Team; Exercise Referral Scheme; Durham CREE evaluation; Real Time Suspected Suicide Surveillance Early Alert Pilot; Asset based tobacco control evaluation; Relax Kids Evaluation; B Mindfulness in Schools Evaluation; Teenage Parent Support and Teenage Apprentice Programme Evaluation; Healthy Horizons Evaluation. Current collaborations include Operation Encompass; Safer Home Visits; Excess Winter Deaths and Youth Aware Mental Health Evaluation. These evaluations have informed de-commissioning decisions as well as identifying which interventions should be expanded due to their success.

Next steps

90 This report has provided an overview of national, regional and local developments during the last 12 months. Going forward public health is passionate about collaborating across the whole of DCC and continues to build on the positive relationships with wider stakeholders. Public health aims to be seen as a core part of DCC at policy and strategy level as well as front line delivery. With the accountability *dotted line* between public health and culture and sport there is a significant opportunity to build upon existing work and further exploit the links between the two service areas.

91 Priorities going forward are in alignment with PHE and best available evidence, building on community assets and impacting on the health needs of our population. Wellbeing for life and AAP connections will be pivotal in achieving this.

92 As the County Durham Plan gathers pace public health has much to offer to describe the impact on health and how growth in the local economy benefits health outcomes. *Work and Health with an aging population* will be the DPH annual report for 2016.

93 Further work will be undertaken through the housing and health group and links with the poverty action group to consider how by maximizing income and improving the quality of housing can reduce premature mortality and increase life expectancy.

94 The work with the NHS on the STPs and the Health and Social Care Commission will take up increasing amounts of time within the public health team to ensure prevention and early intervention is at the forefront of thinking across all work streams.

95 The public health budget remains uncertain so further work needs to be done at a local level to ensure the mandated and statutory functions are delivered effectively and that the continued drive to reduce health inequalities is maintained as a shared priority.

Recommendations

96 The Adult Wellbeing and Health Overview and Scrutiny Committee is requested to:

- note the content of this report
- agree to receive an annual update on public health in relation to ongoing transformations in service delivery and commissioned services.

Contact: Gill O'Neill
Email: Gill.O'Neill@durham.gov.uk **Tel:** 03000 267696

Appendix 1: Implications

Finance
Public health budget has been used to commission services designed to reduce health inequalities and improve health outcomes for the local population.

Staffing
There is a core public health team which is paid for out of the public health grant. The public health workforce goes beyond those specifically trained in public health. Part of the making every contact count (MECC) work is to ensure that multiple professionals provide health improving messages as part of their routine work.

Risk
All commissioned services are performance managed which includes risk management.

Equality and Diversity / Public Sector Equality Duty
Public health aims to reduce health inequalities and narrow the gap in health outcomes.

Accommodation
Public health team is based within County Hall.

Crime and Disorder
Impact on the reduction of crime and disorder through partnership working and specific commissioned services.

Human Rights
Mandated functions, such as sexual health services, are available to those who need them.

Consultation
Following commissioning and procurement guidelines any changes to service delivery are consulted upon where required.

Procurement
Close working with DCC procurement colleagues for all commissioned services to ensure due diligence processes are adhered to.

Disability Issues
Considered as part of equality impact assessments for services.

Legal Implications
Close partnership working with legal and democratic services.

Appendix 2

Public Health Outcomes Framework 2013–2016
At a glance

VISION
To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest
Outcome measures
Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

- * Indicator shared with the NHS Outcomes Framework.
- ** Complementary to indicators in the NHS Outcomes Framework
- † Indicator shared with the Adult Social Care Outcomes Framework
- †† Complementary to indicators in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification

Rectangular Snip

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

- 1.1 Children in poverty
- 1.2 School readiness
- 1.3 Pupil absence
- 1.4 First time entrants to the youth justice system
- 1.5 16-18 year olds not in education, employment or training
- 1.6 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)*
- 1.7 People in prison who have a mental illness or a significant mental illness
- 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5) †† (iii-ASCOF 1F)*
- 1.9 Sickness absence rate
- 1.10 Killed and seriously injured casualties on England's roads
- 1.11 Domestic abuse
- 1.12 Violent crime (including sexual violence)
- 1.13 Re-offending levels
- 1.14 The percentage of the population affected by noise
- 1.15 Statutory homelessness
- 1.16 Utilisation of outdoor space for exercise / health reasons
- 1.17 Fuel poverty
- 1.18 Social isolation † *(ASCOF 1I)*
- 1.19 Older people's perception of community safety †† *(ASCOF 4A)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- 2.1 Low birth weight of term babies
- 2.2 Breastfeeding
- 2.3 Smoking status at time of delivery
- 2.4 Under 18 conceptions
- 2.5 Child development at 2 – 2 ½ years
- 2.6 Excess weight in 4-5 and 10-11 year olds
- 2.7 Hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14 and 15-24 years
- 2.8 Emotional well-being of looked after children
- 2.9 *Smoking prevalence – 15 year olds (Placeholder)*
- 2.10 Self-harm
- 2.11 Diet
- 2.12 Excess weight in adults
- 2.13 Proportion of physically active and inactive adults
- 2.14 Smoking prevalence – adults (over 18s)
- 2.15 Successful completion of drug treatment
- 2.16 People entering prison with substance dependence issues who are previously not known to community treatment
- 2.17 Recorded diabetes
- 2.18 Alcohol-related admissions to hospital
- 2.19 Cancer diagnosed at stage 1 and 2
- 2.20 Cancer screening coverage
- 2.21 Access to non-cancer screening programmes
- 2.22 Take up of the NHS Health Check programme – by those eligible
- 2.23 Self-reported well-being
- 2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

- 3.1 Fraction of mortality attributable to particulate air pollution
- 3.2 Chlamydia diagnoses (15-24 year olds)
- 3.3 Population vaccination coverage
- 3.4 People presenting with HIV at a late stage of infection
- 3.5 Treatment completion for TB
- 3.6 Public sector organisations with board approved sustainable development management plan
- 3.7 Comprehensive, agreed inter-agency plans for responding to health protection incidents and emergencies

4 Healthcare public health and preventing premature mortality

Objective

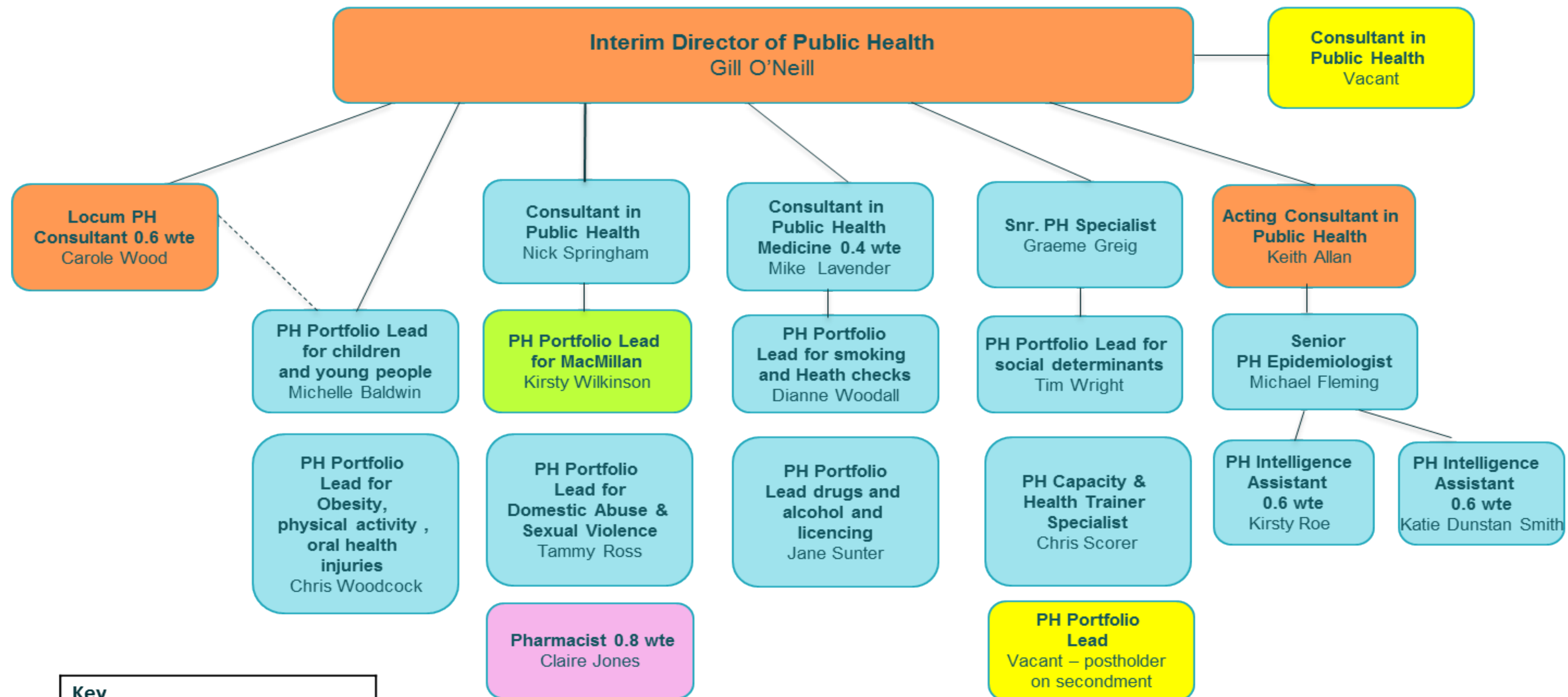
Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

