Health and Wellbeing Board

Date **Thursday 16 March 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 for Absence

2. Substitute Members

3. Declarations of Interest

4. Minutes of the meeting held on 31 January 2017 (Pages 5 - 18)

5. Transformation of Partnerships - Presentation of Head of Partnerships and Community Engagement, Transformation and Partnerships, Durham County Council (Pages 19 - 20)

6. Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan - Report of Chair, North Durham CCG (Pages 21 - 24)

7. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Draft Sustainability and Transformation Plan - Report of Clinical Chair, Durham Dales, Easington and Sedgefield CCG (Pages 25 - 28)

8. Better Care Fund Quarter 3 Performance 2016/17 - Report of Strategic Programme Manager Care Act Implementation and Integration, Adult and Health Services, Durham County Council (Pages 29 - 34)

9. Community Hubs / Teams Around Practices- Report of Director of Integration, North Durham CCG, Durham Dales, Easington and Sedgefield CCG, Durham County Council (Pages 35 - 42)

10. Prioritising Prevention - Presentation of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 43 - 44)

11. Preventative Mental Health Review and Recommissioning - Report of Interim Head of Commissioning, Adult and Health Services, Durham County Council (Pages 45 - 54)

12. Dementia Work Across County Durham - Joint Report of Chair, North Durham CCG and Interim Head of Commissioning, Adult and Health Services, Durham County Council (Pages 55 - 68)

13. Mental Health Crisis Care Concordat - Report of Director of Corporate Programmes Delivery and Operations, North Durham CCG (Pages 69 - 76)

14. Self-Harm and Suicide Audit 2012-14 - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 77 - 102)

15. Urgent Care Services - Report of Clinical Chair, Durham Dales Easington and Sedgefield CCG (Pages 103 - 118)

16. Transforming Care for People with Learning Disabilities (Fast Track Plan) - Report of Senior Commissioning Manager, Joint Commissioning and Continuing Health Care, North of England Commissioning Support (Pages 119 - 124)

17. Motor Neurone Disease Charter - Report of Strategic Manager Policy, Planning and Partnerships, Durham County Council (Pages 125 - 136)

18. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration

19. Any resolution relating to the exclusion of the public during the discussion of items containing exempt information

Part B

Items during which it is considered the meeting will not be open to the public (consideration of exempt or confidential information)

20. Pharmacy Applications - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 137 - 144)

21. 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
8 March 2017

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

To: The Members of the Health and Wellbeing Board, Durham County Council

Councillors L Hovvels, O Johnson and J Allen

J Robinson	**Corporate Director of Adult and Health Services, Durham County Council**
M Whellans	**Corporate Director of Children and Young People's Services, Durham County Council**
G O'Neill	**Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council**
N Bailey	**North Durham and Durham Dales Easington and Sedgefield Clinical Commissioning Groups**
Dr D Smart	**North Durham Clinical Commissioning Group**
Dr S Findlay	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
Dr J Smith	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
S Jacques	**County Durham and Darlington NHS Foundation Trust**
A Foster	**North Tees and Hartlepool NHS Foundation Trust**
C Martin	**Tees, Esk and Wear Valleys NHS Foundation Trust**
C Harries	**City Hospitals Sunderland NHS Foundation Trust**
B Jackson	**Healthwatch County Durham**
S Lamb	**Harrogate and District NHS Foundation Trust**
L Jeavons	**North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups and Durham County Council**
A Reiss	**Office of the Police, Crime, and Victim's Commissioner**

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DURHAM COUNTY COUNCIL

At a Meeting of **Health and Wellbeing Board** held in Committee Room 2, County Hall, Durham on **Tuesday 31 January 2017 at 9.30 am**

Present:

Councillor L Hovvels (Chairman)

Members of the Committee:
Councillors J Allen and O Johnson, P Coglan, Dr S Findlay, B Jackson, G O'Neill, J Robinson, R Rooney, Dr D Smart, Dr J Smith and M Whellans

Also in Attendance:
J Carling, L Jeavons, M Patterson and A Reiss

1 Apologies for Absence

Apologies for absence were received from Councillor O Johnson, N Bailey, A Foster, C Harries, S Jacques, C Martin and J Robinson.

2 Substitute Members

R Rooney for N Bailey and P Coglan for S Lamb

3 Declarations of Interest

There were no declarations of interest.

4 Minutes

The minutes of the meeting held on 17 November 2016 were agreed as a correct record and signed by the Chairman.

5 Membership of the Health and Wellbeing Board

The Board considered a report of the Head of Legal and Democratic Services, Resources, Durham County Council that sought views on inviting additional representatives to become voting members of the Board (for copy see file of Minutes).

The Strategic Manager – Policy, Planning and Partnerships, Durham County Council informed the members that in November 2016 a letter was received by the Chair of the Health and Wellbeing Board from the Rt Hon Amber Rudd MP and the Rt Hon Jeremy Hunt MP to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

In order to achieve benefits from joint working it was recommended that a representative from the Office of the Durham Police, Crime and Victims' Commissioner would be invited to become a voting member. Alan Reiss, Chief of Staff, Office of the Durham Police, Crime and Victims' Commissioner had been identified as the representative.

It was also recommended that Lesley Jeavons, Director of Integration be invited to become a voting member in the capacity of a joint appointee of Durham County Council and Health partners.

Resolved:

(i) That a representative from the Office of the Durham Police, Crime and Victims' Commissioner becoming an additional voting member of the Health and Wellbeing Board be agreed;

(ii) That the Director of Integration becoming an additional voting member of the Health and Wellbeing Board be agreed.

The Chairman welcomed Alan Reiss, Office of the Durham Police, Crime and Victims' Commissioner, his substitute Jon Carling and Lesley Jeavons, Director of Integration to the meeting.

6 County Durham Youth Offending Service: Speech, Language and Communication Needs Strategy

The Committee received a report of the Strategic Manager, County Durham Youth Offending Service, Durham County Council on the progress and outcomes of the County Durham Youth Offending Service (CDYOS) Speech, Language and Communication Needs (SLCN) Strategy (for copy see file of Minutes).

The Strategic Manager, County Durham Youth Offending Service and Practice Improvement Officer gave a detailed presentation (for the full copy see file of Minutes) that highlighted the following points:-

- Statistics – 10% of young people will potentially have long-term speech, language and communication needs. 60-90% of young people who offend had speech, language and communication needs.
- Impacts of poor communication.
- The Strategy – focusing on staff and the service, young victims and young people who offend.
- ClearCut Communication Screening Pack and Toolkit – a new toolkit designed to support communication. This has copyright to DCC and marketed to other Local Authorities. The Youth Justice Board had found it useful.
- Wordbuster – as young people struggled with some terminology and words used by the service, 83 words were gathered from young people and victims that they did not understand what they were.

Councillor Allen congratulated the service on the hard work carried out that was benefitting young people. The Strategic Manager CDYOS said that she was grateful that partners were on board.

Councillor Johnson said that it was good to see young people that were struggling with communication now being supported and hoped that the good practice would be disseminated through partner organisations. He asked if there were any practical examples of this work in secondary schools. The Practice Improvement Officer said that more training was required in secondary schools to look at better identification and support for young people.

The Interim Director of Public Health asked if the Health Education North East had been engaged and the Strategic Manager agreed that this would be useful.

Resolved:-

(i) That the content of the report be noted.
(ii) That further updates would be received in due course.
(iii) That CDYOS SLCN Strategy be referred to the Healthy Child Programme Board to inform future developments and consider commissioners' implications.

The Chairman advised that the next two items on the agenda would be considered together.

7 Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan and

8 Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan

The Committee considered the following reports:-

(i) From the Chief Clinical Officer, North Durham Clinical Commissioning Group that gave an update on the Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan (STP) (for copy see file of Minutes).

The Commissioning Manager, North Durham CCG advised that the engagement phase of the draft Sustainability and Transformation Plan had ended on 20 January 2017 and work on the consultation process was being developed in February but that consultation was not expected before June 2017.

(ii) From the Chief Clinical Officer, Durham Dales, Easington and Sedgefield CCG, and Clinical Chair Durham Dales, Easington and Sedgefield CCG that gave an update on the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW) draft Sustainability and Transformation Plan (STP) (for copy see file of Minutes).

The Chief Clinical Officer, DDES CCG advised that the draft plan had been published at the end of November 2016. He went on to explain that all STPs had been asked to look for gaps in the system and highlight funding and efficiency

savings. The Southern STP is chaired by Alan Foster. The wider agenda was being looked at including out of hospital care and how much more could be done in the community closer to the patient. He stated that clinicians were of the view that only 2 emergency centres were required for the area. The James Cook Hospital was one and the location of the other was still undecided. The STP team were currently working through the decision making process. There were four key priority areas and he believed that the quality of the service and the workforce were the important areas although there was a financial driver and a financial efficiency was expected.

The Clinical Chair, DDES CCG added that the engagement process involved over 50 events. He further advised that Phase 5 would begin this week with Maternity and Children's Services and the number of units that were to be provided. Due to the workforce and sustainability issues there would be fewer units. The engagement events would also target the hard to reach groups.

The Chief Clinical Officer gave a reminder of the timelines and advised that the preferred option would be expected or consulted on in June 2017.

The Chairman said that she was pleased that the STPs had been pro-active in sending information out and engaging with the wider communities. However, she had received a number of queries and questions from members of the public regarding the STPs. People found that the information was not always clear and she suggested that improvements are required in putting the message across in a clearer way. She also suggested that better communication was needed for the next phases of engagement. She further added that people need to be informed as to the reasons why the number of hospitals could not be sustained. She also asked who would sign off the final plans and what the process would be for that.

The Chief Clinical Officer, DDES CCG advised that this was not a new topic and had been discussed for the past 5 years in terms of proposals for the Southern STP. He said that there were significant issues regarding the sustainability of the acute hospital workforce. He said that it was important to look at newer working models as medicine continues to advance. The Chairman re-iterated her point about letting the public know this and to be open and honest about the whole process.

The Chairman referred to the Accident and Emergency Department at University Hospital Durham and the plans to extend this and asked what the future held. The Commissioning Manager explained that originally North Durham was part of the Southern STP and as the footprint changed this became part of the Northumberland, Tyne and Wear and North Durham STP. She advised that as this was early in the process, relationships were being built with providers and work was being learnt from the Better Health Programme. It had been a frustrating process and so far specific plans for this STP were not developed.

The Clinical Chair, North Durham CCG added that it would be unfair for the acute trust to put extension plans on hold while the STP was developed. He said that there was a chronic lack of A&E capacity at present at UHND and the changes would be a huge benefit.

The Chairman asked how the STPs would link into the NECA Public Health proposals.

The Interim Director of Public Health County Durham said the NECA recommendations would be taken forward.

The Corporate Director of Adults and Health Services added that the recommendation was for the whole footprint of Health and Social Care to be included in this prevention work.

The Chief Clinical Officer, DDES CCG said that it was difficult as NECA did not cover the whole of the region.

The Chairman asked what message had been received from local people throughout the engagement events. The Commissioning Manager responded that people were frustrated and nervous of what would happen. They had expressed concerns about where their local hospital would be and where to access services. She believed that people were aware of the financial challenges and that they had the responsibility to use facilities appropriately.

The Clinical Chair, DDES CCG found that people had come along to the events with a view and by talking to clinicians it had helped them to understand the issues. The public had been able to see that what we had now was not sustainable. Ultimately, people wanted to know where the changes would happen. He advised that no decisions had been made as they were still at the engagement phase.

The Corporate Director of Adult and Health Services was aware that the feedback on the draft North STP had ended on 20 January 2017 however she had asked for the Integration Board to consider the implications for both STPs.

The Chief Clinical Officer, DDES CCG reported that some changes would not require consultation and that they would allude to that. The public facing document would be made available to the Board. He advised that people would be informed where to access Emergency and Urgent Care Services. He added that transport was key and the STP were working through issues to ensure that other services were on board to help support any changes. He mentioned that they did not want to change the BHP branding as it was part of the STP. Workforce is a key consideration as part of the STPs.

The Corporate Director of Adult and Health Services referred to the sign off process involving two footprints.

Councillor Allen said that it was important to have the best outcome for all, including the best clinicians and to learn lessons going forward. From speaking to the public she was aware that there were concerns in rural communities. Those people often did not have transport to get to hospital or to visit relatives in hospital on a daily basis for a number of weeks at a time. She asked if information about outcomes of patient flow was available. She added that it would be a big challenge to get people where they required treatment and to ensure transport and parking issues were addressed.

The Chief Clinical Officer, DDES CCG said that returning people home after a hospital visit was also important.

Councillor Johnson was aware that the general public were concerned about the process. He asked what would happen following the Phase 5 Maternity and Children's Services process. The Clinical Chair advised that engagement events would take place in February and March 2017 and taken back to the STP board that would determine what options would go out for consultation.

The Chairman of Healthwatch asked NHS colleagues to elaborate on what was happening with University Hospital North Durham as he had been led to believe that it was not being considered as part of the STP. The Commissioning Manager, North Durham CCG advised that it was no longer part of the BHP and Southern STPs considerations. She further explained that the Northern STP had not reached that stage of the engagement process. The Chairman of Healthwatch said that the concerns of local people needed to be addressed.

The Director of Integration said that access to services and the development of services within the local community would give re-assurance to people. She advised that an update would be available at the next Board meeting.

Resolved:-

(i) That the contents of the reports be noted;
(ii) That comments on the draft Northumberland, Tyne and Wear and North Durham STP be received;
(iii) That comments on the draft Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby STP be received.
(iv) That a letter be sent to the STP leads from the Health and Wellbeing Board outlining additional issues as part of the engagement process be agreed.

9 North Durham CCG and Durham Dales, Easington and Sedgefield CCG Operational Plans

The Board considered a report of Chief Operating Officer, North Durham CCG and Durham Dales, Easington and Sedgefield CCG that provided an update on the North Durham (ND) Clinical Commissioning Group (CCG) and Durham Dales, Easington and Sedgefield (DDES) CCG two year Operational Plans submitted in December 2016 (for copy see file of Minutes).

The Commissioning Manager, North Durham CCG presented the two year operational plans for both North Durham and Durham, Dales, Easington and Sedgefield CCGs that were aligned to the STPs. The plans had been submitted to NHS England and final feedback was awaited. She informed the Board that public versions of the documents would be made readily available.

Councillor Johnson was assured that engagement was being carried out in a meaningful way and reported that a child friendly document was also being looked at.

The Commissioning Manager advised that as GPs were ageing there were career start programmes in place. The Clinical Chair North Durham CCG added that this was going from strength to strength. National work was ongoing to ensure GPs remained working for longer and to offer a more flexible option for working as they came to the end of their careers. In order to retain GPs there was a need to make the system more attractive and to fill the gaps and make sure that it was more sustainable.

The Head of Planning and Service Strategy, DCC was interested to see how the two plans had become more united within a wider planning framework. He said it was difficult for people to see how plans fit together. The Chief Clinical Officer said that it was important to have the local focus.

The Chairman asked if End of Life Care was a priority and contained within the plans and was advised that this was the case.

Resolved:-

(i) That the content of this report be noted;
(ii) That the nine must-do's to be delivered be noted; and
(iii) That each CCG's plan on a page be noted.

10 Better Care Fund Quarter 2 Performance 2016/17

The Board considered a report of the Strategic Programme Manager – Care Act Implementation and Integration, Adults and Health Services, Durham County Council that gave an update on the high level metrics and deliverables on the Better Care Fund Quarter 2 2016/17 (for copy see file of Minutes).

The Head of Planning and Service Strategy, DCC reported that it was important to keep people in their own homes. The indicator for permanent admissions of older people to residential/ nursing care homes was slightly behind target.

He reported that performance for the percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into Reablement / Rehabilitation was on target for quarter 2. There were no significant issues for delayed transfers of care from hospital as performance was good. The target had just been missed for non-elective admissions. There was real pressure on carers and a response was awaited about whether they were satisfied with the support services they receive from a national carer's survey undertaken last November.

Finally, the Head of Planning and Service Strategy reported that the annual target for the number of people in receipt of telecare had been exceeded.

Councillor Allen was interested to see the results of the national carers survey. She asked if this information was also fed back to the carer. The Head of Planning and Service Strategy explained that if carers had indicated that they wanted feedback on the form then they would receive it. The results would be circulated to the Board when available.

Resolved:

(i) That the report be noted.

(ii) That further updates in relation to the Better Care Fund be received.

11 Oral Health Strategy for County Durham

The Board considered a report of the Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council that presented the Oral Health Strategy for County Durham (for copy see file of Minutes).

The Interim Director of Public Health informed the Board that following the draft strategy in October a wide consultation exercise had been carried out, including at the Big Tent Event, and was pleased to present the Oral Health Strategy for agreement.

Councillor Allen asked how soon we would see the benefits following implementation. The Interim Director of Public Health said that through targeted work it was hoped to see the benefits within 5 years and results would be seen more quickly if there was an introduction of fluoridated water.

Councillor Johnson was pleased to see the work being carried out to ensure children and young people were being targeted to make improvements to their oral health. He asked if targeted work would be carried out with individual families. The Interim Director of Public Health responded that close working with housing would help to identify those vulnerable families that required additional support. Health visitors would speak to families about dental care and would make sure that they knew how to access it.

The Locality Manager for Harrogate and District NHS Foundation Trust explained that they encourage families to register with a dentist.

Councillor Allen referred to foodbanks and the growing demand and suggested that this was a good way to engage and educate people. The Locality Manager advised that their health visitors work closely with foodbanks to help identify vulnerable families.

The Interim Director of Public Health added that toothpaste and toothbrushes were items that should be encouraged to be donated to foodbanks.

The Interim Corporate Director of Children and Young People's Services asked what was happening in schools to encourage the promotion of this strategy. The Interim Director of Public Health advised that work was ongoing with schools to promote the importance of oral health.

The Chief Clinical Officer, DDES CCG said that he had seen no improvement in oral health over the last 30 years despite some major changes. He felt that this would change if fluoride was in the water supply. The Interim Director of Public Health agreed that the presence of fluoride in the water in Derwentside since the 1960s had seen a lot less problems than in areas where no fluoride was present.

Resolved:

(i) That the Oral Health Strategy attached at Appendix 2 be agreed.

(ii) That the feasibility study on fluoridation was underway awaiting results which would inform action plan at a later date, be noted.

12 County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan

The Board considered a joint report of the Interim Director of Public Health County Durham, Adult and Health Services and the Interim Corporate Director of Children and Young People's Services, Durham County Council that gave an update on the progress on implementing the County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan (for copy see file of Minutes).

Referring to the Crisis Service the Board were informed of the Public Health involvement in a Scrutiny Review into Suicides, Mental Health and Wellbeing and were awaiting the recommendations from that piece of work.

Councillor Johnson said that he was pleased to see that the CAMHS initiative would be available 24/7 and asked how this information would be made public. The Interim Director of Public Health said that she was unsure of the timelines but that communications would be an important factor going forward.

Councillor Allen asked how the service intended to share learning and was advised that there was a need to understand the data and this would form part of the Suicide Strategy.

The Director of Integration referred to the transition between leaving CAMHS as a young person and moving into adult care, an issue that had been flagged as a concern from the young people. Work had been ongoing with Tees Esk & Wear Valleys NHS Foundation Trust and the young people concerned and she asked if there had been any progress with this. The Interim Director of Public Health would come back to her with that information.

The Head of Policy and Communications, Office of the Durham Police, Crime and Victims' Commissioner said that it was good to see that linkages were being made with the levels of offending and mental health issues.

The Interim Director of Public Health informed the Board that they were trying to ensure that there was no wrong door for people who required help and that they were trying to establish a single point of access for all.

Resolved:

(i) That the information provided in the report about new services currently being progressed be noted.

(ii) That the refreshed County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan and priorities for action in 2017/18 be agreed.

13 Cardiovascular Disease Framework and Prevention Programmes

The Board considered a report of the Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council that provided an update on the progress made on the Cardio-Vascular Disease (CVD) Framework and associated programmes. The Strategic Framework for the Prevention of Cardiovascular Disease identified a number of risk factors for heart disease and other related conditions that may, through lifestyle and other forms of intervention, be reduced (for copy see file of Minutes).