- 4.1 Infant mortality* *(NHSOF 1.6i)*
- 4.2 Tooth decay in children aged 5
- 4.3 Mortality rate from causes considered preventable ** *(NHSOF 1a)*
- 4.4 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
- 4.5 Under 75 mortality rate from cancer* *(NHSOF 1.4i)*
- 4.6 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
- 4.7 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
- 4.8 Mortality rate from communicable diseases
- 4.9 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5)*
- 4.10 Suicide rate
- 4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
- 4.12 Preventable sight loss
- 4.13 Health-related quality of life for older people
- 4.14 Hip fractures in people aged 65 and over
- 4.15 Excess winter deaths
- 4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

Appendix 3

PH TEAM – SEPTEMBER 2016



Key	
	Funded from baseline
	Vacant posts
	MacMillan funded
	Funded from reserves
	Interim
	Line management

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Adults Wellbeing and Health Overview and Scrutiny Committee

20 January 2017

CAS – Quarter 2: Forecast of Revenue and Capital Outturn 2016/17

Report of Paul Darby, Head of Financial & HR Services

Purpose of the Report

1. To provide the Committee with details of the forecast outturn budget position for the CAS service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of September 2016 as reported to Cabinet in November 2016.

Background

2. County Council approved the Revenue and Capital budgets for 2016/17 at its meeting on 24 February 2016. These budgets have subsequently been revised to take account of transfers to and from reserves, grant additions/reductions, budget transfers between service groupings and budget reprofiling between years. This report covers the financial position for:

   - *CAS Revenue Budget - £252,817m(original £247,863m)*
   - *CAS Capital Programme – £29.406m (original £31.351m)*

3. The original CAS revenue budget has been revised to incorporate a number of budget adjustments as summarised in the table below:

	£'000
Original Budget	247,863
Reason For Adjustment	
Transfer From Contingency - Closed School Premises Cost	189
Transfer From Contingency - Pay Award	772
Transfer From Contingency - Residential Care Fees	630
Transfer From Contingency - Auto Enrolment	121
Transfers to Other services	(45)
Transfers From Other services	15
Use of (+)/Contribution to CAS reserves (-)	2,357
Use of (+)/Contribution to Corporate reserves (ERVR) (-)	915
Revised Budget	252,817

4. The use of /(contribution) to CAS reserves consists of:

Reserve	£'000
AWH- Social Care Reserve	1,644
AWH-Cash Limit	2,206
CHS-INNOVATIONS Cash Limit Support	(1,059)
CHS-NQSW Academy Reserve - 16&17 Academic year	(372)
CHS-Secure Services Capital Reserve	204
CHS-Tackling Troubled Families Reserve	(167)
CPD-Accumulated fund CPD Reserve	(70)
EDU-Durham Learning Resources Reserve	20
EDU-EBP Reserve	220
EDU-Emotional Wellbeing Reserve	(90)
EDU-Re-Profiling Activity Reserve	3
EDU-School Condition Survey	200
PHE-Grant Reduction Support Reserve	(382)
Total	**2,357**

5. The summary financial statements contained in the report cover the financial year 2016/17 and show: -

- The approved annual budget;
- The actual income and expenditure as recorded in the Council's financial management system;
- The variance between the annual budget and the forecast outturn;
- For the CAS revenue budget, adjustments for items outside of the cash limit to take into account such items as redundancies met from the strategic reserve, capital charges not controlled by services and use of / or contributions to earmarked reserves.