The Interim Director of Public Health reported that a more targeted approach had been made in relation to health checks which would be more likely to find the right people at risk of CVD.

Resolved:

(i) That the multifaceted approach to reducing the risks of CVD and associated conditions as identified in the CVD prevention framework be noted;

(ii) That the experience of delivering the Health Check programme in County Durham be noted;

(iii) That the changes to the health check programme that will be included in the revised services specifications from April 2017 be endorsed.

(iv) That the work being undertaken by the CCGs to increase uptake of the diabetes prevention programme be noted;

(v) That partners delivering evidence based tobacco control interventions be supported.

(vi) That a bid of £99,200 over two years had been submitted to the British Heart Foundation to complement the community health check programme be noted.

14 Progress update of Director of Public Health Annual Report 2014 - All the Lonely People: Social Isolation and Loneliness in County Durham

The Board considered a report of the Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council that gave an update on the response in tackling social isolation and how to have a more coordinated response further to the 2014 Annual Report of the Director of Public Health entitled *'All the lonely People'* focused on social isolation and loneliness and its effects on health and wellbeing (for copy see file of Minutes).

The Interim Director of Public Health reported that work had been carried out with the Area Action Partnerships on tackling isolation in the community.

Councillor Allen referred to the good work happening in the community through the AAPs in terms of health and asked how good lessons were shared within the County. The Interim Director of Public Health said that there was information sharing but that we could do more by looking at the different themes and what each area required.

The Head of Planning and Service Strategy suggested that an event be organised to deal with how to tackle loneliness. He referred to a mid Durham scheme that

had not worked but lessons had been learned and could be shared. He said that there was a danger of stigmatising people - just because someone was alone did not mean that they were lonely.

The Chairman commented that some areas had a lot of support such as Shildon through Livin Housing but that some areas received no support at all.

Referring to poor nutrition and diet Councillor Allen mentioned that an event had taken place in Shildon about the impact of high energy sugar drinks and asked if this would be rolled out to other areas. The Interim Director of Public Health said that discussions were taking place with local businesses who sell the drinks.

The Director of Integration supported the recommendation on Integrated Community Hubs as they had picked isolation up as an issue.

The Chairman referred to Safe and Wellbeing visits and asked how the public could inform someone who needed one. The Interim Director said that conversations took place within the community and people were advised how to refer.

Resolved:
That the contents of the report be noted and support given to the specific recommendations that:

- Organisations and partners who prioritise reducing social isolation and loneliness should develop interventions that are based on the current evidence of what works: befriending services, community navigator programmes and group activities;
- That commissions, where relevant should continue to consider 'building in' indicators which will tackle social isolation and loneliness;
- That a basic common training package on how to engage and identify social isolated individuals and groups should be developed;
- The Community Wellbeing Partnership will design and develop an evaluation framework to support organisations to be able to capture a range of outcome measures to demonstrate value and contribute to learning;
- Given the numbers of older people in County Durham with one or more long term conditions, work to reduce social isolation and loneliness, will need to integrate with the proposed CCG integrated community hubs model;
- On the back of recommendation that contact schemes should train individuals in using making every contact count (MECC) and undertake some brief and sensitive questionnaires to identify and appropriately refer people to local programmes using Locate;
- The Community Wellbeing Partnership should consider placing social isolation and loneliness as a key focus of work for the foreseeable future to support, steer and enable the above recommendations to take place.

15 Healthwatch County Durham Work Plan 2016/17

The Board considered a report of the Lay Chair, Healthwatch County Durham that presented the Healthwatch Work Plan 2016/17 (for copy see file of Minutes).

The Lay Chair reported that two meetings of the new board had been held and meetings were being arranged in school holidays and at varied times to ensure people could attend. He advised that part of the work plan would be to support the Sustainability and Transformation Plans.

The Programme Manager of Healthwatch informed the Board that the work plan had been published in November 2016 as a public document and there was scope to add items to the workplan.

She was pleased to advise that the development of the board and voluntary programme had been successful. Two young people were now on the board and 30 volunteers had been appointed. An apprentice had also been appointed.

With regards to the work plan she reported that the uptake of health checks for people with learning disabilities had increased and that they were supporting DCC Adult Social Care. One to ones with service users and GPs had been carried out where good practice this had been working well so that information could be shared.

There had been seven visits to care homes and a pilot with primary care about the benefits of learning would be carried out within the next quarter.

Councillor Johnson was grateful for the joined up approach especially with the uptake on oral health for children and young people, their parents and carers. He thanked the service for this piece of work. He was also pleased to see that the meetings had been arranged so as to engage further with young people in school holidays. He asked that harder to reach children be included in work going forward.

The Strategic Manager, Policy, Planning and Partnerships, Durham County Council informed the board that the work plan aligned with that of the Joint Health and Wellbeing Strategy.

Resolved:
That comments on the HWCD Work Plan and any further areas of work for the future to be considered by the HWCD Board be noted.

16 Exclusion of the public

Resolved:

That under Section 100(a)(4) of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of the Local Government Act 1972.

17 Pharmacy Applications

The Board considered a report of the Interim Director of Public Health County Durham, Adults and Health Services, Durham County Council which provided a summary of a Pharmacy Relocation Application received from NHS England in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 since the last formal meeting of the Board in November 2016 (for copy see file of Minutes).

Resolved:
That the report be noted.

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Health and Wellbeing Board

16 March 2017

Transformation of Partnerships

Report of Gordon Elliott, Head of Partnerships and Community Engagement, Transformation and Partnerships, Durham County Council

Purpose of the Report

1 The purpose of this report is to inform the Health and Wellbeing Board of the forthcoming presentation on the Transformation of Partnerships. Gordon Elliott, Head of Partnerships and Community Engagement, Durham County Council will attend the meeting of the Health and Wellbeing Board on 16 March 2017 and deliver a presentation entitled 'County Durham Partnership – Good to Great'.

Background

2 The County Durham Partnership held an away day in May 2016 where partnership working was highlighted as an important part of the Council Transformation Programme.

3 It is recognised that County Durham has good partnership arrangements in place and that partnership working has enabled good outcomes to be achieved. However, in order to move partnership working from good to great there are further opportunities to improve how we work together.

Recommendations

4 The Health and Wellbeing Board is recommended to:

- Note and provide feedback on the forthcoming presentation at the HWB meeting 16 March 2017.

Contact: **Gordon Elliott, Head of Partnerships and Community Engagement, Transformation and Partnerships**
Tel **03000 263605**

Appendix 1 – Implications

Finance
N/A at this time

Staffing
N/A at this time

Risk
N/A at this time

Equality and Diversity / Public Sector Equality Duty
N/A at this time

Accommodation
N/A at this time

Crime and Disorder
N/A at this time

Human Rights
N/A at this time

Consultation
N/A at this time

Procurement
N/A at this time

Disability Issues
N/A at this time

Legal Implications
N/A at this time

Health and Wellbeing Board

16 March 2017

Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan

Report of Dr David Smart, Chair, North Durham Clinical Commissioning Group

Purpose of the Report

1 To provide an update to the Health and Wellbeing Board (HWB) on the Northumberland, Tyne and Wear and North Durham (NTWND) Sustainability and Transformation Plan (STP). A copy of this draft STP has been published and can be viewed on the North Durham CCG website (Link).

Progress to date

2 An eight week programme of engagement on the draft STP document concluded at the end of January 2017. A full report analysing all the feedback received to date will be available at the end of March 2017. The report will summarise all of the engagement activity to date and key themes of issues arising. All of the information collated will be used to influence the next draft version of the STP. A strategic timeline outlining next steps for consultation and engagement will be available by the end of March 2017.

3 A number of workstreams are currently being established across the NTWND STP footprint. Figure 1 shows the Sponsor and Lead for each different workstream. The prevention workstream is being undertaken across the North East. A schedule of meeting dates, terms of reference, membership, including partner and stakeholder representation, is being developed for each workstream.

Figure 1: Workstreams: Sustainability and Transformation Plan for Northumberland, Tyne and Wear, and North Durham

Workstream	Chief Executive Sponsor and Workstream Lead
Prevention	Chief Executive Sponsor: Terry Collins Workstream lead: Amanda Healy
Mental Health	Chief Executive Sponsor: John Lawlor Workstream lead: James Duncan
Neighbourhoods and Communities	Chief Executive Sponsor: Dr Neil O'Brien Workstream lead: Dr Dan Cowie
Optimal use of the acute sector	Chief Executive Sponsor: Ken Bremner Workstream lead: Susan Watson

Recommendations

4 The Health and Wellbeing Board is recommended to:

- Note the contents of this report.

Contact: Michael Houghton, Director of Commissioning and Development, North Durham Clinical Commissioning Group
Tel: 0191389 8575

Appendix 1: Implications

Finance
The financial implications are included in the draft STP document.

Staffing
Details about workforce are included in the draft STP document.

Risk
Risks are outlined in the draft STP document.

Equality and Diversity / Public Sector Equality Duty
N/A

Accommodation
N/A

Crime and Disorder
N/A

Human Rights
N/A

Consultation
A strategic timeline and next steps for consultation and engagement will be published at the end of March 2017.

Procurement
N/A

Disability Issues
N/A

Legal Implications
N/A

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Health and Wellbeing Board

16 March 2017

Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Draft Sustainability and Transformation Plan

Report of Dr Jonathan Smith, Clinical Chair, Durham Dales Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1 To provide the Health and Wellbeing Board (HWB) with an update on progress in relation to the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW) Draft Sustainability and Transformation Plan (STP). The DDTHRW Draft STP is available to view online on the Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group (CCG) website (Link).

Background

2 The NHS shared planning guidance asked every health and care system to come together to create their own ambitious local blue print for accelerating the implementation of the Five Year Forward View. STPs are place based, multi-year plans built around the needs of local populations. STPs are expected to support closing three gaps across health and care systems that were highlighted in the Five Year Forward View:

- Health and wellbeing;
- Care and quality;
- Funding and financial efficiency.

3 STPs bring organisations together to develop a shared plan for better health and social care for local populations. STP footprints are not new statutory organisations. An umbrella plan has been developed containing specific plans to address key challenges.

Progress to date

Engagement

4 The inaugural meeting of the Neighbourhood and Communities Group was held on 6 February 2017. Membership included representation from each CCG within the STP, Medical Directors from North Tees and Hartlepool (NTEES) NHS Foundation Trust (FT) and South Tees (STEES) NHS FT. A representative for GP Federations, a representative for North East Ambulance Service and Yorkshire Ambulance Service, a representative from the Voluntary

and Community sector, and a representative from Healthwatch were also included. Local Authority leaders within the STP will confirm a representative to attend the group following a planning workshop in March 2017.

5 A number of workstreams are currently being established across the DDTHRW STP footprint. Figure 1 shows the Sponsor and Lead for each different workstream.

Figure 1: Workstreams: Sustainability and Transformation Plan for Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW)

Workstream	Chief Executive Sponsor and Workstream Lead
Prevention	Chief Executive Sponsor: TBC Workstream lead: Gill O'Neil
Mental Health	Chief Executive Sponsor: Colin Martin Workstream lead: Nicola Bailey
Neighbourhoods and Communities	Chief Executive Sponsor: Janet Probert Workstream lead: Dr Jenny Steel
Optimal use of the acute sector	Chief Executive Sponsor: CEO of the trusts (STEES/NTEES/County Durham and Darlington NHS FT [CDDFT]) Workstream lead: Company secretaries of the Foundation Trusts (STEES/NTEES/CDDFT)

6 In February 2017, the NHS Better Health Programme continued to engage with the public and patients through a series of public meetings across Durham Dales, Easington, Sedgefield, Darlington and Tees. This follows 50 engagement events that were held last year. The events in February focussed on maternity and children's services, what is important to families about the care they receive, and how we can make it better including what influences choice about where to have a baby.

7 Key issues from engagement to date include:

- Quality of care, and results for patients;
- The right staffing;
- Travel and transport to hospital;
- Access to primary care;
- Access to mental health services;
- Communication;
- Discharge support;
- Integration of services.

8 An event is being planned to engage with voluntary and community sector organisations. This will be an opportunity to identify opportunities for effective working with the sector thinking in particularly about how we support people to stay in their own homes, transport, and service provision.

Recommendations

9 The Health and Wellbeing Board are recommended to:

- Note the contents of this update.

Contact: Sarah Burns, Director of Commissioning, Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Tel: 0191 3713217

Appendix 1: Implications

Finance

N/A

Staffing

N/A

Risk

N/A

Equality and Diversity / Public Sector Equality Duty

N/A

Accommodation

N/A

Crime and Disorder

N/A

Human Rights

N/A

Consultation

Consultation and Engagement is live and ongoing across Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby

Procurement

N/A

Disability Issues

N/A

Legal Implications

N/A

Health and Wellbeing Board

16 March 2017

Better Care Fund Quarter 3 Performance 2016-17

Report of Paul Copeland, Strategic Programme Manager – Better Care Fund and Integration, Durham County Council

Purpose of the Report

1 The purpose of this report is to provide an update on the Better Care Fund (BCF) Quarter 3 2016-17 to the Health and Wellbeing Board.

2 The Better Care Fund Quarterly Data Collection Template Q3 2016-17 is available on request.

Background

3 The BCF allocation for Durham in 2016-17 increased to £44.579m from £43.735m in 2015-16.

4 BCF Policy and Planning issued by NHS England for 2016-17 indicated a need to maintain stability.

5 In response to the above, BCF Planning in Durham has focussed upon maintaining and rolling forward all of the current programmes and projects following agreement with partners.

6 Previous BCF stipulations relating to payment for performance have been replaced by two national conditions:

- Agreement to invest in NHS commissioned out of hospital services (which could include a broad range of community services);
- Agreement on local action plans and targets to reduce delayed transfers of care.

7 BCF Planning requirements for 2016-17 required Health and Wellbeing Boards to continue collecting information on the following four key metrics which are identified below.

- Permanent admissions of older people (aged 65yrs+) to residential / nursing homes, 100,000 population;
- Percentage of older people (aged 65yrs+) who were still at home 91 days after discharge from hospitals into reablement / rehabilitation services;
- Delayed transfers of care (delayed days) from hospital, per 100,000 of the population (per 3 month period);

- Non Elective admissions per 100,000 population (per 3 month period).

8 In addition, BCF Plans had to include two locally determined metrics which are as follows:

- Percentage of carers who are very / extremely satisfied with the support services they receive;
- The number of people in receipt of telecare per 100,000 population.

Performance Update

9 Performance in relation to the six key metrics and deliverables are measured against the BCF 2015-16 position. BCF Q3 2016-17 indicated positive performance in four of the indicators with the majority of data on track to meet their targets going forward. The exceptions being admissions to residential or nursing care where some improvement in performance is noted but may not meet the full year target and non-elective admissions where there is no improvement in performance.

10 A traffic light system is used in the report, where green refers to on or better than target, amber is within 2% of target and red is below target.

Permanent admissions of older people (aged 65 and over) to residential/ nursing homes, per 100,000 population

Indicator	Historical	Actual	Targets		Performance against target
	Q3 2015-16	Q3 2016-17	Q3 2016/17	Total 2016/17	
Permanent admissions of older people (aged 65yrs+) to residential / nursing homes per 100,000 population	**583.7**	**549.3**	**565.6**	**1842.3**	

11 The Q3 2016-17 rate for older people aged 65 yrs+ admitted to residential / nursing care homes per 100,000 population on a permanent basis was 549.3. This is better than the Q3 2016-17 target of 565.6 and is lower than the same period last year.

12 Ongoing scrutiny of admissions to residential / nursing care homes continues to remain a priority in order to ensure that only those people who are unable to be supported safely in their own homes are admitted to permanent residential or nursing care.

13 Expenditure on residential / nursing care placements remains within budget.

Percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into Reablement / Rehabilitation

Indicator	Historical	Actual	Targets		Performance against target
	Q3 2015-16	Q3 2016-17	Q3 2016-17	Total 2016-17	
Percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation	87.7	87.8	86.0	86.0	

14 Performance in Q3 2016-17 at 87.8% is above target of 86.0% and is comparable to the same period in 2015-16 (87.7%)

Delayed transfers of care (delayed days) from hospital per 100,000 population (per 3 month period)

Indicator	Historical		Actual	Targets	Performance against target
	Q3 2015-16	Q2 2016-17	Q3 2016-17	Q3 2016-17	
Delayed transfers of care (delayed days) from hospital per 100,00 population (per 3 month period)	363	285	315	352.2	

15 Delayed transfers of care (delayed days) at 315 per 100,000 population is better than the target set for Q3 2016-17 of 352.2. Although higher than the Q2 2016-17 figure of 285 it is lower than the same period last year Q3 2015-16 at (363 per 100,000 population)

16 Durham continues to have a significantly lower rate of delayed discharges per population than all comparator groups.

Non Elective Admissions per 100,000 population (per 3 month period)

Indicator	Historical		Actual	Targets	Performance against target
	Q3 2015-16	Q2 2016-17	Q3 2016-17	Q3 2016-17	
Non Elective Admissions per 100,000 population (per 3 month period)	3039	2962	3062	2987	

17 The Q3 outturn figure for non-elective admissions was 3062 per 100,000 population against a target of 2987. Q3 performance has missed the target by a margin of 2.5% and is worse than the same period last year of 3039.

18 It has been recognised that more detailed analysis of the specialties most affected by non-elective admissions is required to further understand performance.

Percentage of carers who are very / extremely satisfied with the support services they receive

Indicator	Historical		Actual	Annual Target	Performance against target
	2012-13	2014-15		2016-17	
Percentage of carers who are very / extremely satisfied with the support services they receive	48.1	54.4	No data available	50.0	

19 Publications of results from the National Carer's Survey undertaken in October 2016 are awaited.

The number of people in receipt of telecare per 100,000 population

Indicator	Historical		Actual	Annual Target	Performance against target
	Q3 2014-15	Q3 2015-16	Q3 2016-17	2016-17	
The number of people in receipt of telecare per 100,000 population	276	422	527	454	

20 The number of people recorded as being in receipt of telecare for Q3 2016-17 was 527 per 100,000 population which has exceeded the target and continues to indicate an upward trend of people accessing and using telecare in Durham.

21 Currently there is no national benchmarking data available in relation to telecare.

22 BCF Planning Guidance and Policy for 2017-19 which is a two year plan has not yet been published.

Recommendations

23 The Health and Wellbeing Board is recommended to:

- Note the contents of this report;
- Agree to receive further updates in relation to BCF quarterly performance.

Contact: Paul Copeland, Strategic Programme Manager, Better Care Fund and Integration
Tel: 03000 265190

Appendix 1: Implications

Finance
The BCF 2016-17 total pooled budget is £44.579m.

Staffing
None

Risk
A risk sharing agreement has been established between partners.

Equality and Diversity / Public Sector Equality Duty
Equality Act 2010 requires the Council to ensure that all decisions are reviews for their potential impact upon people.

Accommodation
None.

Crime and Disorder
None.

Human Rights
None.

Consultation
As required through the Health and Wellbeing Board.

Procurement
None.

Disability Issues
See commentary relating to Equality and Diversity.

Legal Implications
Any legal implications concerning the BCF Programme and projects are considered and reviewed as necessary

Health and Wellbeing Board

16 March 2017

Community Hubs / Teams Around Practices

Report of Lesley Jeavons, Director of Integration, North Durham Clinical Commissioning Group, Durham Dales Easington and Sedgefield Clinical Commissioning Group, Durham County Council

Purpose of the Report

1 To inform the Health and Wellbeing Board of progress with regard to Community Hubs/Teams Around Practices.

Background

2 The Five Year Forward View and the Care Act 2014 outlined the need to design and implement services around individuals and their communities to further enhance pathways and joint service provision across health and social care.

3 Sustainability and Transformation Plans support the development of services outside of acute settings with a view to preventing admissions and facilitating effective discharge.

4 Work is underway regionally to develop a consistent approach to the Better Health Programme and the Neighbourhood and Communities Strategic Overview Group is included within the remit of Integrated Community Hubs. The Health and Wellbeing Board in County Durham commissioned additional scoping work to inform whether our existing integrated services were sufficient and to identify benefits from extending integrated opportunities further. The developments outlined within this report resulted from this scoping work.

5 Engagement and development work undertaken to date has identified that the term “community hubs” is confusing and is not fit for purpose in describing the new model. Chief Officers have agreed therefore that the term “Teams around Practices” should instead be adopted.

6 Many adult health outcome measures within County Durham fall significantly below the national average presenting a challenge to the local health care system. There are a rising number of people with multiple long-term conditions including respiratory, cardiovascular disease and diabetes. Demographic pressures also place emphasis on the need to manage demand for social care more effectively.

7 At present, distribution of spend is very focussed on the acute and there is a need to move away from using existing organisations spend in secondary care as the basis of determining spend patterns in community services. Health and Care organisations need to review how they can redistribute resources appropriately at a community level in response to local population needs to ensure best use of the "public pound". Continuing with current patterns of funding and delivery is not an option.

Overview of the Teams Around Practices Model

8 The model acknowledges that more care should be delivered in a community setting and at home through better integration of provision. This will involve identifying the front line workforce across a number of disciplines to deliver care that supports more complex patients with a greater focus on prevention and independence.

9 These teams will work across a group of practices. Some may have a physical base whilst others will be "wrapped around" existing groups of GP practices. This is in recognition of the need to utilise existing estate and to avoid disruption to members of the public.

10 In County Durham the work to explore the potential for adapting such a model was completed in Summer 2016 with a proposal for 13 hubs (now Teams Around Practices) to be developed on a countywide basis around a typical population of between thirty and fifty thousand with the principle outcomes being:

- Improved primary care access
- Enhancing the preventative offer
- Enhancing independence and wellbeing through risk stratification
- Less presentation at A&E
- Reduction in bed days
- Less people in residential and nursing care

11 A service specification was developed by Finnamore Consultancy however the main framework and detail for the model is being developed with:

- Primary Care and Federations
- North Durham and DDES CCGs
- Durham County Council
- County Durham and Darlington Foundation Trust (CDDFT)
- Tees, Esk and Wear Valleys NHS Trust
- Voluntary Sector

12 It is envisaged that the voluntary sector and informal care will be utilised as part of any solution. This will help promote preventative approaches. Delivery of services will ultimately be delegated to professionals at a local level who will be responsible for ensuring outcomes are met.

13 An important function within the model will be to identify the most vulnerable adults who are a risk of significant deterioration in their health and wellbeing with a resultant admission to acute and/or permanent care settings. This is expected to be the top 2% of those people on GP lists who fall into that high risk group. Services will then focus upon enhancing health and wellbeing through proactive treatment, reablement and rehabilitation.

14 Budgets could be devolved to hub level and work is underway with finance colleagues to ascertain accurate levels of community nursing resource as a starting point for budget alignment.

15 The following illustrations outline the model with increased preventative approaches wrapped around primary care.

Figure 1 Hub/TAP Services

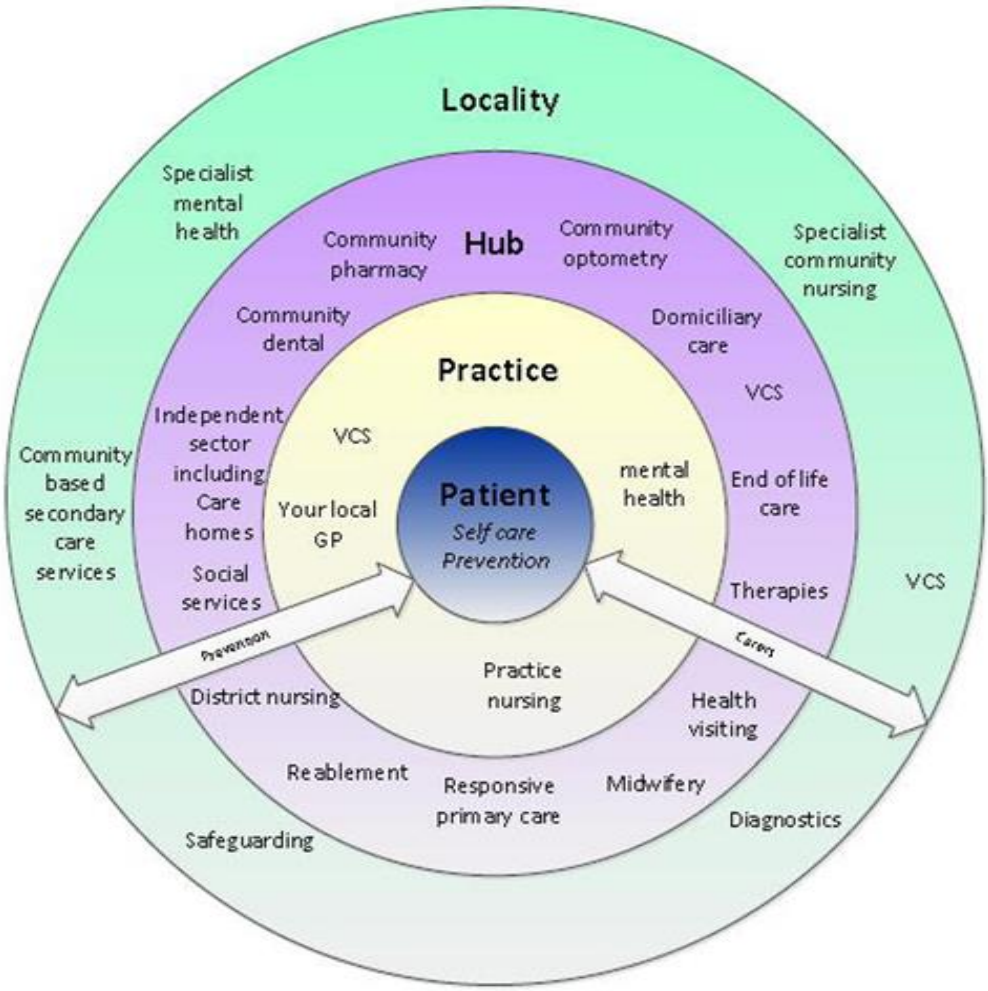
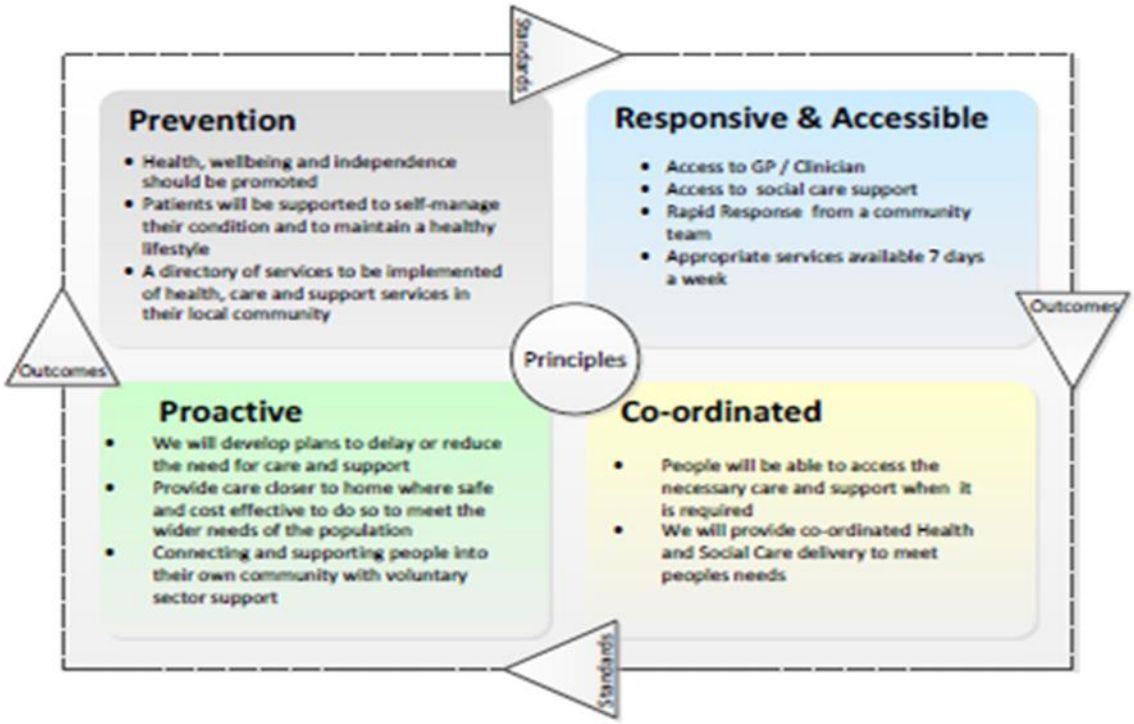


Figure 2 Principles, standards and outcomes associated with TAP delivery



Accountable Care Networks

16 In County Durham an agreement has been reached that the new model of care will progress as part of an Accountable Care Network arrangement.

17 An Accountable Care Network (ACN) is a group of organisations which are not formally enshrined but work as a network to deliver joined up care.

18 Organisations within the ACN will work together to ensure the delivery of efficient, high quality care which meets the needs of the population.

19 The ACN is not a stand-alone organisation. Its work, including progressing opportunities for further integration will be overseen by the Integration Board.

20 A Memorandum of Understanding (MOU) for the ACN will be developed and presented to the Integration Board in April 2017.

21 The Integration Board will update the Health and Wellbeing Board on progress and developments and will also be required to seek support within partners' host organisations through usual governance routes, for agreement to proceed with any new proposals.

Progress to Date

22 In light of the requirement for senior level shared leadership and capacity, Lesley Jeavons has been appointed as Director of Integration. Her role will

require her to work as part of the Chief Officer team to ensure effective leadership and delivery of this agenda.

23 As outlined above a project implementation structure is now in operation and work has been purposeful and effective.

24 Team configurations have been proposed and agreement reached with CDDFT and DCC on staff alignment.

25 Locality briefings are underway and a project and communications and engagement plan is in place. A steering group is overseeing the work and has representation from CCGs, CDDFT, Adult Social Care, GP practices, Federations and the Voluntary Sector.

26 A Communications and Engagement Plan is currently being populated with the use of existing patient engagement forums being the favoured approach.

27 Workstreams have been established and localities are being asked to consider representation to help shape work relating to referrals, work allocation, pathways, risk stratification and performance.

28 A request has been made for early adopters of the model to come forward and several nominations have been received with an expectation they will begin working together by April 2017. It is envisaged that the model will be rolled out fully throughout 17/18.

29 It is particularly important to note there is an intention to engage with all stakeholders during set up and implementation of the proposed model of care. The workforce will be key to supporting the design and rollout of pathways going forward.

30 It is acknowledged that consideration of the existing estate will need to take place to better utilise community buildings within a TAP geography and this is underway currently.

31 Whilst it is understood that challenges exist in relation to delivery of this project the commitment from the NHS and partner agencies across County Durham to further develop integrated provision and commissioning is clear.

32 The commitment was reiterated by Chief Officers at a recent well attended countywide leadership event.

33 Further work will be required to develop staff working within the new model and to encourage new ways of working. This is being considered as part of the project planning process.

34 There is also a need to consider how practices within each grouping interface with each other and establish links to enable work to take place together for the benefit of the local population.

Recommendations and reasons

35 The Health and Wellbeing Board is recommended to:

- Receive this report for information;
- Agree to receive a further update report in three months' time.

Contact: Lesley Jeavons, Director of Integration, North Durham CCG, Durham Dales Easington and Sedgefield CCG, Durham County Council
Tel: 0191 3898618

Appendix 1: Implications

Finance
Existing and future financial challenges facing the NHS, local government and public health, increased demand for health and social care and rising costs of delivering services will make integration health and social care services increasingly difficult. The Better Health Programme framework of care will have to be implemented within current financial resources.

Staffing
A critical element of delivering an integrated model of care will depend upon a suitably trained and skilled workforce.

Risk
Failure to transform and integrate services will result in reputational damage for the Council and its partners. If transformation and system wide reconfiguration is not achieved this will result in services aimed at improving results for patients, life expectancy and quality of life not being delivered efficiently and effectively.

Equality and Diversity / Public Sector Equality Duty
Equality Impact Assessments are carried out as part of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

Accommodation
No direct implications.

Crime and Disorder
No direct implications.

Human Rights
No direct implications.

Consultation
Proposals for integration would be the subject of consultation with stakeholders.

Procurement
No direct implications.

Disability Issues
No implications at this stage.

Legal Implications
There are a number of key legislative and policy developments/initiatives that have led the way and contributed to Adult Care Transformation and further integration with Health and Social Care Services. All changes must be compliant with legal requirements

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Health and Wellbeing Board

16 March 2017

Prioritising Prevention

Report of Gill O'Neill, Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council

Purpose of the Report

1 The purpose of this report is to inform the Health and Wellbeing Board of the forthcoming presentation on prioritising prevention. Gill O'Neill, Interim Director of Public Health County Durham will deliver a presentation on prioritising prevention at the meeting of the Health and Wellbeing Board on 16 March 2017.

Background

2 The presentation will outline the regional context for prioritising prevention and how we can build on current successes to inform how we can work more effectively in the future.

Recommendations

3 The Health and Wellbeing Board is recommended to:

- Note and discuss the forthcoming presentation at the HWB meeting 16 March 2017.

Contact: **Gill O'Neill, Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council**
Tel **03000 267696**

Appendix 1 – Implications

Finance
There will be issues about the potential future use of resources to support a strategic long term vision for prevention and wellbeing in the context of pressures on adult social care the National Health Service (NHS).

Staffing
There will be potential future workforce issues around new ways of working and a multi-disciplinary team approach.

Risk
Risks are related to reducing health inequalities, pressure on services, the ageing population and the future use of resources

Equality and Diversity / Public Sector Equality Duty
None

Accommodation
None

Crime and Disorder
None

Human Rights
None

Consultation
None

Procurement

None

Disability Issues
N/A at this time

Legal Implications
N/A at this time

Health and Wellbeing Board

16 March 2017

Preventative Mental Health Review and Recommissioning Update Report

Report of Denise Elliott, Interim Head of Commissioning, Adult and Health Services, Durham County Council

Purpose of the Report

1 This report provides an overview of mental health promotion and prevention commissioning intentions for 2016/17 and 2017/18 in the context of the strategic review of community preventative mental health and wellbeing services, which was jointly undertaken by Public Health and Commissioning Services.

Background

2 The joint review work and the development of an overarching mental health promotion, prevention and wellbeing model has involved extensive stakeholder engagement undertaken by the Mental Health Project Board, which is jointly led by Public Health and Commissioning Services in partnership with Clinical Commissioning Groups (CCGs) and reports to the County Durham Mental Health Partnership Board.

3 Appendix 1 summarises the key implications of the project. Appendix 2 is a diagrammatic representation of the overarching mental health promotion and prevention wellbeing model.

4 Key elements of the agreed new model are:

- A life course approach: 'Starting Well', 'Developing Well', 'Living Well', 'Working Well' and 'Ageing Well'[1];
- Outcomes related to promotion, prevention, early intervention and recovery;
- A countywide model with a combination of identified bases and outreach to deliver equitable access to help and advice, which is complemented by signposting and support along pathways to other services;
- Improved, more effective links with other workstreams e.g. Think Family, Early Help, Resilience, Dementia and Dual needs.[2]

5 The main objectives of the new model are to promote the mental health and wellbeing of the local population; address the wider determinants of mental

[1] Joint Commissioning Panel for Mental Health (2015) Guidance for Commissioning Public Mental Health Services

[2] 'Dual needs' refers to individuals with substance misuse issues (drugs and/or alcohol) as well as experiencing one or more of the following: mental and behavioural disorders; dementia; learning disability.

health and promote positive outcomes related to good mental health and wellbeing. The model aligns with the Government's *Five Year Forward View for Mental Health*[3] and *Future in Mind*[4] in that it prioritises prevention, access, integration and a positive experience of care. It also takes into account the statutory requirements of some elements of the Care Act 2014.

6 The new model considers the links with wider mental health and public health programmes and mainstream services and activities, aiming to improve service delivery and value for money while ensuring services and opportunities are accessible to anyone needing mental health and wellbeing support.

7 Following agreement of the model, further progress has been made by the project board to develop proposals for future delivery of preventative mental health services and make decisions on existing contracts commissioned through Public Health and Adult and Health Services (AHS).

8 The project board undertook work on the following areas to help shape the future commissioning intentions (some of the work is ongoing):

- Mapping current service provision and identifying areas for development against the proposed model;
- Identification of outcomes required from the new service model and to shape service specifications;
- Exploring current and potential care and support pathways;
- Engagement with key stakeholders on the proposed model and priorities for the future;
- Development and use of a prioritisation tool to help make decisions on the future of current commissioned services.

9 This report provides a summary of the proposed high level commissioning intentions, including a suggested framework for service delivery and expected outcomes.

Mental health promotion, prevention and wellbeing delivery framework

10 Appendix 3 provides an overview of how mental health promotion and prevention services could be delivered in the future; it also shows how services relate to each other and the different referral pathways.

11 Key points are:

- The development of a wider network of support, including peer support, which deliver a range of activities and opportunities that together improve outcomes to promote mental health and wellbeing, prevent mental ill-health and offer early intervention and recovery for mental health problems. This includes tackling stigma and discrimination and developing

[3] Mental Health Taskforce (2016) Five Year Forward View for Mental Health

[4] Department of Health (2015) Future In Mind: Promoting, Protecting and Improving our children and young people's mental health and wellbeing

effective services with people affected by mental health issues (co-production).

- Promotion of the five ways to wellbeing[5]:
  - Connecting with other people;
  - Being physically active;
  - Taking notice of the environment and what's going on around you;
  - Continued learning;
  - Giving and participating in community life:

- Improved access to support through an online gateway linked to wellbeing centres and other points of access for example entry points to specialist services including crisis services and the community hub model being developed by the CCGs. It is proposed that the Wellbeing for Life (WBfL) service, incorporating social prescribing, is at the centre of the new model to improve access and opportunities for mental health and wellbeing support in the community. A signposting and navigation function would be included.

- The role of First Contact/One point in helping children, young people and families to access and receive mental health and wellbeing support and the need to have effective links with the adult elements of the model as well as support provided in education settings.

- This brings together a variety of services commissioned by Public Health, AHS, Children and Young People's Services and CCGs as well as the wider network of services that exist in the community.

12 The proposals were endorsed by the County Durham Mental Health Partnership Board on 12 January 2017. The consensus is that the mental health promotion, prevention and wellbeing model fits with the single "whole system" mental health strategy that the Mental Health Partnership Board is developing for County Durham. This will encompass the whole life span and include actions across the promotion, prevention, early intervention, treatment and recovery spectrum.

13 The proposals are also in line with changes currently being made within the County Council's Transformation Agenda to consider a range of preventative and non-assessed service options for the future. Focused effort is being made to remove the barriers between services and departments, improve and strengthen partnership working and further integrate care and health services, as well as to provide more detailed information in order to enable members of the public to make informed choices about what services they need to access.

[5] http://www.mind.org.uk/workplace/mental-health-at-work/taking-care-of-yourself/five-ways-to-wellbeing/

Outcomes

14 The expected high level outcomes associated with the mental health promotion, prevention and wellbeing model, which apply across the life course, are increased quality of life, improved mental and physical wellbeing, reduced prevalence and impact of mental illness and a reduction in the number of suicides.

15 There are a number of intermediate outcomes, which are the building blocks for the higher level outcomes. These will be supported by the following outcomes related to improved service delivery:

- More people will develop a knowledge and understanding of their own mental health and a range of skills, including resilience to face difficulties, which foster positive mental health and wellbeing at an individual/family/ community level;
- Earlier identification and access to timely and appropriate advice, guidance and support for people affected by mental health issues and the wider determinants of mental health;
- More people have a positive experience of support and are able to exercise choice and control over the personalised recovery-focused care and support they access.