Revenue Outturn

6. The CAS service is reporting a cash limit underspend of £1.781m against a revised budget of *£252.*817m which represents a 0.7% underspend.

7. The tables below show the revised annual budget, actual expenditure to 30 September 2016 and the updated forecast of outturn to the year end, including the variance forecast at year end. The first table is analysed by Subjective Analysis (i.e. type of expense) and shows the combined position for CAS, and the second is by Head of Service.

Subjective Analysis (Type of Expenditure)

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Items Outside Cash Limit £000	Cash Limit Variance £000
Employees	114,680	54,544	111,354	(3,326)	-	(3,326)
Premises	6,955	2,160	6,846	(109)	-	(109)
Transport	17,814	6,415	17,587	(227)	-	(227)
Supplies & Services	17,913	7,446	17,893	(20)	-	(20)
Third Party Payments	238,716	107,482	241,950	3,234	-	3,234
Transfer Payments	13,698	5,195	13,019	(679)	-	(679)
Central Support & Capital	73,521	24,508	74,446	925	-	925
Income	(230,480)	(117,948)	(232,059)	(1,579)	-	(1,579)
Total	**252,817**	**89,802**	**251,036**	**(1,781)**	**-**	**(1,781)**

Analysis by Head of Service Area

	Revised Annual Budget £000	YTD Actual £000	Forecast Outturn £000	Variance £000	Items Outside Cash Limit £000	Cash Limit Variance £000
Head of Adults	126,882	55,502	124,415	(2,471)	-	(2,471)
Central/Other	9,627	215	9,559	(68)	-	(68)
Commissioning inc Supporting People	5,780	(1,752)	5,027	(753)	-	(753)
Planning & Service Strategy	10,944	4,809	10,237	(707)	-	(707)
Central Charges (CYPS)	3,023	(1,280)	3,023	-	-	-
Childrens Services	50,618	17,839	53,579	2,961	-	2,961
Education	42,833	3,600	42,090	(743)	-	(743)
Public Health	3,109	10,870	3,109	-	-	-
Total	**252,817**	**89,802**	**251,036**	**(1,781)**	**-**	**(1,781)**

8. The table below provides a brief commentary of the forecast cash limit variances against the revised budget, analysed by Head of Service for those areas which relate to the Adults area of the service, which is of specific interest to the Adults Wellbeing and Health Overview and Scrutiny Committee. The table identifies variances in the core budget only and excludes items outside of the cash limit (e.g. central repairs and maintenance) and technical accounting adjustments (e.g. capital charges):

Service Area	Description	Cash limit Variance £000
Head of Adults		
Ops Manager LD /MH / Substance Misuse	£220,000 under budget on employees, due to careful vacancy management. £1.133 million net over budget on care provision, in part due to the Transforming Care agenda. £34,000 over budget in respect of premises/transport/supplies and services.	947
Safeguarding Adults and Pract.Dev.	£7,000 over budget on employee costs. £23,000 projected under budget on non-staff costs. £53,000 additional income, mainly to support SPA activity.	(69)
Ops Manager OP/PDSI Services	£304,000 under budget on employees due mainly to effective management of vacancies. £1.873 million net under budget on direct care-related activity. £209,000 under budget in respect of premises/transport/supplies and services/other costs.	(2,386)
Ops Manager Provider Services	£1.045m million under budget on employees in respect of early achievement of future MTFP savings. £82,000 over budget on non-staff costs, mainly in respect of one-off costs.	(963)
		(2,471)
Central/Other		
Central/ Other	£42,000 over budget on employee-related costs, partly offset by additional income. £26,000 under budget on premises/transport/other costs. £85,000 additional income mainly in respect of salary recharges.	(69)
		(69)
Commissioning		
Commissioning	£404,000 under budget on employees in respect of early achievement of future MTFP savings. £349,000 under budget on non-staff costs in respect of early achievement of future MTFP savings.	(753)
		(753)