Commissioning intentions for 2017/18 and 2017/18

16 As part of the longer term commissioning plans, decisions are needed on a number of Public Health and AHS contracts included in the scope of the review, some of which are due to expire on 31 March 2017.

17 These decisions will be based on the findings from the review and the rationale outlined in the previous report; the life course approach to mental health and wellbeing with associated outcomes; the service mapping exercise and the prioritisation exercise. The overall financial envelope, in relation to Medium Term Financial Plan (MTFP) savings, will need to be clarified before final decisions are made on current contracts and recommissioning as part of the new mental health promotion, prevention and wellbeing model.

Public Health Commissioning Intentions

18 Public Health will integrate Wellbeing for Life (WBfL) with social prescribing through service redesign and reprocurement by November 2017 taking into consideration the community hub model being developed by the CCGs. Public Health will work with Commissioning Services on the phased implementation of the new model in 2017/18 and beyond.

19 The majority of the mental health contracts commissioned by Public Health will be offered an extension until 31 October 2017 to allow more time for decision-making and planning.

20 In addition there will be two new services commissioned in 2016/17, which will continue in 2017/18. The *Future in Mind*[6] Transformation Plan Investment funding made available from CCGs through Section 256 will be used to commission a children and young people's bereavement service and a parental peer support service to support the *County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan (2015-2020).* It is not known if there will be a need or available funding to continue these contracts beyond the first year and they will be reviewed early in 2017/18 as part of the development of the new mental health promotion, prevention, and wellbeing model.

Adults Commissioning Intentions

21 The commissioning intentions of partner organisations are currently being reviewed to ensure they align.

Children and Young People's Mental Health and Wellbeing

22 The mental health promotion, prevention and wellbeing project supports and links with the *County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan*, which is aligned to the overall County Durham mental health strategy. The aims of the plan are to improve access and standards of children and young people's mental health services; promote positive mental health and wellbeing and work towards greater system coordination to meet children and young people's needs.

23 In addition to the young people's Crees and the children and young people's bereavement support and parental support commissioned through Public Health, there are a number of Durham County Council (DCC) Public Health/Children's Services/Education initiatives outside of the scope of the mental health promotion and prevention project that relate to the mental health and wellbeing of children and young people. These include the following:

- Solihul approach (parenting skills) for the under 5 age group;
- Strengthening the antenatal pathway and early response for vulnerable children and families including attachment issues;
- As part of the 0-19 specification, the 0-5 Healthy Child Programme and the five emotional wellbeing and resilience nurses embedded in the 5-19 School Nursing Service based in DCC premises;
- Resilience programme for 75 schools in County Durham based on 25 per year target;
- Youth Aware Mental Health (YAM) programme to be rolled out in early adopter schools from January 2017. 15 individuals have been trained in early November in order to become YAM instructors. The programme will be evaluated through collaboration between Teesside University and DCC. Elsewhere, the programme has shown a clear association with

[6] DoH/NHS England (2015) *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*.

reduced levels of suicide attempts and severe suicidal ideation among young people;
- Mental Health and Emotional Health and Wellbeing Support, including therapeutic interventions and professionals based within or linked to education establishments;
- Early help, advice and support provided by the One Point service, which is accessed through First Contact and is part of wider mental health provision that includes Education, Primary Mental Health Care and Children and Adolescent Mental Health Services (CAMHS) e.g. through 'Team Around the Family' and 'Team Around the School'.

24 There will be a continued focus by the different partners on strengthening the work to support schools in delivering the resilience and YAM programmes; improving capacity in schools and pathways between services (including vulnerable young people) and describing a standardised, evidence-based offer for mental health and wellbeing programmes and support in education settings. The objectives will be to improve value for money, avoid duplication and address gaps in provision, whether by geography, age group or protected characteristics.

Implementation of the mental health prevention model

25 Successful transition to new ways of working will need a coordinated focus on workforce development, cultural change and appropriate training as well as clear information, awareness raising and effective interagency protocols.

26 Co-production and a think family approach will be vital to implementing the new model and achieving the overall vision of improving the mental health and wellbeing of the local population.

27 Implementation of the new mental health promotion, prevention and wellbeing model will take place within the current work to refresh the mental health strategy, governance and work streams.

Next Steps

28 The Mental Health Project Board will establish several workstreams and develop detailed project plans to manage a phased implementation of the new model. This will involve the relevant stakeholders through the established engagement mechanisms. The workstreams are:

1) **Commissioning and Finance** - to progress the commissioning intentions and finance decisions; develop outcomes and specifications; explore systems and processes to support future service delivery (hubs/pathways etc.)

2) **Reprocurement and decommissioning** - to manage the processes for reprocurement and decommissioning, taking into account TUPE (Transfer of Undertakings (Protection of Employment) Regulations 2006) implications, risks, equality impact, consultation, governance and communication.

3) **Workforce development and culture change** – linking to wider mental workforce planning in partnership with CCGs and Tees, Esk and Wear NHS Foundation Trust (with a focus on capacity and skills, training and development, joint working, IT and information sharing).

29 An application to extend relevant contracts to October 2017 is in the process of being submitted to Corporate Procurement. Once approved, providers will be formally notified of their revised contract end dates and will be informed of longer term plans.

30 A communication plan will ensure management teams and stakeholders are kept informed of plans as they progress; any significant changes and decommissioning will require equality impact assessments to be updated; risks and communication will be managed through the mental health project board.

Recommendations

31 The Health and Wellbeing Board is requested to:

- Note the contents of the report and endorse the proposed service delivery model and framework for future mental health promotion, prevention and wellbeing services, which will influence Public Health and Adults commissioning intentions in 2016/17 and 2017/18;
- Note the further work required to confirm the financial envelope; develop the model into detailed specifications for service redesign and/or reprocurement in 2017/18; and develop workforce skills, culture change, clear pathways and data sharing agreements;
- Receive a further report in due course outlining progress and key implementation stages.

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Appendix 1: Implications

Finance
Current budgets will be subject to savings.

Staffing
Decommissioned services may impact on provider staffing. Providers will be kept informed and given sufficient notice of contract extensions and future. decommissions

Equality and Diversity / Public Sector Equality Duty
An Equality Impact Assessment initial screening has been completed for this review and will be updated if there are significant changes.

Accommodation
No impact

Crime and Disorder
No impact

Human Rights
No impact

Consultation
Consultation/engagement process followed with providers, elected members and other stakeholders; a communication and engagement plan has been developed.

Procurement
Procurement exercise will follow agreement of model and commissioning options.

Disability Issues
Included in Equality Impact Assessment – no impact

Legal Implications
No impact

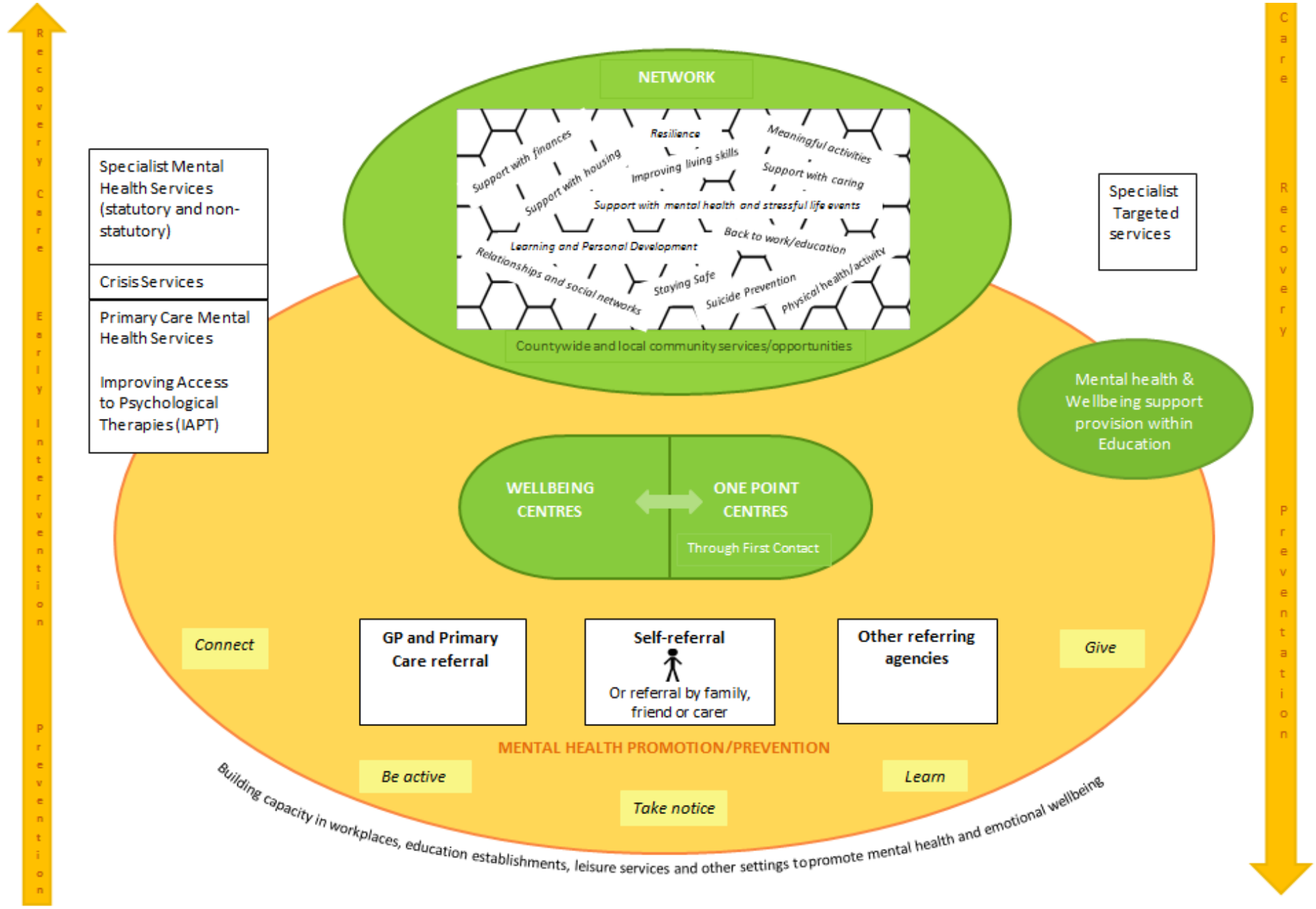
Appendix 2 - Mental Health Promotion, Prevention and Wellbeing Model

PEOPLE Life Course	Starting Well	Developing Well	Living well	Working Well	Ageing Well
Care and Recovery Reduce complications of mental health problems, support recovery and prevent/reduce risk of recurrence	Care and recovery from maternal mental illness, including specialist/ community services, early discharge planning, crisis support, carer support, self-help and peer support.	Care, recovery and social inclusion for children and young people with mental health problems including specialist/ community services, early discharge planning, crisis support , parent/carer support, self-help and peer support.	Care, recovery and social inclusion for people with mental health problems including specialist/ community services early discharge planning, crisis support, carer support, self-help and peer support; help to be independent and have a good quality of life until the end of life.	Recovery and support for people with mental health problems to find and retain suitable employment and to maintain positive mental health at work – support at work alongside specialist/community services.	Care, recovery and social inclusion for older people with mental health problems/dementia including specialist/community services, early discharge planning, crisis support, carer support; self-help and peer support; help to be independent as possible and have a good quality of life until the end of life.
Early Intervention Detect signs of mental health problems early and seek timely help, intervention and treatment, involving targeted approaches to groups at higher risk of poor mental health and wellbeing	Early detection/ intervention for maternal mental illness, parental mental health problems and for children with emerging mental health problems; plus early help to cope with relationship problems, financial worries and difficult life events e.g. bereavement, loss, separation, abuse and trauma- accessed through primary care/family services	Early detection /interventions for children and young people with emerging mental health problems; including early help to cope with relationship/, financial worries, bereavement, loss, separation, bullying, abuse and trauma- accessed through schools, primary care and other community services	Early detection/ interventions for people with emerging mental health problems and their carers; plus early help to cope with relationship/ financial worries and difficult life events e.g. bereavement, loss, separation, abuse and trauma- accessed through primary care and other community services	Early detection/ interventions for people with emerging mental health problems; plus early help to cope with difficult life events such as relationship/financial worries, bereavement , loss and redundancy; support at work and access to primary care and other community services	Early detection/ interventions for older people with the onset of dementia or emerging mental health problems and their carers; plus early help for relationship/ financial worries, bereavement, loss, isolation, abuse and trauma -accessed through primary care and other community services
Promotion/ Prevention Prevent mental health problems happening in the first place by addressing the wider determinants and promoting health and wellbeing at an individual, community or structural level	Mental health promotion and preventative interventions within families and communities that aim to give new-born and young children a good start in life including support to parents before, during and after birth and interventions aimed at the child; to help develop resilience, mutual support, good mental and physical wellbeing, prevent mental disorder and reduce stigma/discrimination.	Mental health promotion and preventative interventions/ activities in families, schools and communities to help children and young people develop resilience, mutual support, good mental and physical wellbeing and prevent mental disorder, e.g. whole school and targeted approaches as well as awareness and reducing stigma/ discrimination.	Mental health promotion and preventative interventions/activities within homes, communities and care settings to help people of all ages develop resilience, mutual support, good mental and physical wellbeing; prevent mental disorder and reduce stigma/discrimination.	Mental health promotion and preventative interventions/activities within the workplace to help develop resilience, mutual support, good mental and physical wellbeing; prevent mental disorder and reduce stigma/ discrimination.	Mental health promotion and preventative interventions/activities within homes, communities and care settings to help older people and their carers develop resilience, mutual support, good mental and physical wellbeing, quality of life; prevent mental disorder and reduce stigma/discrimination.

PLACES

Access and delivery points, including signposting and navigation to other preventative, early intervention or specialist services (PATHWAYS)

Appendix 3 – Mental Health Promotion, Prevention and Wellbeing Delivery Model and Framework for Future Services



Health and Wellbeing Board

16 March 2017

Dementia Work Across County Durham

Joint Report of Dr David Smart, Chair, North Durham Clinical Commissioning Group, and Denise Elliott, Interim Head of Commissioning, Adult and Health Services, Durham County Council

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Board with a progress report on the implementation of the County Durham and Darlington Dementia Strategy 2014-2017, focusing on the following areas:

- Identifying achievements and progress to date;
- Highlighting areas of the strategy that are yet to be implemented for 2017-2020;
- Outlining the key improvement areas to focus upon in order to refresh the strategy and continue to improve services for people with dementia, their families, and carers.

Background

2 The County Durham and Darlington Dementia Strategy 2014-2017 was launched in August 2014. Since its inception and with wide representation across partners, the group has been able to maximise the opportunities to help meet National Dementia Strategy objectives. Engagement of key stakeholders has enabled the County Durham and Darlington Dementia Strategy Implementation Group (DSIG) to ensure that relevant organisations work in partnership for the mutual benefit of people with dementia and the people who support and care for them. Furthermore exchanges of information have enabled group members to contribute to other areas of improvement.

3 A range of specific work streams were identified in order to help take the Strategy forward from 2014-2017, these comprised of:

- GP Practices
- Single point of Information
- Community Initiatives
- Training
- Acute
- Health Needs Assessment (HNA)
- Research

Identification of priority areas in the Strategy

4 The strategy is an extensive document and contains over 160 references to actions, many of which are repeated and used in differing action areas throughout the text.

5 In order to assess implementation progress it is necessary to summarise the key actions identified in the strategy.

Priorities that were identified:

Prevention

- Look at ways to make more people aware of what they can do to prevent dementia.

Training

- Deliver dementia training more widely to all key staff including GPs and frontline staff;
- Plan to standardise care home dementia awareness training.

Single Point of Information

- Develop a single point of knowledge/ information, such as a directory, that holds up to date information on all services, so people with dementia and their carers can have better control over their care throughout all stages of their dementia. This information will be used by clinicians and commissioners to help signpost a wide range of service to people with dementia.

End of Life/Palliative Care for People with Dementia.

- Better links between the End of Life and Dementia Strategies;
- Implement plans for dementia support to be a part of end of life pathways and planning ahead by the person with dementia, so every person is treated with dignity and respect;
- Standardised pathway for decisions on End of Life within all teams.

Dementia Friendly Communities

- Support communities in Durham and Darlington to enter the accreditation process and become recognised as dementia friendly, with the aim of communities retaining accreditation across Durham and Darlington.

Health Needs Assessment

- Carry out a Dementia HNA so that we have a better understanding of the needs of people with dementia in the region, and engage with various groups to obtain their views.

Capacity to meet diagnosis needs

- Strategically plan and communicate as to how we will meet the increasing demand in the number of people with dementia who need screening and access to diagnostic services.

Waiting Time and Antipsychotics auditing

- Work with providers to monitor and review waiting times for tests and results, and agree on improving targets and bringing uniformity in waiting times across the areas covered;
- Explore how we can audit the prescribing of antipsychotics with appropriate resources.

Research

- Review literature and examples of good practice to identify suitable initiatives for development which we will jointly invest in with the aim of reducing the need for people with dementia to stay in hospitals for longer than necessary and to reduce the likelihood of them dying in hospital.

Monitor and Improve Diagnosis Rates

- Review activity data connected to the Dementia Direct Enhanced Service;
- Support practices that have not yet signed up to the Dementia Enhanced service or have a low uptake and share the best practice;
- Nominate a Dementia Clinical Lead in each GP practice;
- Take steps to continue the emphasis on screening for and diagnosis of dementia by GPs.

Black, Asian and Minority Ethnic Groups (BAME)

- Explore options for establishing a user led group or consultancy that will engage directly with the range of BAME groups to scope their needs, gaps and priorities for improving support for people with dementia, which the strategy group will consider implementing.

Develop Dementia Admission and Readmission Avoidance Services

- Share examples of good practice across the county where people with dementia are being discharged from hospital faster, and learn from those case studies;
- 'Deep dive' into readmission data to obtain a wider understanding of possible reasons, differences in conditions that require readmission for a patient with dementia, between the Clinical Commissioning Group (CCG) areas, and take any necessary action to address those differences.

Learning Disabilities and Dementia

- Promote greater awareness to primary care services, of issues around the diagnosis of dementia of people with learning disabilities;
- Explore appropriateness of existing pathways to memory clinics and strengthen the interface between primary and secondary care services for people with learning disabilities.

Young Onset Dementia

- Review the services for Young Onset Dementia (YOD) and consider actions to address gaps in provision and resources. The CCG's decided not to commission YOD services and therefore Tees, Esk, Wear Valley NHS Foundation Trust (TEWV) were asked to deliver these services from within their existing resource.

Prisoners with Dementia

- There is a pressing need to consider how to manage the health/social care interface and meet the needs of prisoners and others with social care needs (linking in with Public Health and NHS England).

Carer and Post Diagnosis Support

- The DSIG will appoint a carer representative on to the group. The group will identify what improvements to supporting people with dementia and carers can be made. DSIG will consider improvements to the wider sharing of appropriate information, with a view to using tools such as patient passports to enable improvements to the implementation of care packages and referrals.

Achievements and Service Improvements (August 2014 – January 2017)

6 Achievements and service improvements for the period August 2014 – January 2017 were identified as follows:

- **Dementia Advisor Service** – commissioned by Durham County Council in February 2016 and funded by the Local Authority until February 2018. Future funding is yet to be identified. The Alzheimers Society was successful in securing the contract.

  The Dementia Adviser Service offers pre and post diagnosis support, advice and information to people living with memory problems/dementia, their families, and carers.

  There are five Dementia Advisors covering the geographical area of County Durham. Since February 2016, over 800 referrals have been made to the service, which include referrals from GPs, Social Care, community psychiatric nurses, self-referrals etc. Referral pathways have also been established with Durham County Carers Support and County Durham and Darlington Fire and Rescue Service (CDDFRS).

  Durham County Council, have also funded a further £45k for the remaining of the contract so the Alzheimers Society can employ two Dementia Support Workers to work across the County, working with those identified by dementia advisors as needing additional and / or more long-term support.