Service Area	Description	Cash limit Variance £000
Planning & Service Strategy		
Performance & Information Mgmt	£62,000 under budget on employees re effective vacancy management/early achievement of future savings.	(62)
Policy Planning & Partnerships	£45,000 under budget on employees, mainly re future MTFP savings. £9,000 under budget on transport/supplies and services/other budgets. £6,000 under achievement of income.	(60)
Service Quality & Development	Future MTFP savings linked in the main to employees.	(267)
Service Support	£148,000 under budget on employees, mainly re future MTFP savings. £170,000 under budget on transport/supplies and services/other budgets towards future MTFP savings.	(318)
		(707)
Public Health		
Cancer Awareness/ Vulnerable Groups/Sexual Health/Domestic Violence	Activity in relation to sexual health services is forecast to be over budget by £114,000 against the £4.5 million available due to increased activity related to fees and drugs costs associated with contraceptive implants.	114
Health Checks/Smoking Cessation/Drugs and Alcohol	Activity in relation to NRT is forecast to be £127k lower than the £573k budget available. Health checks are forecast to be over budget by £21k against a budget of £1.02m due to greater than anticipated activity.	(106)
Public Health CYP Services/Oral Health /Obesity and Physical Activity	Additional premises income (£47K) is being received from 0-19 provider for use of DCC premises.	(47)
Public Health Team And grant Reserve	Employee related expenditure is forecast to be £461k lower than the core team salary budget of £2m due to proactive management of vacancies. Net unbudgeted income from secondment arrangements is forecast to achieve £37k. The in-year underspend has been earmarked to fund the increased activity in commissioned services else with in Public Health.	(498)
Social Determinants/Adult Wellbeing/ Mental Health	The variance of £537k against a current budget of £7m relates primarily to the extension of a number of commissioned services, including £11k for suicide prevention, Workplace Health £93k, Targeted Wellbeing £81k, Adult Wellbeing variation to contract £130k, Patient Transport £152k, Waddington Street Health Trainer £32k, Warm and Healthy Homes £25k.	537
		-
CAS Total		**(1,781)**

9. In summary, the CAS service is on track to maintain spending within its cash limit overall. The outturn position incorporates the MTFP savings built into the 2016/17 budgets, which for CAS in total amount to £17.326m.

Capital Programme

10. The CAS capital programme has been revised earlier in the year to take into account budget re-profiled from 2015/16 following the final accounts for that year. This increased the 2016/17 original budget.

11. Further reports to the Member Officer Working Group (MOWG) in May, July, September and October included revisions to the CAS capital programme. The revised capital budget currently totals £29.406m.

12. Summary financial performance to the end of September is shown below.

CAS	Actual Expenditure 30/09/2016 £000	Current 2016-17 Budget £000	Remaining 2016-17 Budget £000
LD Provider Services	51	62	11
Support For Childs Homes	-	43	43
Increased Provision for Two Year Olds	(28)	129	157
Free School Meals Support	1	75	74
Secure Services	71	210	139
Planning & Service Strategy	26	159	133
Drug & Alcohol Premises Upgrade	184	383	199
Drugs Commissioning DACT	9	72	63
Public Health	-	431	431
School Devolved Capital	1,141	4,419	3,278
DFE School Capital Inc Basic Need	12,294	20,949	8,655
DSG Structural Maintenance	-	2	2
PSBP - Additional Works Not Covered by EFA	27	182	155
School Modernisation	41	106	65
BSF	849	2,146	1,297
PFI	38	38	-
TOTAL	**14,704**	**29,406**	**14,702**

Recommendations:

13. It is recommended that Adults Wellbeing and Health Overview and Scrutiny Members note the financial forecasts included in the report, which are summarised in the Quarter 2 forecast of outturn report to Cabinet in November 2016.

Contact: Andrew Gilmore – Finance Manager Tel: 03000 263 497
Andrew Baldwin – Finance Manager Tel: 03000 263 490

Appendix 1: Implications

Finance

Financial implications are detailed throughout the report which provides an analysis of the revenue and capital projected outturn position.