- **Dementia Diagnosis Rates –** have continued to improve with all CCGs in County Durham successfully exceeding the national target of 67.5%. Information and guidance on how to improve dementia diagnosis rates is sent out to GPs on a monthly basis by CCG commissioning colleagues. Data available on Dementia Diagnosis Rates collected for the period August 2015 – January 2017 is attached at Appendix 2.

- **Waiting times / Access to Secondary Care Diagnosis Services -** regular meetings are now taking place between senior management in TEWV and Dr Khin Nini, Dementia Clinical Lead from the County Durham and Darlington NHS Foundation Trust (CDDFT) in order to track actions around access to diagnostic scans.

- **Single Point of Information** – Dementia Connect has been established as the main web based dementia information site. The site has been populated with comprehensive and up to date information on dementia services and resources. Advice and guidance has been sent out to relevant organisations to publicise the website (including GP systems) and to enable them to delete /add services as appropriate.

- **Carer views and involvement** – have continued to be promoted and recognised in a number of ways in shaping the implementation of the strategy. There is carer representation on DSIG and carer views and input have been central, for example, to the development of the integrated dementia pathway, the work of the Community Initiatives Work Stream and the Dementia HNA in County Durham. More specifically, a policy document on carer support developed by local carers has been supported by the DSIG in setting an overall framework and context on carer issues and is being used to inform the development of the Integrated Dementia Pathway and to identify service and support gaps.

- **Integrated Dementia Pathway/Service Mapping** – commissioning colleagues from County Durham and Darlington have worked with partners on the development of an Integrated Dementia Pathway with particular emphasis on improving information and support for people with dementia, their families and carers. This will be included as an integral part of the strategy.

- **Dementia Action Alliances** – have been set up in County Durham and Darlington. A key role of the Dementia Action Alliances is to create dementia friendly communities and develop associated activities.

- **Dementia Friendly Communities** - have been established at Spennymoor, Bishop Auckland and Stanley. Progress in establishing Dementia Friendly Communities is being made at Barnard Castle, Chester le Street, Trimdon and Evenwood. A gentleman who has dementia, was the driving force behind the campaign to make Evenwood dementia friendly, and also secured funding to run a dementia café for a year. He received an ‘Inspiring Individual’ award at the Alzheimer’s

Society's 2016 Dementia Friendly Awards in London. Dalton Park Retail Centre in Murton is becoming 'dementia friendly'. The Centre has agreed to use appropriate signage in new retail units and the cinema will work more 'dementia friendly'. All staff will also complete 'Dementia Friends' training.

- **Orchard Cottage Beamish** – weekly activity sessions are run for people with dementia and their carers from a 1940's themed cottage at Beamish Museum. Adult and Health Services commissioning worked with Beamish on development of the cottage and have also helped Beamish Museum secure funding from Public Health for a men's CREE.

- **Dementia Friendly Transport** – British Transport Police have promoted dementia friendly rail travel at Darlington and Durham train stations. Arriva buses in Darlington are all displaying coin recognition charts to assist customers who may struggle to understand their coins.

- **Safe and Wellbeing Visits** - as part of these new visits, County Durham and Darlington Fire and Rescue Service fire crews have been trained to identify those living with dementia and are able to provide practical help and referral to the dementia advisor service where appropriate.

- **Dementia Friends/Dementia Champions Training** – over the past two years some 7,000 Dementia Friends and 200 Dementia Champions have been trained in Darlington and Durham.

- **Dementia Awareness Training** – is currently being delivered to primary care staff in Darlington, North Durham (ND) and Durham Dales, Easington, Sedgefield (DDES) CCG areas. Dementia awareness sessions have also been provided to CDDFT staff and to a range of organisations in County Durham and Darlington. ND CCG Protected Learning Time (PLT) sessions will be held in May 2017. DDES CCG PLT sessions were held in early 2016. Dates in Darlington are to be agreed.

  The Dementia Advisors have developed close links with the Prisons in County Durham, including the recruitment of 'Dementia Friends' among staff and inmates – e.g. 129 inmates and seven staff members at Frankland Prison are now Dementia Friends. Frankland Prison is a member of the Dementia Action Alliance and have committed to ensuring they will work closer with the Dementia Advisor Service.

  There has been successful recruitment of students and staff from County Durham schools as Dementia Friends, e.g. Framwellgate Moor School sixth formers and a group of 19 Head Teachers in the Durham Dales area. The Dementia Advisors are at present supporting approximately 29 veterans and work is progressing on the possibility of a dementia café being set up for veterans in County Durham. Work is progressing with colleagues in the Alzheimers Society and the Local Authority on making Durham County Council a dementia friendly council. An action plan has

been developed with our marketing colleagues, including dementia friends training for over 2,000 taxi drivers.

- **Dementia Hub Darlington** – has been established in Crown Street Library and provides a one stop shop for information, advice and referral to services for people with dementia, their families and carers.

- **Community Pastimes Service** – is now being delivered in County Durham by the Hospital of God and aims to support people to live well with dementia through providing 1:1 support to reduce social isolation and improve access to community facilities and activities.

- **Outcomes Based Commissioning** - Durham County Council are working with Hospital of God on a pilot with service users and staff based in the Easington Locality around outcomes based commissioning for service users with dementia. This will enable the Hospital of God to develop service arrangements that are defined on the basis of an agreed set of outcomes either for an individual or a group of people.

- **Side by Side Service** – has been established in County Durham by the Alzheimer's Society to help people with dementia to continue to live independently and remain active members of their local community.

- **Dementia Friendly Swimming** – this initiative is run in conjunction with Durham County Council leisure colleagues and the Amateur Swimming Association. Sessions are now being delivered in Chester-Le-Street, Barnard Castle and Durham City where trained staff and volunteers support people to continue to enjoy swimming as part of an active lifestyle. The Dementia Friendly Swimming Pilot is a phased programme over three years.

- **Singing for the Brain** – sessions provided by the Alzheimer's Society are now taking place in Darlington, Chester-le- Street, Spennymoor, and Barnard Castle.

- **Games for the Brain** – sessions provided by the Alzheimer's Society are being delivered in County Durham at Brandon, Spennymoor, and Teesdale.

- **Dementia Housing Options** – work has commenced and is ongoing to assess options and develop an agreed dementia housing model including telecare options for County Durham. Extra care housing is not an issue in Darlington.

- **Dementia Commissioning for Quality and Innovation (CQUIN)** - has been agreed with CDDFT to improve dementia friendly environments in their hospitals including initiatives such as dementia friendly signage, adapted crockery, appropriate menus, and installing large face clocks.

- **BAME groups** – Healthwatch are scheduled to do some general engagement work around BAME and dementia. Community Connectors have developed links with the Alzheimer's Society and are able to offer support to individuals.

- **Dementia Health Needs Assessment (HNA)** - The HNA has taken a new direction and Durham County Council are transforming the HNA into a more succinct Integrated Needs Assessment which will be available on the County Durham Partnership website as an Integrated Needs Assessment Factsheet.

- **Improving Value in Dementia Care (a co-design approach)** – a five year study involving commissioners, North of England Commissioning Support (NECS), local stakeholders and staff from Oxford University, London School of Economics and Bradford University, commissioned by CCGs in County Durham, has commenced. The aim of the study is to develop practical strategies that will improve care for those living with dementia and those who support them without increasing costs. This is also known as the STAR approach (Staff Training in Assisted living Residences). Richard Glover from NECS Service Planning and Reform team has lead on this piece of work.

- **Inpatient services** - The inpatient services for people with dementia related needs went through a comprehensive consultation process which culminated in the provision of two 30 bed, purpose designed wards, at Auckland Park Hospital.

- **General Dementia Awareness Raising** – events such as Dementia Awareness Week and primary care protected learning time sessions have been used to promote dementia awareness in the general public and professionals and to help reduce stigma and discrimination. Darlington Dementia Action Alliance produces a newsletter and a Carers Rights Day Event for employers was held in Darlington. Healthwatch Darlington and Healthwatch County Durham have also played a key role in dementia awareness raising and providing information to local communities whilst also obtaining views from local communities on dementia.

- **Engagement with appropriate groups** – in order to ensure that the needs and requirements of people with dementia, their families, and carers are taken into account, representation has been secured on groups such as the End of Life Group, County Durham Mental Health Stigma and Discrimination Group, Improving Physical Health of People with Mental Health Group, and the Mental Health Prevention Project Board. In particular links have been improved in respect of dementia issues and the Mental Health Crisis Care Concordat Group.

- **Reporting arrangements** – update reports on the implementation of the Dementia Strategy are provided on a monthly basis to all three CCGs in County Durham and Darlington. Walk the Wall updates have been

delivered to CCG commissioning colleagues and presentations on dementia strategy implementation have also been given by members of the DSIG to various groups such as the Darlington Borough Council Dementia Review Group (Adult and Housing Scrutiny Committee) and management groups within Durham County Council.

- **Governance** – the DSIG group is part of the Mental Health Governance Structure for County Durham. Dementia issues from the DSIG will be governed by the Mental Health work streams groups and reported to the Mental Health Partnership Board in County Durham

Overall Assessment of the Strategy Implementation Group Work

7 As outlined above, there has been significant progress in implementing the County Durham and Darlington Dementia Strategy such as the development of dementia friendly communities/dementia friends training and a wide range of associated community initiatives and services.

8 Systems are now in place to update and engage GPs in respect of improving dementia diagnosis rates and providing them information on key actions they can take to increase dementia diagnosis rates.

9 A single point of information on local dementia services, support and general information is now available through Dementia Connect and the Darlington Dementia Hub.

10 Post diagnosis support has been strengthened (in addition to dementia friendly community developments) through the introduction of the Dementia Advisor Service.

11 Dementia awareness training has taken place both in County Durham and Darlington NHS Foundation Trust, primary care and the wider community.

12 The development of the Integrated Pathway and the related service mapping provides an invaluable template for further work to identify areas for service and support improvement, key points for provision of appropriate information to people with dementia, their carers and families.

13 The Community Initiatives Work Stream has been the main focus of activity that has been feeding into the DSIG and has ensured carer involvement in more detailed service improvement initiatives.

14 DSIG has continued to meet on a regular basis and has maintained the active involvement of key stakeholders, including carer representation in the implementation process.

15 DSIG has also provided a forum for the exchange of information between key stakeholders and improved coordination and communication between organisations who deliver dementia care. The group has also fielded representatives to raise issues of dementia in other groups and meetings.

16 There is however a number of areas of the strategy that have not been addressed as fully as other areas, or which require further implementation:

- Clinical Lead – there is no identified Clinical Lead for dementia in two of the CCGs in County Durham. Dr Chandra Anand has been appointed as the Clinical Lead in North Durham for Mental Health and has stated that she will provide overall GP Clinical Guidance for DSIG. There is still a clinical lead gap at DDES CCG and Darlington CCG;
- BAME and Lesbian, Gay, Bisexual, and Transgender (LGBT) communities and dementia, identification of work;
- Research;
- Monitoring of anti-psychotics;
- People with learning difficulties and dementia;
- Prisoners with dementia;
- Admission and readmission avoidance services;
- Improve links with End of Life Strategy and Pathway;
- HNA – needs to be finalised and have Public Health sign off.

17 Furthermore a number of commissioning intentions for 2016/17 that were developed through the DSIG were not supported by the CCGs'.

Recommendations for Future Work

18 In addition to addressing the previously identified areas of the strategy that require more attention, the recommended action across the 'Dementia Journey' are highlighted as follows:

- Strategic Context / Integrated Pathway:
  - Development of the County Durham and Darlington Dementia Strategy 2018- 2020 Plan on a Page to support the overall Mental Health Strategy;
  - Development of strategic documents to support the Dementia Strategy Plan on a Page;
  - Identify and develop work streams to support the action plans and strategic Plan on a Page;
  - Identify the service and support gaps arising from the work associated with the production of the Integrated Dementia Pathway for County Durham and Darlington and agree how best to address the gaps in services and support and the provision of information to people with dementia as well as their carers and families;
  - Continue to work in close association with the Co-Design five year County Durham Dementia Research Project;
  - Identify clinical leads for dementia in CCGs and practices.

- Preventing Well:
  - Public Health in both County Durham and Darlington to organise more local campaigns to raise public and professional awareness of dementia and risk factors;
  - Increase awareness and focus on preventative services in partnership for people from BAME and LGBT communities. Healthwatch were leading on this but since the group have been informed that Dementia is now not a priority for Healthwatch;
  - Increase dementia awareness among young people.

- Diagnosing Well:
  - Continue to support measures aimed at improving dementia diagnosis rates;
  - Ensure performance monitoring mechanisms are in place to improve the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face to face review in the preceding 12 months.

- Living/Caring Well:
  - Monitor and evaluate on an ongoing basis the Dementia Advisor Service in terms of impact and capacity and funding and provision of the role post 2018;
  - Provision of appropriate, timely, and good quality information on dementia including support/service availability. Giving dementia patients, carers and their families this information pre-diagnosis and at the point of diagnosis. This needs to be the main priority and the first step to supporting people to maintain their independence and to make informed choices;
  - Identify post-diagnosis services and support service developments;
  - Continue roll-out of Dementia Friendly Communities and develop associated community activities such as Dementia Friendly Swimming, Singing for the Brain, Games for the Brain, transport initiatives, Community Pastimes Service.

- Supporting Well:
  - All opportunities are taken to promote and expand the use of assistive technology to enable people living with dementia to remain independently in the community for as long as possible;
  - Identify housing options/housing support/extra care housing requirements;
  - Ensuring dementia connect continues to be publicised and remains up to date and comprehensive;
  - Continue Dementia Friends and Dementia Champions training;
  - Provision of ongoing Dementia awareness training programmes in primary care and CDDFT;
  - Address issues of admission and readmission avoidance services.

- Dying Well:
  - Develop End of Life Care Pathway across all agencies;
  - Ensure any End of Life Care Strategies/Pathways takes the needs of people with dementia into consideration;
  - Improve support in care homes regarding End of Life Care;
  - Increase the number of people with dementia who have died in their preferred place of care;
  - Achieve Gold Standard Framework accreditation for dementia.

Recommendations

22 The Health and Wellbeing Board is recommended to:

- Note the findings of the County Durham and Darlington Dementia Strategy Implementation 2014-2017 update and comment upon the report;
- Agree the direction of work for the future Dementia Strategy in the form of a plan on a page and supporting strategic documents;
- Provide feedback on the future work, recommendations and priorities to ensure it meets with local and national guidance.

Contact: Michelle Hagger, Senior Commissioning Support Officer, North of England Commissioning Support Unit
Tel: 0191 374 4243

Appendix 1: Implications

Finance
While it is acknowledged that some additional resources may be required via partner organisations to fully implement the strategy, many commitments are already planned for, with existing resources allocated to achieve them.

Staffing
None

Equality and Diversity
Equality impact assessments will be conducted in respect of any relevant service development / service redesign processes instigated by implementation of the strategy.

Accommodation
None

Crime and Disorder
None

Human Rights
None

Consultation
A consultation process has been carried out as part of strategy development.

Procurement
Any new services, or changes to services, instigated as a result of strategy implementation will be subject to the procurement rules of the nominated lead organisation for the relevant work.

Disability Discrimination Act
None

Legal Implications
Legal services will be consulted on any relevant issues which arise during implementation of the strategy, such as, for example, procurement exercises.

Appendix 2: Dementia Diagnosis Rates – data collection August 2015 – January 2017 (data available)

National estimated Dementia Diagnosis Rate	**67.4%**
Durham Dales, Easington & Sedgefield as at Jan-17	80.1%
North Durham as at Jan-17	68.2%

CCG	Date	Sum of Dementia Registers (65+ only)	Estimated Dementia Prevalence (65+ only)	Gap – number of additional diagnoses required to reach 65+ prevalence
Durham Dales, Easington & Sedgefield	August 2015	**2741**	**3421**	**680**
North Durham	August 2015	**1957**	**2833**	**876**
Durham Dales, Easington & Sedgefield	January 2016	**2821**	**3421**	**600**
North Durham	January 2016	**1946**	**2833**	**997**
Durham Dales, Easington & Sedgefield	January 2017	**2813**	**3513**	**700**
North Durham	January 2017	**1983**	**2910**	**927**

Health and Wellbeing Board

16 March 2017

Mental Health Crisis Care Concordat

Report of Mike Brierley, Director of Operations and Delivery, North Durham Clinical Commissioning Group

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of work being undertaken by the Mental Health Crisis Care Concordat.

Background

2 The Mental Health Crisis Care Concordat (the Concordat) is a nationally mandated collaboration which was signed in 2014 by a variety of partners including Durham Constabulary, Durham County Council, Darlington Borough Council, Tees, Esk and Wear Valley (TEWV) NHS Foundation Trust, North East Ambulance Service (NEAS), North Durham Clinical Commissioning Group (CCG) as lead CCG, Durham Dales Easington and Sedgefield CCG, Darlington CCG and voluntary and community sector providers. It is a commitment to joint working to improve the response to people in mental health crisis across services. There is also a service user who sits on the Mental Health Crisis Care Concordat Steering Group.

3 The Concordat currently focusses on adult crisis care but there is no age specified in the original plan and there are specific actions relating to children's crisis response.

4 Work is also underway independently looking at Child and Adolescent Mental Health Services (CAMHS) crisis and liaison and intensive home treatment services as part of the Children and Young People's Local Transformation Plan.

5 This paper sets out the work undertaken by the Concordat in 2016 and details the two main workstreams currently identified for 2017.

Current Position

Conveyancing

6 This refers to conveying (driving) a patient who has been detained under the Mental Health Act 1983 (the Act) and needs to go to hospital. The patient will have been professionally assessed in line with the Act and the Mental Capacity Act 2005 and the decision already taken to detain either to further assess or to treat. Therefore, there will already be a bed identified to which the patient needs to be securely taken. Patients who are picked up by the police in a public place (detained under section 136 [s136] of the Act) are taken to an s136 suite, assessed, and then conveyed to hospital if required. These patients are currently transported by the police but we are investigating whether this service can support our police colleagues by transporting patients in an appropriate manner from the place they are picked up to the nearest available s136 suite.

7 Legally, the vehicle needed to transport the patient has to be an ambulance and so the provision of the transport for patients has been provided by NEAS as part of their emergency response. The problem has been that NEAS will routinely provide a fully equipped blue light ambulance which can be frequently diverted to physical health emergencies (e.g. cardiac arrest, stroke, road traffic accidents) which delays response and attendance to the mental health crisis. Delays have been significant; up to 12 hours on occasion which can result in significant deterioration of the patient's condition and a number of professionals tied up trying to keep the patient safe as well as causing distress for family and friends.

8 The solution which has been put in place is the commissioning of a private ambulance provider to focus solely on attending mental health crisis incidents. This provides a much faster response time and greatly improves the better use of resources across all the agencies involved. The contract has been awarded for a year until November 2017, during which time we can gather and analyse activity and demand data to inform any future provision.

9 Most CCGs across the region have put a similar local service in place but ideally a region wide contract would be more cost effective to procure and manage.

10 Going forward, the analysis of activity data is underway and the Business Case to enable CCGs to consider longer term investment is being drafted. Discussion is underway with other Concordat groups to see if we can undertake a single procurement exercise for one service across a wider area. This would enable the successful provider to plan more effectively and is likely to attract a greater range of bidders for a larger contract.

Crisis Pathway Mapping

11 Mapping a pathway such as Mental Health Crisis Care is very complex; many access points exist and there are numerous agencies and providers involved. When talking about crisis care, services are also included which support individuals when they are escalating towards clinical crisis and manage them to either avert the crisis, or help the person into the right clinical care. Many of these services are provided by the voluntary and community sector and may not necessarily be directly commissioned either by CCGs or the Local Authority. This means that we have little to no direct control over them and they are vulnerable to fluctuations in demand. Equally, as financial pressures continue to be applied to all sectors, we need to ensure that we have system wide planning focus to avoid unnecessary adverse impact caused by commissioning decisions taken.

12 The mapping work being undertaken is trying to make sense of the current situation so that we can establish what needs to be improved, what is working well, and if there are any gaps. A workshop was held in Darlington in September 2016 which mapped out the current crisis pathways and identified a number of areas for improvement. The most significant, which was agreed by the workshop, was to develop a single point of access for individuals in crisis, their parents/carers/friends/support network and professionals. This would ensure that people get correct help at the right time.