Staffing

There are no implications associated with this report. Any over or under spending against the employee budgets are disclosed within the report.

Risk

The management of risk is intrinsic to good budgetary control. This report forms an important part of the governance arrangements within CAS. Through routine / regular monitoring of budgets and continual re-forecasting to year end the service grouping can ensure that it manages its finances within the cash envelope allocated to it.

Equality and Diversity / Public Sector Equality Duty

There are no implications associated with this report.

Accommodation

There are no implications associated with this report.

Crime and Disorder

There are no implications associated with this report.

Human Rights

There are no implications associated with this report.

Consultation

There are no implications associated with this report.

Procurement

There are no implications associated with this report.

Disability Issues

There are no implications associated with this report.

Legal Implications

There are no implications associated with this report.

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Adults, Wellbeing and Health Overview and Scrutiny Committee

20 January 2017

Quarter 2 2016/17 Performance Management Report

Report of Corporate Management Team
Lorraine O'Donnell, Director of Transformation and Partnerships
Councillor Simon Henig, Leader

Purpose of the Report

1. To present progress against the council's corporate performance framework for the Altogether Healthier priority theme for the second quarter of the 2016/17 financial year, covering the period July to September 2016.

Background

2. Work is underway to review how we present performance information in the clearest possible way. This quarter we have tightened the format of the report to make it more concise. We have included an Executive Summary which outlines key performance messages from data released this quarter. We have reviewed the Altogether theme moving from a narrative format to an at a glance, more visual style presentation of one summary page per Altogether theme which presents key data messages showing, where available, the latest position in trends and how we compare to others.

3. A more comprehensive table of all performance data is presented as usual in Appendix 3.

4. Key performance indicator progress is still 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; 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.

5. We will continue to look at ways to further develop the format of the report, as part of the transformation programme, to provide a clearer way of understanding how the council is performing, with the leanest possible process.

6. An outline of the colour rating applied to our performance and the groups we use to compare ourselves is outlined in Appendix 2.

7. To support the complete indicator set, a guide is available which provides full details of indicator definitions and data sources for the 2016/17 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.

Executive Summary

Key performance messages from data released this quarter

8. With regard to adult social care and health, we are effectively managing social care support with the number of people supported by the council decreasing from the same period last year. Although the number of adults admitted on a permanent basis to residential or nursing care has increased since the same period last year, the number of bed days commissioned by the council has remained stable since April 2015, with its lowest level being in July 2016. Panels continue to scrutinise permanent admissions in order to ensure that only those who are unable to be supported safely at home are admitted to permanent care and people are being supported to live independently at home for longer. There are 64% of older people that are supported by the council, living independently in their own home and the average age of older people admitted to residential care has increased since 2014/15.

9. There is a continuing trend of low levels of delayed transfers of care from hospital, which have decreased in County Durham compared to last year and are better than regional and national rates. Our reablement and rehabilitation service is working well with a high percentage of older people still at home three months after discharge from hospital.

10. Our service users are satisfied with our adult social care services according to the recent national adult social care survey, in which we performed better than the North East and England averages

11. National Public Health statistics show the number of smokers in County Durham is falling. Self- reported smokers (as declared in the Annual Population survey) have decreased since last year, in line with regional and slightly above national figures and the target for the number of smoking quitters has been exceeded this quarter.

Risk Management

12. Effective risk management is a vital component of the council's agenda. The council's risk management process sits alongside our change programme and is incorporated into all significant change and improvement projects.