13 A significant issue for the TEWV crisis team currently is that individuals contact them when they are facing a life crisis rather than a clinical crisis and it is difficult for the crisis team to know where to send them for the right support. This single point of access would allow individuals to make contact and have a discussion with a suitably trained, but not clinical, individual to work through what their needs are at the root of the crisis and get support for these.

14 The Concordat took outcomes from the mapping workshop and held a development session in October 2016 which has resulted in a new two year action plan to be delivered between 2016 and 2018. This included the development of a single point of access and also improving links to local authority suicide prevention work, police training, and the use of digital technologies as well as others mentioned in this report.

15 Work is ongoing with Crisis Pathway Mapping and features strong links between this work and the mapping exercise recently undertaken by Public Health colleagues. Both pieces of work identified the need for a single point of access and the longer term vision is for the two to be delivered jointly as a true single access point for patients, professionals, families, carers and the wider public.

Section 136 suites

16 A section 136 suite (also known as a Place of Safety) is somewhere where a patient in crisis can be taken, usually by the Police from a public place or place to which the public have access, for assessment under the Mental Health Act 1983.

17 There are a number of issues nationally with these and it's important to understand them for background and context. Nationally, police cells are still used as places of safety in some areas for people of all ages. This is widely acknowledged to be inappropriate. CCGs are now required to reduce the use of police cells as places of safety for adults and to eliminate their use for those under 18 by 2017 in line with the Policing and Crime Act 2017.

18 In order to deliver the requirements of this Act, there will be the need to identify health based places of safety; usually places of safety based in a health location, i.e. hospital. Currently, we have one in Lanchester Road Hospital, North Durham and one in West Park Hospital, Darlington. These are staffed from the hospital wards. The provider, TEWV, were given additional funding from what was the System Resilience Group (SRG) which is now the Local A&E Delivery Board (LADB) to enable them to staff the hospitals to a level where nurses could come off the wards into the s136 suite when required. The suites are used mainly by the police when they have picked someone up under s136 of the Act and they need assessment in a place of safety.

19 Working jointly with the Police and TEWV, CCGs have assessed that the current model does not work efficiently and ties up resource frequently. It has proven more difficult than anticipated to get a member of staff from a ward to the s136 suite quickly. Consequently, we are working with TEWV and the Police to develop a street triage model which would involve TEWV staff (a mental health professional) working in the police force control room and another out on the street in the Police car to provide support in cases where mental health issues may be a factor in an incident. Both interventions have proven very successful in other areas across the country.

20 This work is progressing quickly to develop a specification to enable TEWV to recruit staff, initially into the Force Control Room, as quickly as possible to ensure compliance with the Policing and Crime Act.

21 Police cells are not frequently used as places of safety in Durham and we have not had anyone under the age of 18 taken to a police cell as a place of safety since April 2014. We anticipate that this will enable the requirements of the Policing and Crime Act relating to reducing the use of Police cells as places of safety for adults to be met and eliminating their use for children (those under age 18). This will be monitored by the Mental Health Act Operational Group as well as the Concordat.

Other key work areas

Identification of high intensity users

22 The original 2014 action plan contained an action to identify the high intensity users of all emergency services. The Tees Concordat, supported by the North of England Mental Health Development Unit (NEMHDU), has done some significant work in this area and we are keen to learn from their work. The Mental Health Clinical Network is working with NEMDHU to develop a package which can be shared across other Concordats and also provide support in this work. The Tees Concordat identified a small number of individuals who were calling all emergency services (Police, ambulance, social care and attending A&E) regularly and so were clearly not receiving the support they needed.

23 There are two strands to this piece of work; a) Identification of individuals currently contacting emergency services frequently, assessing their needs and addressing them; b) Devise a multi-agency method or plan to assess and address the needs of people who start to behave in this way in future.

24 This will involve all statutory bodies on the Concordat working together and sharing information. This is a complex area due to the protection of information and data as well as information sharing but it is not insurmountable. Work is underway through the Safe Durham Partnership (SDP) to look at information flows between agencies. This issue of high intensity users highlights only a relatively small cohort of citizens/patients, but these small numbers can take up a large amount of time and resource from a number of services and can bounce around and in and out of the system regularly. This can result in them not receiving optimum care or quality outcomes.

25 Workshops are scheduled for 22 and 31 March 2017, with the final report scheduled to be presented to the Concordat steering group in May 2017. The concordat will then consider how best to deliver the recommended interventions.

Single Point of Access

26 This is a piece of work which has been identified by all Concordat partners as a priority. It links strongly with work currently underway in the County Durham Local Authority Public Health Team which has been undertaking a gap analysis of all their commissioned Public Mental Health services in order to support future commissioning decisions. One significant gap identified has also been a single point of access and so it is important that these two strands of work are strongly linked to ensure that we achieve our common goal of making access easier for patients.

27 Currently, we expect patients in crisis to work out if they are in a social crisis (and need social services support); an emotional crisis (and need support for that such as bereavement or relationship counselling); or a clinical crisis (and are in need of support from the TEWV crisis team). Patients consequently direct themselves to what the system considers to be the wrong place.

28 The September 2016 workshop identified from all partners that we need one point of access where patients can go and say they need help, then be given the time to talk through the help which they need so that they can be directed to the right place. This could be the patient themselves, or a third party. A parent, for example, could ask where to find help for their teenager who they fear has an eating disorder. The service would receive self-referrals as well as referrals from other professionals (GPs could refer someone they are seeing for sleep problems but are concerned that there is a different underlying cause) as well as from the community and voluntary providers.

29 A Plan on a Page has been developed as an early design to share more widely and connections have been made to the mental health prevention model which is looking to establish a similar model. The idea being that we harmonise process, estate, resource and systems where possible.

Recommendations

30 The Health and Wellbeing Board is recommended to:

- Note the progress and achievements made by the concordat in relation to conveyancing and Street Triage / s136;
- Support the work taking place in relation to implementing the projects detailed within this report.

Contact:	**Mike Brierley, Director of Operations & Delivery, NHS North Durham CCG**
Tel:	**0191 3744175**

Appendix 1 Implications

Finance
No direct implications at this point.

Staffing
No direct implications.

Risk
No direct implications.

Equality and Diversity / Public Sector Equality Duty
No direct implications.

Accommodation
No direct implications.

Crime and Disorder
Links with Durham Constabulary and the Police, Crime and Victims Commissioner.

Human Rights
No direct implications.

Consultation
Further comments will sought from partners and service users building on the local response towards the delivery and improvements of the crisis care concordat.

Procurement
No implications.

Disability Issues
Issues in relation to disability have been considered throughout the development of the action plan.

Legal Implications
The Health and Social Care Act 2012 places clear duties on Clinical Commissioning Groups and local authorities for the commissioning of mental health services. There is national policy direction that requires local areas to publish a local declaration and action plan.

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Health and Wellbeing Board

16 March 2017

Self-Harm and Suicide Audit 2012-14

Report of Gill O'Neill, Interim Director of Public Health, Adult and Health Services, Durham County Council

Purpose of the Report

1 This report is to update the Health and Wellbeing Board regarding deaths by suicide and undetermined injury that occurred in the County Durham area from 2012 to 2014, the full Audit report is attached at Appendix 2. This report covers three years and provides a bridge between the previous audit undertaken by Tees, Esk and Wear Valleys NHS Foundation Trust and the last full calendar year (2014). Whilst providing the analysis of cases the report will also make recommendations for future prevention work.

Background

2 In 2013 suicide prevention became a local authority responsibility. Suicide prevention cannot be undertaken in isolation by the local authority but requires working in partnership with the police, Clinical Commissioning Groups (CCGs), NHS England, Coroners and the voluntary sector to be effective. The rate of suicide per 100,000 of the population is a performance indicator in the Public Health Outcomes Framework (PHOF).

3 Public Health England in its 2014 Guidance for developing a local suicide prevention action plan identified local suicide audits as being an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots.

4 An audit of suicides through the systematic collection and analysis of local data on suicides can provide valuable information to learn lessons and inform suicide prevention plans. In order to draw together meaningful numbers while still preserving the anonymity of those involved, a three year pool of data is used. This audit uses information from 2012 to 2014. The next will use 2013 to 2015 data and will be written this year.

5 The early alert and review process, from which the information for this audit was drawn, is only one part of the suicide prevention and wider wellbeing work carried out in the county.

6 Over the last few months Durham County Council's Overview and Scrutiny have undertaken a detailed review of suicide. The information received is currently being analysed and a number of recommendations will be produced. The recommendations will be integrated with the new County Durham Mental Health Strategy. This is to be an overarching mental health strategy amalgamating children, adults, and suicide into one document. Underneath the overarching strategy will be a dedicated suicide prevention plan on a page. It is important to note that County Durham's Local Safeguarding Children Board (LSCB) have taken a specific interest

in self harm through a dedicated work stream. There is a standalone Self-Harm Action Plan being progressed. For the remainder of this report suicide will be the focus.

7 There are a number of activities which seek to minimise onward risk of those people exposed to suicide and to support individuals. These are highlighted below:

Suicide Prevention Interventions in County Durham

8 Suicide Postvention support is offered in County Durham via 'If U Care Share' (a local charity) which is based on the American model where support is facilitated by people who themselves have been bereaved by suicide. The team offers outreach to those bereaved by suicide within two days of receiving a referral, with family members being offered practical and emotional support by responding officers.

9 Durham commissions a dedicated welfare rights service targeted through the Men's and Women's Sheds programme (locally known as CREEs). Welfare rights and financial issues can impact on suicide rates especially in periods of economic recession.

10 Evidence suggests that family support and debt relief programmes may be beneficial to those who are at risk of suicide due to financial worries and should therefore be incorporated into any suicide prevention strategy.

11 Participants identified as being bereaved by suicide are eligible for support from a welfare rights worker who provides them with a wide range of services.

12 Relationship breakdown was identified by the County Durham suicide audit as a risk factor in someone taking their own life, therefore it is important to offer relationship support and advice to those who may be socially isolated, or find it difficult to maintain meaningful relationships.

13 A national charity within County Durham, RELATE, is commissioned to offer counselling, support and information for all relationships including couples and family therapy.

14 Reducing social isolation is a priority for County Durham and loneliness has an association with suicide. Joint working has progressed with Area Action Partnerships, partners such as fire and rescue and other commissioned services to deliver effective and evidence based community interventions which engage vulnerable people into services and become an active member of their community.

15 The Durham CREE programme is based on the Australian Men in Sheds model to reach out to people who may be isolated and vulnerable in the community. There are a number of CREEs across County Durham that can offer community based support and reduce social isolation. Welfare rights support is also available through the CREEs (**Link**).

16 Durham has also developed an on line support for people who may be at risk of suicide and for people who are concerned about others. This contains a range of information, links to the CREE programme, and telephone support lines (**Link**).

17 The WBfL service is managed and delivered by a consortium of voluntary sector and public sector organisations. The service provides 'one to one' support, group activities, volunteering opportunities and community development approaches. 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 (**Link**).

18 Other sources of support and help are detailed on the Suicide Safer Durham webpages (**Link**).

19 Further work is planned with the Criminal Justice System (CJS) to ensure pathways of support are seamless for people going through probation or are being released from prison. Partnership working is being progressed with Durham prison services.

20 The CCGs in County Durham have been leading on improvements in mental health crisis care. The Mental Health Partnership Board are approving plans and the Health and Wellbeing Board will receive for further discussion and ratification.

Summary

- There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and therefore have not been included in the analysis. The analysis is therefore based on 190 deaths;
- Of the 190 deaths, 75% were male (142) and 25% were female (48);
- 67% (128) of all cases were people under the age of 50;
- There were relatively high numbers of deaths by suicide in those aged 20 to 59, with higher numbers seen in males;
- Whilst suicide is relatively rare in children and young people there were nine deaths recorded in those 19 and younger;
- Just over a third of cases were employed at the time of death 33% (63), a further 31% (59) were unemployed, 11% (21) were retired, and 7% (14) were long-term sick or disabled;
- In 34% (65) of cases the person lived alone at the time of death;
- Hanging/strangulation was the most common method of suicide and occurred in 68% (129) of cases. In a further 22% (42) of cases the method was self-poisoning. In 66% (126) of cases the location was home;
- Toxicology reports indicate that 32% (61) cases had alcohol in the blood at the time of death. Of these cases 64% (39) were over the legal driving limit of 80 milligrams of alcohol per 100 millilitres of blood;
- 51% (97) of cases had been known to the police prior to their death, 25% (24) had been in contact with the police in the three months preceding their death;

- 5% of all cases (9) were prisoners at the time of death. A further five people died within a year of being released from prison;

- A date of last contact with a GP was known for 125 cases, of which 65% (80) had been seen by a GP within three months of their death;

- 50% (95) of cases were recorded as being known to mental health services at some point prior to their death. Of these cases, 4% (7) had been referred to mental health services but were never seen. 57% (54) cases had been seen by mental health services in the three months prior to death;

- Themes were identified for 158 of the 190 cases. The most common single theme was relationship problems/breakdown which features solely in 22 of the cases. This also featured in a further 16 cases where there were multiple themes. 24% of all cases (38) featured relationship problems/breakdown. Financial/debt featured in 13% (20) of cases and bereavement in 12% (19).

Recommendations

21 The Health and Wellbeing Board is requested to accept the audit and the following recommendations:

- A focus should be put on upstream interventions designed to support mental health and wellbeing in residents of County Durham;
- Prevention of deaths amongst the high risk groups identified in the audit should remain a priority;
- Support for those self-harming, possibly targeted towards the at risk group of young females identified in the audit, should be a priority. This may take the form of work to support mental resilience within school age children (to provide lifelong skills which will promote mental wellbeing) and/or the collating of available services in an easy to access portal. This will be covered in the children's mental health plan on a page and LSCBs work on self-harm;
- The Suicide Prevention Alliance continues to review the most up to date data available;
- Additional work with criminal justice agencies should be undertaken to support staff in considering suicide risk when an individual has been in contact with the police or wider criminal justice system;
- Work to support access to welfare and benefits should continue and be supplemented with access to debt management advice as financial problems were a theme identified in a significant proportion of cases;
- Consider opportunities to reduce social isolation (especially in those known to mental health services) within the population;
- Work with partners to promote appropriate access to out of hours and weekend crisis support.

Contact: Dr Keith Allan, Specialty Registrar in Public Health
Tel: 03000 267676

Appendix 1: Implications

Finance
Suicide prevention response had a financial implication as a number of the services put in place are paid for from the Public Health grant.

Staffing
Currently suicide prevention is part of the portfolio of a PHSMT member and also a suicide co-ordinator role is paid for. This is in addition to procured programmes and services.

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
Risk of suicide may be higher in some minority groups. It is therefore necessary to understand this local risk.

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
The Public Health team procures a number of services to reduce the risk of suicide within the county.

Disability Issues
Risk of suicide may be higher in some minority groups. It is therefore necessary to understand this local risk.

Legal Implications
In 2013 suicide prevention became a local authority responsibility.

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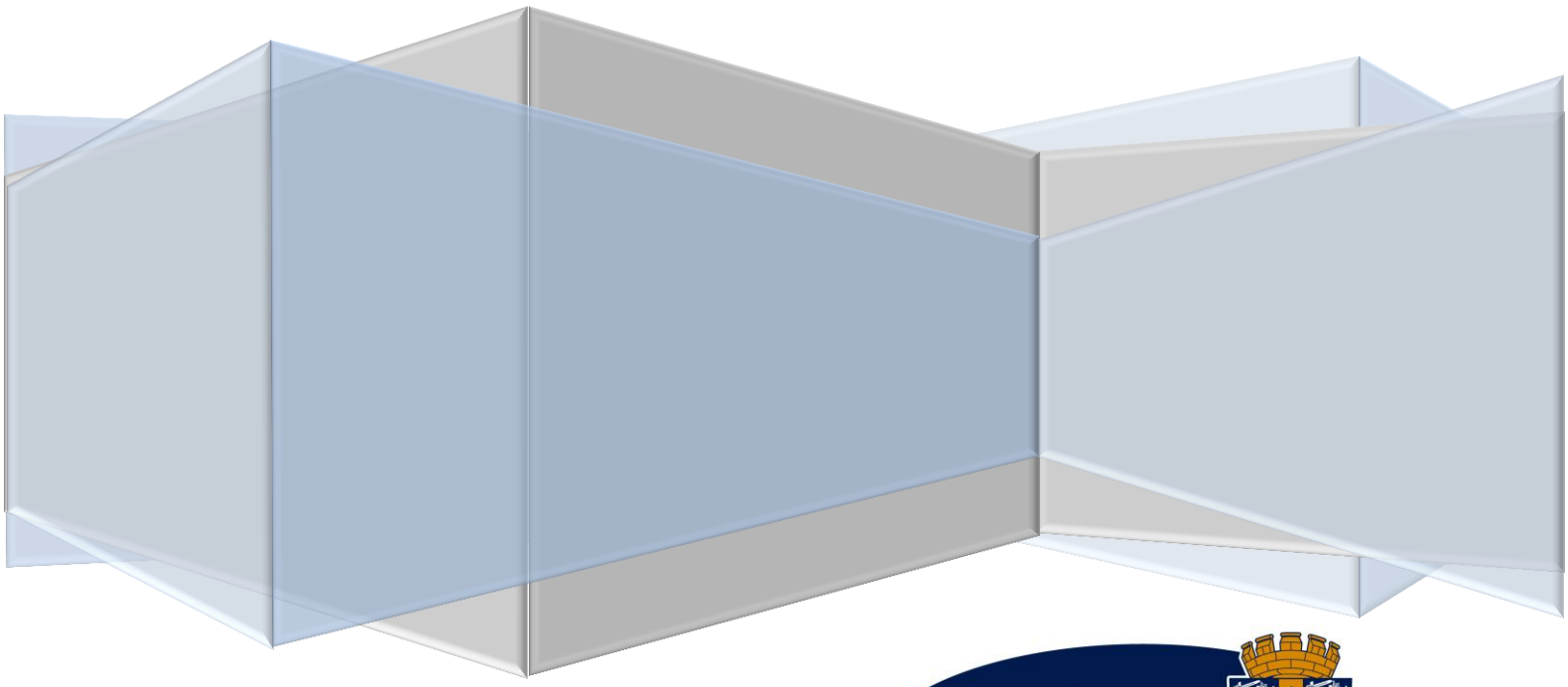
Self-harm and Suicide Audit 2012-14

County Durham

Authors: Kirsty Gail Wilkinson and Keith Allan



Durham County Council

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Contents

1. Purpose

This report presents the analysis of deaths by suicide and undetermined injury that occurred in the County Durham area from 2012 to 2014. This report covers 3 years and provides a bridge between the previous audit undertaken by Tees, Esk and Wear Valleys NHS Foundation Trust and the last full calendar year (2014).

Whilst providing the analysis of recent cases the report will also make recommendations for future prevention work.

2. Background

In 2013 suicide prevention became a local authority responsibility. Suicide prevention cannot be undertaken in isolation by the local authority but requires working in partnership with the police, clinical commissioning groups (CCGs), NHS England, Coroners and the voluntary sectors to be effective. The rate of suicide per 100,000 population is a performance indicator in the Public Health Outcomes Framework (PHOF).

Public Health England, in its 2014 Guidance for developing a local suicide prevention action plan identified local suicide audits as being an effective way for authorities to identify and respond to high risk groups in their areas, as well as reveal hot spots.

An audit of suicides through the systematic collection and analysis of local data on suicides can provide valuable information to learn lessons and inform suicide prevention plans.

3. Methodology

This report is based on data collected locally as part of the locally established audit and prevention scheme. Following a Coroner's report of suicide, open verdict or narrative verdict information was collated by the Public Health Team drawing together information from a variety of partners including primary care, social care, substance misuse, hospital and mental health services.

4. Summary

There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and therefore have not been included in the analysis. The analysis is therefore based on 190 deaths.

Of the 190 deaths 75% were male (142) and 25% were female (48).

67% (128) of all cases were people under the age of 50.

Just over a third of cases were employed at the time of death 33% (63), a further 31% (59) were unemployed, 11% (21) were retired and 7% (14) were long-term sick or disabled.

In 34% (65) of cases the person lived alone at the time of death.

Hanging/strangulation was the most common method of suicide and occurred in 68% (129) of cases. In a further 22% (42) of cases the method was self-poisoning. In 66% (126) of cases the location was home.

Toxicology reports indicate that 32% (61) cases had alcohol in the blood at the time of death. Of these cases 64% (39) were over the legal driving limit of 80 milligrams of alcohol per 100 millilitres of blood.

51% (97) of cases had been known to the police prior to their death, 25% (24) had been in contact with the police in the three months preceding their death.

5% of all cases (9) were prisoners at the time of death. A further five people died within a year of being released from prison.

A date of last contact with a GP was known for 125 cases, of which 80 (65%) had been seen by a GP within three months of their death.

95 (50%) of cases were recorded as being known to mental health services at some point prior to their death, of these cases 7 (4%) had been referred to mental health services but were never seen. 54 cases (57%) had been seen by mental health services in the three months prior to death.

Themes were identified for 158 of the 190 cases. The most common single theme was relationship problems/breakdown which features solely in 22 of the cases. This also featured in a further 16 cases where there were multiple themes. 24% of all cases (38) featured relationship problems/breakdown. Financial/debt featured in 13% (20) of cases and bereavement in 12% (19).

5. Public Health Outcomes Framework: Suicide Rates

According to the Public Health Outcomes Framework (PHOF) County Durham has a suicide rate of 13.3 per 100,000 population for the 2012-14 aggregated data. This remains above the suicide rate for the North East (11.0 per 100,000 population) and significantly higher than the suicide rate for England (8.9 per 100,000).

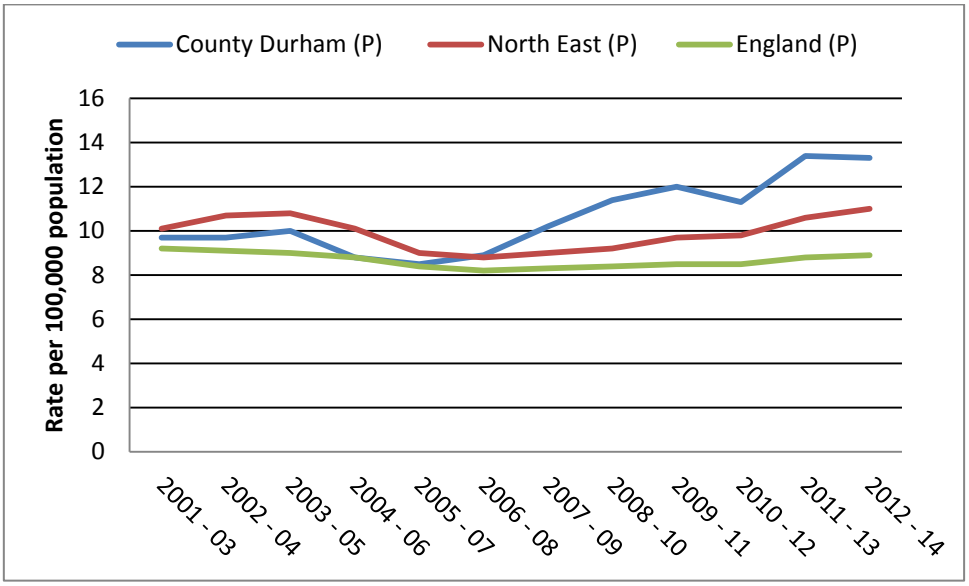


Figure 1: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Persons)

Suicide rates for males in County Durham are continuing to increase. In 2012-14 they stood at 20.6 per 100,000 population. The suicide rates for males are higher than those in the North East (17.9 per 100,000 population) and England (14.1 per 100,000 population).

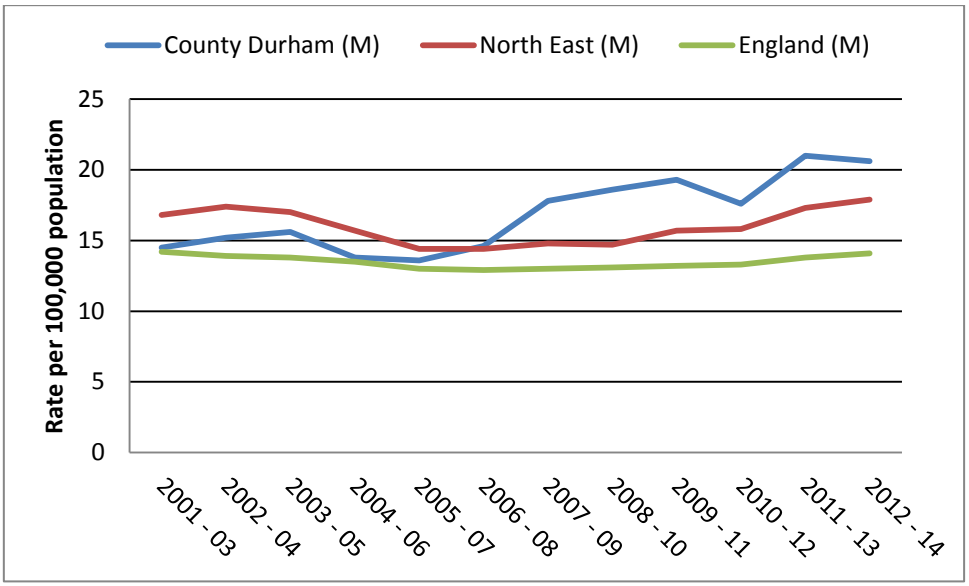


Figure 2: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Males)

Suicide rates for females in County Durham are increasing. In 2012-14 they stood at 6.1 per 100,000 population. The suicide rates for females are significantly higher than those in the North East (4.5 per 100,000 population) and England (4.0 per 100,000 population).

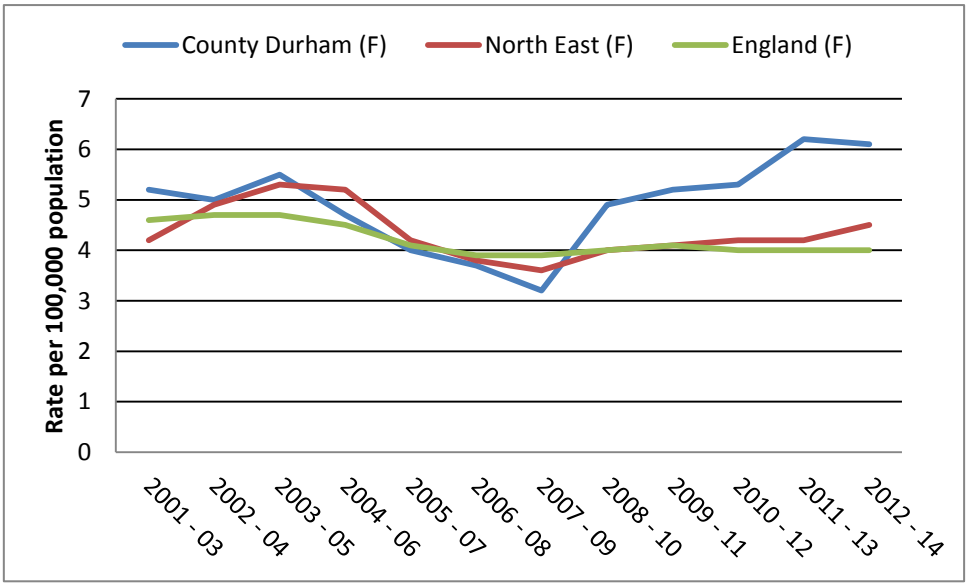


Figure 3: Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (Females)

The suicide rate reported in the PHOF data is recorded by date of registration of death rather than date of death. This means there are minor discrepancies between the rates reported nationally and the local audit data.

6. Self-harm rate of admission

Certain forms and sustained patterns of self-harm may be a risk factor for dying by suicide. Recording of self-harm is highly problematic however. The term can be used to describe a wide variety of behaviour from self-cutting to attempted suicide. An added complication is that the intent behind the action is often not known. Furthermore data is only routinely available for cases which result in admission to hospital. Most incidences of self-harm will not result in an attendance at hospital and of those that do only a proportion will actually be admitted rather than treated and sent home. Therefore the reported statistics may be the tip of an iceberg in terms of incidence and prevalence and consequently risk.

Figure 4 below demonstrates the differences in self-harm admission rates between genders and age groups. In males, across the date range, the highest rates are seen in those aged 25 to 34. In females the rates tend to be higher in females in general with a peak amongst 15 to 24 year olds.

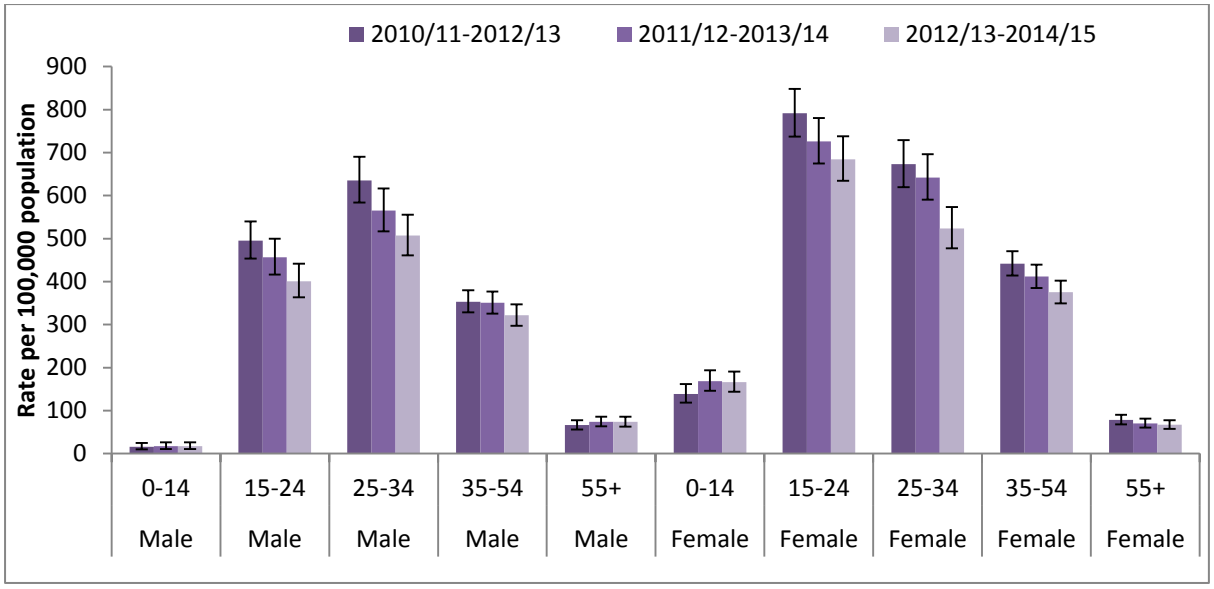


Fig. 4 Rate of admissions for self-harm by age and sex per 100,000, County Durham, 2010/11-2012/13 to 2012/13-2014/15

Figure 5 below that the majority of admissions for self-harm are in people who live in more deprived areas.

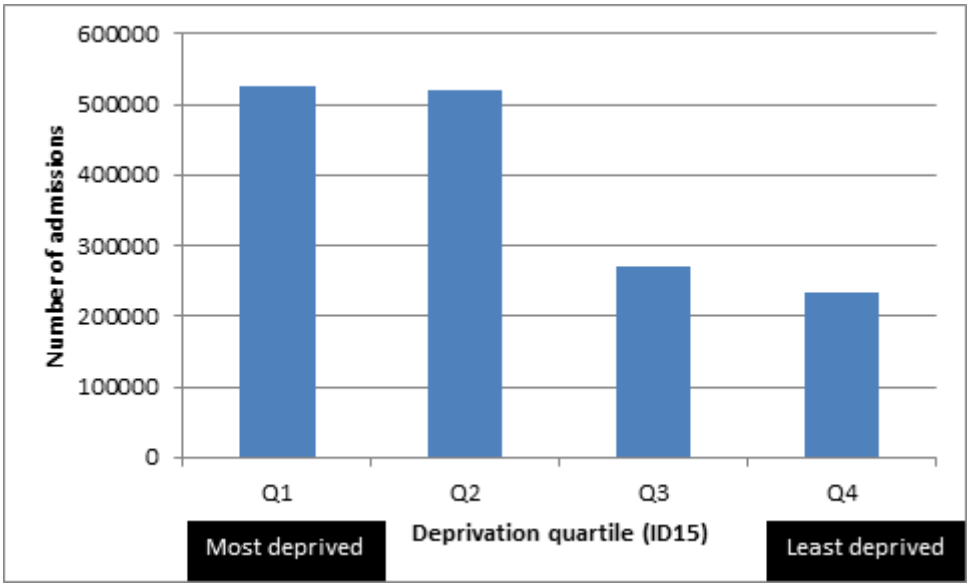


Fig. 5 Number of admissions for self-harm by deprivation quintile, County Durham, 2010/11-2012/13 to 2012/13-2014/15

7. Local Audit Suicide Rates

The following information is based on the local audit findings, which is presented by date of death rather than registration of death. The audit includes the deaths of County Durham residents where the coroner has reached the verdict of suicide or misadventure as well as open and narrative verdicts.

The suicide rate taken from the local audit data stood at 11.13 per 100,000 population in 2014 which had reduced from 13.5 per 100,000 population seen in 2013.

Year of Death	Female	Male	Total	Population	Rate per 100,000 population
2012	13	50	63	515,578	12.22
2013	21	48	69	518,330	13.50
2014	14	44	58	521,202	11.13

Table 1: Suicide numbers & rates per 100,000 population in County Durham 2012-14

The geographical breakdown of numbers of suicides reveals Durham and Derwentside areas as areas with high numbers of suicides between 2012 and 2014. Removing the cases where the death has occurred in prison identifies the former Derwentside and Durham areas as having the highest numbers and rates across the three years. Elvet ward, which includes Durham Prison and University student accommodation, was identified as experiencing the highest numbers of deaths by suicide in 2012-14. Coxhoe ward featured the second highest numbers of deaths by suicide.

Former local authority area	2012 rate per 100,000 (n)	2013 rate per 100,000 (n)	2014 rate per 100,000 (n)	Population (2013 mid year)
Durham	14.5 (14)	16.5 (16)	15.5 (15)	96,680
Derwentside	16.3 (15)	16.3 (15)	14.1 (13)	92,146
Easington	11.6 (11)	7.4 (7)	7.4 (7)	95,153
Sedgefield	8.0 (7)	12.6 (11)	8.0 (7)	87,537
Chester Le Street	Suppressed (no. less than or equal to 5)	12.9 (7)	11.1 (6)	54,228
Durham Dales	12.2 (11)	14.4 (13)	11.1 (10)	90,213

Table 2: Suicide rates & numbers by former lower level local authority area 2012-14

8. Local Analysis

8.1 Demographics

There were 198 deaths by suicide or undetermined injury in County Durham between 2012 and 2014. Eight of these deaths were non-County Durham residents and therefore have not been included further in the analysis. The analysis is therefore based on 190 deaths.

Of the 190 deaths recorded in County Durham between 2012 and 2014 75% (142) were male and 25% (48) were female. The number of male suicides has decreased year on year since 2012. There was a peak in female suicides in 2013.

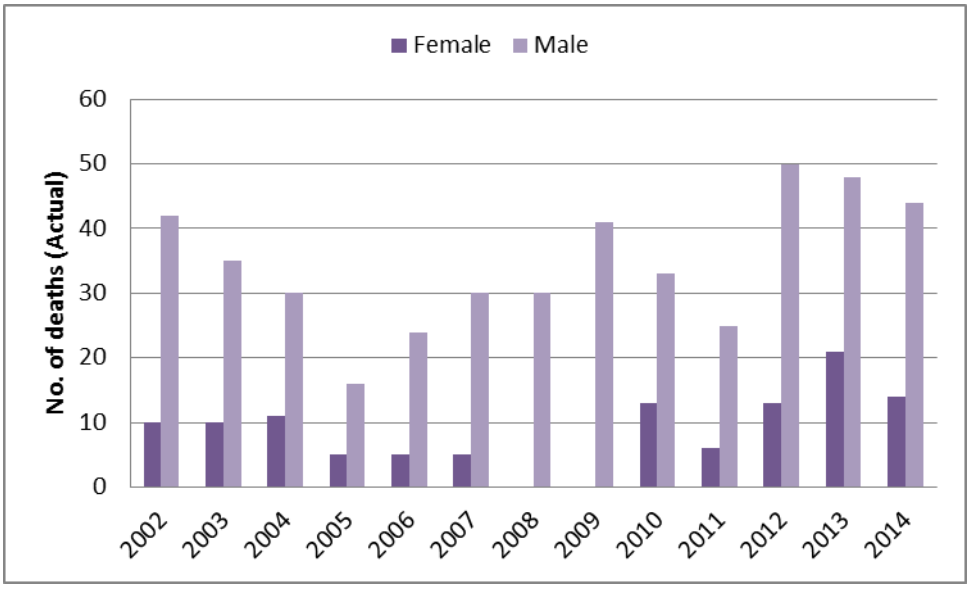


Figure 6: County Durham deaths by suicide and undetermined injury by gender 2002-2014 (N.B. numbers of deaths in females for 2008 and 2009 have been suppressed due to low numbers)

Of the suicides and undetermined injuries 67% of both male and female cases were of people who were under the age of 50 at time of death. The greatest numbers of deaths were seen in those aged 40 to 49 (in part due to the age structure of the county). There was however relatively high numbers of deaths by suicide in those aged 20 to 59, with higher numbers seen in males. Whilst suicide is relatively rare in children and young people there were nine deaths recorded in those 19 and younger. At the other end of the age distribution there were eight deaths by suicide or undetermined injury in those aged 70 years or more.

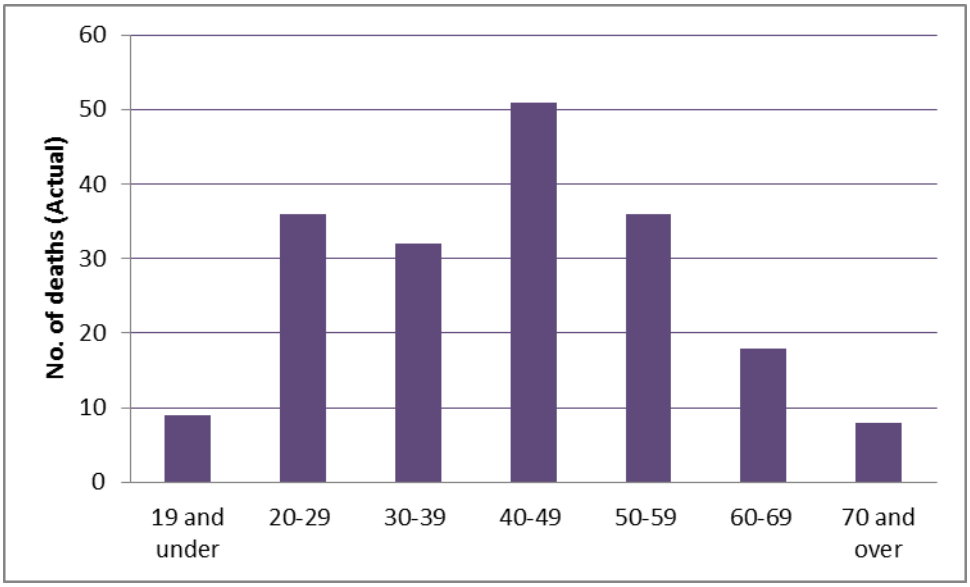


Figure 7: Deaths by suicide and undetermined injury by age cohort 2012-14

Table 3 below shows the living arrangements of those who are suspected of dying by suicide. The largest group was those living alone (34%) however the majority of people who died were thought to have lived with other people. A total of 32 people who lived alone (49% of those living alone) also had contact with mental health services. This may be an issue as social isolation and some forms of mental health problems are known to be associated with increased suicide risk.