13. There are no key risks in delivering the objectives of this theme.

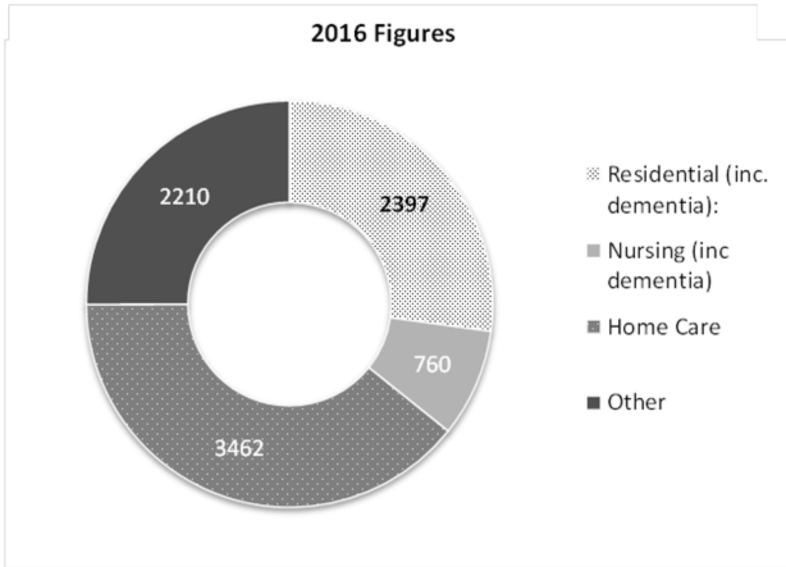
Key data messages by Altogether Theme

14. The next section provides a one page summary of key data messages for the Altogether Healthier theme. The format of the Altogether theme has been revised to provide a snap shot overview aimed to ensure that key performance messages are easy to identify. The Altogether theme is supplemented by information and data relating to the complete indicator set, provided at Appendix 3.

Altogether Healthier

Adult Social Care

The number of people supported by the council is decreasing with a total of 8,829 receiving ongoing social care support at 30 September 2016 compared to 8,874 for the same period last year.

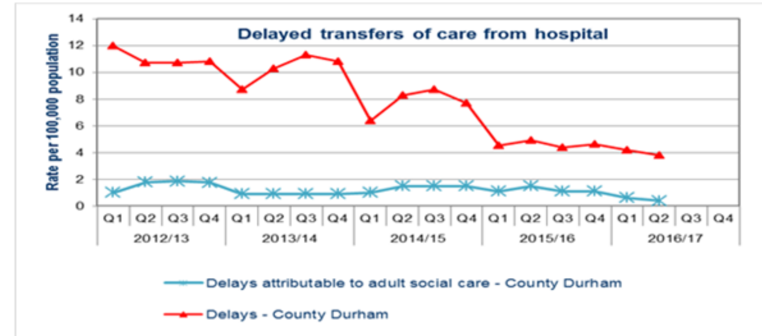


The number of bed days in residential and nursing care has decreased gradually from 77,233 in July 2012 to 69,737 in April 2015 and has since plateaued, with a current figure of 70,463 in September 2016.

86 years old - Average age of older people admitted to residential care this period, an increase from 84.4 years in 2014/15.

Durham performs above the national average in all 7 measures from the 2015/16 Adults Social Care Survey, including people's overall satisfaction with the service and the proportion of people who feel safe

Delayed Transfers of care



✓ Delayed transfers of care are decreasing in County Durham - between April and August 2016 there were:

- 79 delayed transfers of care (3.8 per 100,000 population)
- 8 delayed transfers of care which were fully or partially attributable to adult social care (0.4 per 100,000)

Reablement Service - Between January and June 2016:

- 1,067 (86%) service users were still at home 91 days after their discharge from hospital, achieving the target of 86%

Public Health

The number of smokers in County Durham is falling:

✓ **644** people quit smoking following support between April – June 2016 (682.4 per 100,000 population), exceeding the target of 555 (588 per 100,000)

✓ **19%** - self reported smokers identified in the 2015 Annual Population Survey, a decrease from 20.3% in the 2014 survey.

Recommendations and Reasons

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

Contact: Jenny Haworth, Head of Planning and Performance
Tel: 03000 268071 E-Mail jenny.haworth@durham.gov.uk

Appendix 1: Implications
Appendix 2: Report Key
Appendix 3: Summary of key performance indicators

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: Report key

Performance Indicators:

Direction of travel/benchmarking		Performance against target
Same or better than comparable period/comparator group	GREEN	Meeting/Exceeding target
Worse than comparable period / comparator group (within 2% tolerance)	AMBER	Getting there - performance approaching target (within 2%)
Worse than comparable period / comparator group (greater than 2%)	RED	Performance >2% behind target

National Benchmarking
We compare our performance to all English authorities. The number of authorities varies according to the performance indicator and functions of councils, for example educational attainment is compared to county and unitary councils however waste disposal is compared to district and unitary councils.

North East Benchmarking
The North East figure is the average performance from the authorities within the North East region, i.e. County Durham, Darlington, Gateshead, Hartlepool, Middlesbrough, Newcastle upon Tyne, North Tyneside, Northumberland, Redcar and Cleveland, Stockton-on-Tees, South Tyneside, Sunderland, The number of authorities also varies according to the performance indicator and functions of councils.

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											
24	CASAH2	Percentage of eligible people who receive a NHS health check	1.9	Apr - Jun 2016	2.0	RED	1.9	GREEN	2.0 RED	1.8* GREEN	Apr - Jun 2016
25	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
26	CASAH 10	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
27	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
28	CASAS 23	Percentage of successful completions of those in alcohol treatment **(Also in Altogether Safer)**	27.9	Oct 2015 - Sep 2016	39.3	RED	26.9	GREEN	39.3 RED		Oct 2015 - Sep 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	CASAS7	Percentage of successful completions of those in drug treatment - opiates **(Also in Altogether Safer)**	5.7	2015/16	8.1	RED	6.5	RED	6.6 RED		2015/16
30	CASAS8	Percentage of successful completions of those in drug treatment - non-opiates **(Also in Altogether Safer)**	22.9	2015/16	41.9	RED	41.0	RED	36.9 RED		2015/16
31	CASCYP 8	Percentage of mothers smoking at time of delivery **(Also in Altogether Better for Children and Young People)**	16.6	Apr - Jun 2016	17.2	GREEN	18.1	GREEN	10.2 RED	15.6* RED	Apr - Jun 2016
32	CASAH1	Four week smoking quitters per 100,000 smoking population	682	Apr - Jun 2016	588	GREEN	712	RED			
33	CASAH 11	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	367.8	Apr - Sep 2016	362.2	AMBER	356.2	RED			
34	CASAH 12	Percentage of adult social care service users that receive self-directed support such	93.5	As at 30 Sep 2016	90.0	GREEN	91.0	GREEN	86.9	82.9**	2015/16

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
		as a direct payment or personal budget							GREEN	GREEN	
35	CASAH 14	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	86.0	2015/16	86.0	GREEN	88.0	RED	82.7 GREEN	85.2** GREEN	2015/16
36	CASAH 24	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

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											
132	CASCY P18	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
133	CASCY P19	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
134	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
135	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
136	CASAH 6	Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke) per 100,000 population	81.7	2012-14	88.3	GREEN	88.3	GREEN	75.7 RED	85.9* GREEN	2012-14
137	CASAH 7	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

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
138	CASAH 9	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
139	CASAH 8	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
140	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
141	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
142	CASAH 22	Estimated smoking prevalence of persons aged 18 and over	19.0	2015	20.6	GREEN	20.6	GREEN	16.9 RED	18.7* AMBER	2015
143	CASAH 25	Number of residential/nursing care bed days for people aged 65 and over commissioned by Durham County Council	234,603	Jul - Sep 2016	234,348	NA	233,130	NA			
144	CASAH 13	Percentage of service users reporting that the help and support they receive has made their quality of life better	88.2	Apr - Aug 2016	86.6	AMBER	91.9	AMBER	92.2 AMBER	93.1* AMBER	2015/16
145	CASAH 20i	Delayed transfers of care from hospital per 100,000 population	3.8	Apr - Aug 2016	4.17	GREEN	4.9	GREEN	12.1	5.6*	2015/16

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
									GREEN	GREEN	
146	CASAH 20ii	Delayed transfers of care from hospital, which are fully or partially attributable to adult social care, per 100,000 population	0.4	Apr - Aug 2016	0.6	GREEN	1.5	GREEN	4.7 GREEN	1.1* GREEN	2015/16
147	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
148	CASCY P26	Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years) **(Also in Better for Children and Young People)**	489.4	2011/12 - 2013/14	504.8	GREEN	504.8	GREEN	367.3 RED	532.2* GREEN	England - 2011/12 - 2013/14 NE - 2010/11 - 2012/13
149	NS11	Percentage of the adult population (aged 16+) participating in at least 30 minutes sport and active recreation of at least moderate intensity on at least three days a week	24.0	Apr 2014 - Mar 2016	25.0	RED	24.9	RED			