Lived with	Cases (n=190)
Alone	65
Spouse/partner	41
Spouse/partner and children under 18 years	22
Parents	21
Other or not known	13
Other family and other shared	12
Prison	8
Children	8

Table 3: status at time of death 2012-14

In 2012-14 the employment status in most cases at time of death was employed or unemployed. There were also higher numbers of retired, long-term sick or disabled and students than the 2011-13 audit.

Employment Status	Cases (n=190)
Employed	63
Unemployed	59
Retired	21
Long-term sick or disabled	14
Student (full time)	12
Other	6
Self Employed	Suppressed (no. less than or equal to 5)
Unknown	Suppressed (no. less than or equal to 5)
Caring for home/family; Housewife / househusband; Employed part-time	Suppressed (no. less than or equal to 5)

Table 4: Employment status at time of death 2012-14

In the 2012-14 period covered by this audit, 68% (129) of the cases the method of death was by hanging/strangulation with 22% (42) through self-poisoning. This mirrors the pattern seen in previous years. The substances used for self-poisoning were identified in 38 cases, this was most commonly an opiate or opioid analgesic (14 cases), followed by the use of multiple substances in 10 cases.

In 61 cases (32%) toxicology indicates alcohol in the blood at time of death. One in five of all cases of suicide had more than the drink drive limit in their blood at time of death (80 milligrams of alcohol per 100 millilitres of blood).

The most common suicide location was the home with 66% (126) accounting for this location.

Location	Cases (n=190)
Home	126
Wooded Area	18
Hospital	11
Prison	8
Other	17
Other Address (including friends or family)	10

Table 5: Location of suicides 2012-14

More suicides occurred on a Sunday than any other day across the three-year audit period with one in five occurring on this day.

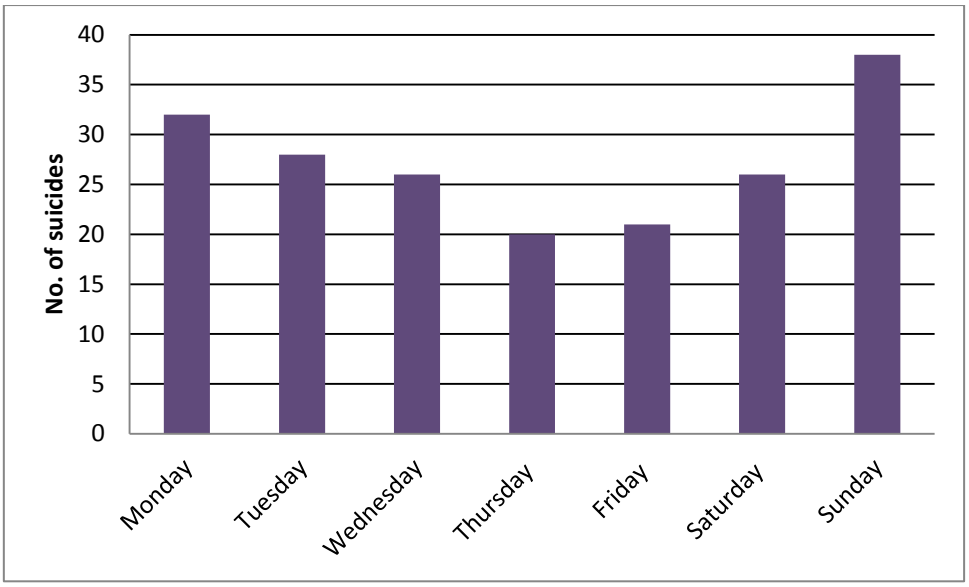


Figure 8: Death by suicide by day 2012-14

The months of February, March, April, July and October experienced higher than average numbers of deaths by suicide across the three years.

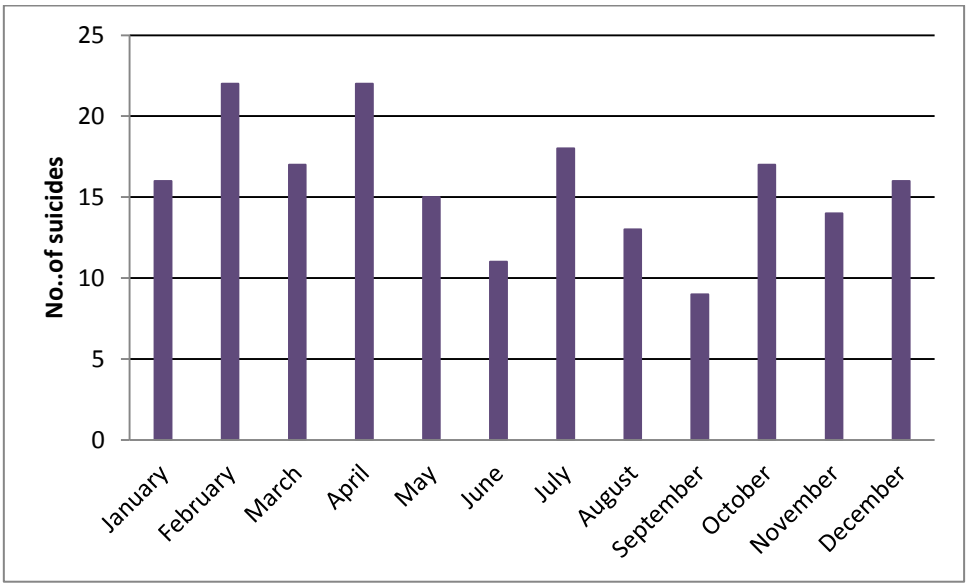


Figure 9: Death by suicide by month 2012-14

8.2 Minority groups

Nationally Gay, lesbian and bisexual adolescents are at higher risk for mental health problems and associated risk behaviours including suicidal behaviour (Blake et al, 2001). The risk appears to be greatest during adolescence and early adulthood, diminishing as people age (Cochran, 2001).

There are a number of environmental factors such as victimisation experiences, social isolation and the use of substances to cope with associated stress which may explain this increased risk (Blake et al, 2001).

Whilst sexual orientation is a field within the audit data it tends to be poorly recorded. There is usually only data available where this has been raised within the Coroner's investigations. Within the current data sexuality was not known for the majority of cases, 'heterosexual' was given as the next largest group. It seems unlikely that the number of people who would have identified as homo- or bisexual who died from suicide would be as few as recorded in the dataset (fewer than five).

Suicide risk has also been linked to being part of a minority ethnic group or being a recent immigrant to a country (McKenzie et al, 2003). Again while ethnicity is recorded within the dataset it does not provide fine grain description, therefore we are limited in the inferences that may be drawn from the available information. The current data shows that 125 of the deaths were in people who were identified as being 'white British'. In 57 cases ethnicity was not known. The remaining deaths were amongst people of 'other ethnic groups'.

8.3 Contact with Criminal Justice Services

Between 2012 and 2014 there were 9 deaths from suicide in prison. A further five suicides took place within a year of release from prison.

Only a minority of 14% (27) of cases had ever been known to the Probation Services. Eight people had their last contact with the probation service within three months prior to their death and a further four people had contact a year prior to their death.

A small majority of cases (51%, 97) were known to the police prior to death. A quarter (24) had their last police contact within three months of death. A further 18% (17) had their last contact with the police within a year of their death.

8.4 Contact with GP Services

A date of last contact with GP services was known in 125 cases. Of these cases 64% (80) were seen within three months of their death. The majority of these consultations may not have been directly related to suicidal ideation or mental health. In nine cases a suicide risk was noted in GP records, with a further 19 people having multiple risks noted. Previous attempted suicides were recorded in eight cases.

8.5 Contact with Acute Services

There were 39 cases which had contact with A&E/hospital services in the year prior to their death. While 10 were associated with overdose (of which we do not know the proportion which were intentional or indeed attempted suicide), the majority were from a range of conditions not necessarily associated with suicidal ideation or mental ill health.

Treatment for general medical conditions was the next most common cause of an A&E/hospital contact (six cases) followed by gastrointestinal (five cases). There were fewer than five cases per each of the remaining categories, including contact for reasons of mental illness or alcohol problems. 6 cases were known to have a psychological assessment prior to discharge.

8.6 Contact with Mental Health Services

Fifty percent of cases (95) had been referred to or were known to mental health services at some point in their lives. Of these individuals 63 had been seen in the 12 months prior to their death, with the majority (54 people, 57%) being seen in the three months prior to death. Of those referred to mental health services seven cases had never been seen.

Where cases had been seen by mental health services in the six months prior to death (57) a known diagnoses were:

Mental Health Diagnosis	Cases
Multiple diagnosis	7
Depressive illness	6
Bipolar affective disorder	Suppressed (less than or equal to 5)
Other (including personality disorder; Schizophrenia & other delusional disorders; Adjustment disorder/reaction; Anxiety/phobia/panic disorder/OCD; and drug misuse)	19

Table 6: Mental Health Diagnosis 2012-14

Other and multiple diagnoses include:

- Depression, pathological jealousy, bi-polar and emotionally unstable personality disorder
- Alcohol and drug misuse
- Anxiety and Depression
- Bipolar Affective Disorder & Emotionally Unstable Dependant Personality Disorder
- HIV, Mental and Behavioural Disorder due to multiple drug use & use of other psychoactive substances
- Mixed anxiety, depressive disorder and schizophrenia
- Mixed anxiety and depression

- Alcohol dependence, suicidal idealisation, severe depressive disorder
- Psychotic depression, differential OCD
- Schizoaffective disorder, Personality Issues, Polydrug misuse
- Moderate depressive episode with somatic symptoms, low mood & anxiety
- Autism spectrum disorder (ASD) & Attention deficit hyperactivity disorder (ADHD)
- Mixed Anxiety and Depressive disorder
- Social anxiety & low mood

8.7 Themes

Themes were identified in 158 cases. Most cases were identified as displaying multiple themes. The most common single theme was relationship problems/breakdown. Relationship problems/breakdown was also mentioned most in the multiple themes followed by financial/debt problems (although it is unclear if relationship break-up triggered suicide or if mental illness, poor coping strategies and suicidal ideation contributed to relationship break-up).

Themes	Cases (n=158)
Multiple themes	42
Relationship problems/breakdown	22
Mental Health Diagnosis	16
Ill-health/Illness	13
Bereavement	9
Financial/debt problems	6
Emotional distress	Suppressed, 5 or fewer
Family problems/breakdown	Suppressed, 5 or fewer
Court Hearing pending	Suppressed, 5 or fewer
Under Police Investigation	Suppressed, 5 or fewer
Depression	Suppressed, 5 or fewer
Drug misuse	Suppressed, 5 or fewer
Alcohol misuse	Suppressed, 5 or fewer
GP – Mental Health diagnosis	Suppressed, 5 or fewer
Other	25

Table 7: Identified themes

9. Conclusion

The pattern of suicide in County Durham mirrors the national picture with young males making up a significant proportion of deaths by suicide in County Durham. In County Durham for 2012-14 the greatest number of cases of deaths by suicide was in males age 40-49. While there are often multiple possible triggers or themes associated with a death by suicide we can see that a sudden change in

circumstances, be that financial or social, was associated with a significant number of the recorded deaths.

10. Beyond the Audit

The early alert and review process, from which the information for this audit was drawn, is only one part of the suicide prevention and wider wellbeing work carried out in the county. A number of activities which seek to minimise onward risk of those people exposed to suicide and to support individuals

10.1 Support following suicide

Suicide postvention support is offered in County Durham via 'If U Care Share' (a local charity), which is based on the American model, where support is facilitated by people who themselves have been bereaved by suicide. The team offers outreach to those bereaved by suicide within two days of receiving a referral, with family members being offered practical and emotional support by responding officers.

10.2 Welfare Rights

Durham commissions a dedicated welfare rights service targeted through the Men's, and Women's Sheds programme (locally known as CREEs). Welfare rights and financial issues can impact on suicide rates especially in periods of economic recession.

Evidence suggests that family support and debt relief programmes may be beneficial to those who are at risk of suicide due to financial worries and should therefore be incorporated into any suicide prevention strategy.

Participants identified as being bereaved by suicide are eligible for support from a welfare rights worker who provides them with a wide range of services.

10.3 Relationship support

Relationship breakdown was identified by the County Durham suicide audit as a risk factor in someone taking their own life, therefore it is important to offer relationship support and advice to those who may be socially isolated, or find it difficult to maintain meaningful relationships.

A national charity within County Durham, RELATE is commissioned to offer counselling, support and information for all relationships including couples and family therapy.

10.4 Men's, Women's and Young People's Sheds (CREEs)

The Durham CREE programme is based on the Australian Men in Sheds model to reach out to people who may be isolated and vulnerable in the community. There are a number of CREEs across County Durham that can offer community based support

and reduce social isolation. Welfare rights support is also available through the CREEs:

http://www.suicidesaferdurham.uk/get-involved/

10.5 On-line support

Durham has also developed an on line support for people who may be at risk of suicide and for people who are concerned about others. This contains a range of information, links to CREE programme, and telephone support lines:

http://www.suicidesaferdurham.uk/i-need-help/

10.6 Wellbeing support (WBfL)

The WBfL service is managed and delivered by a consortium of voluntary sector and public sector organisations. The service provides 'one to one' support, group activities, volunteering opportunities and community development approaches. 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:

http://www.wellbeingforlife.net/

10.7 Others sources of support and help:

http://www.suicidesaferdurham.uk/i-need-help/

11. Recommendations

It is recommended that:

- A focus should be put on upstream interventions designed to support mental health and wellbeing in residents of County Durham.
- Prevention of deaths amongst the high risk group identified in the audit should remain a priority.
- Support for those self-harming, possibly targeted towards the at risk group of young females identified in the audit, should be a priority. This may take the form of work to support mental resilience within school age children (to provide lifelong skills which will promote mental wellbeing) and/or the collating of available services in an easy to access portal.
- The Suicide Prevention Alliance continue to review the most up to date data available.
- Additional work with criminal justice agencies should be undertaken to support staff in considering suicide risk when an individual has been in contact with the police or wider criminal justice system.

- Work to support access to welfare and benefits should continue and be supplemented with access to debt management advice as financial problems were a theme identified in a significant proportion of cases.
- Consider opportunities to reduce social isolation (especially in those known to mental health services) within the population.
- Work with partners to promote appropriate access to out of hours and weekend crisis support.

12. References

Blake, S.M., Ledsky, R., Lehman, T., Goodenow, C., sawyer, R., Hack, T., 2001. Preventing Sexual Risk Behaviors Among Gay, Lesbian, and Bisexual Adolescents: The Benefits of Gay-Sensitive HIV Instruction in Schools. American Journal of Public Health, 91 (6), pp. 940-946.

Cochran, S.D., 2001. Emerging issues in research on lesbians' and gay men's mental health: does sexual orientation really matter? Am Psychol, 56 (11), pp. 931-947.

McKenzie, K, Serfaty, M., Crawford, M., 2003. Suicide in ethnic minority groups. The British Journal of Psychiatry, 183 (2), pp. 100-101.

Health and Wellbeing Board

16 March 2017

Urgent Care Services

Report of Dr Jonathan Smith, Clinical Chair, Durham Dales Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Board with an update on:

- Durham Dales, Easington and Sedgefield (DDES) Clinical Commissioning Group's (CCG) Urgent Care Service change and the ongoing Communication and Engagement plan to support those changes;
- Urgent and Emergency Care Strategy.

Background

2 "Getting Care Right for You", was a public consultation and an opportunity for the public to have their say about potential changes to the way we deliver Urgent Care Services. When we say 'urgent care' we mean the range of health services available to people who need urgent advice, diagnosis and treatment quickly and unexpectedly for needs that are not considered to be life threatening.

3 Urgent care is currently delivered from:

- Easington Healthworks
- Seaham Primary Care Centre
- Peterlee Community Hospital
- Bishop Auckland Hospital

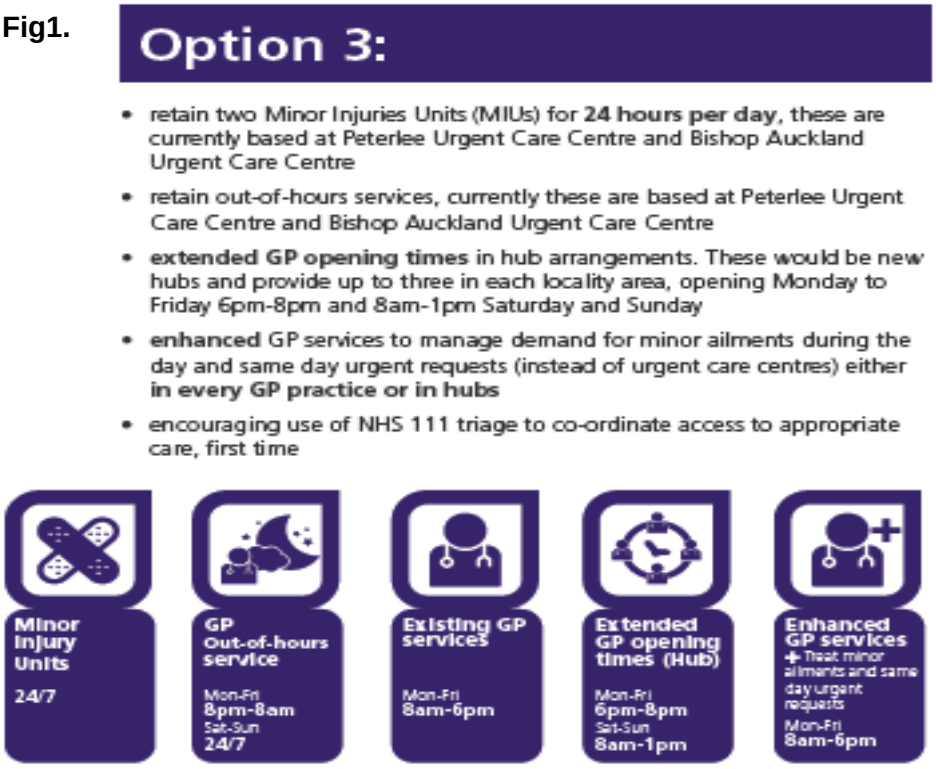
The CCG consulted with the public on the following:

- Day time urgent care (8:00 am-8:00 pm)
- Minor injury services

Consultation Outcome

4 The consultation proposed three prospective models for the future provision of Urgent Care Services. The most popular option amongst members of the public was option 3 (Figure 1.). Following a Governing Body meeting on 13 September 2016, it was agreed option 3 would be taken forward in support of the public's preference.

Fig1.



5 DDES CCG will provide an improved service to meet the urgent care needs of the local population, resulting in some changes to services currently being delivered:

- Minor injuries services will remain the same from Bishop Auckland and Peterlee 24 hours per day, seven days per week;
- GP Out of Hours services will remain the same and will be provided from Bishop Auckland and Peterlee Community Hospital as they are now from 8pm to 8am weekdays and 24/7 on a weekend;
- There will be changes to GP services which are in line with the vision set out by NHS England for GP 7 day services in the GP 5 Year Forward View, including:
    - Extended GP services from 6:00 pm-8:00 pm weekdays as well as weekend provision on a Saturday and Sunday morning;
    - Enhanced availability of same day urgent appointments with GP practices working together from common single sites to serve larger populations for these extended and enhanced GP services for some areas in DDES – these will be known as 'Primary Care Services'.

6 The preferred option chosen by the public following consultation was to base these services at: Bishop Auckland, Barnard Castle, Stanhope, Peterlee, Seaham, Easington, Sedgefield, Newton Aycliffe and Spennymoor.

7 DDES CCG is currently working with Primary Care Services to improve GP access and to understand how their appointment systems work to further improve these.

8 In future DDES CCG will be encouraging use of the NHS 111 service to book appointments and to coordinate access to the right care, first time.

9 The CCG are working hard as an urgent care collaborative with all stakeholder groups through a robust mobilisation and implementation plan to ensure services are ready for 1 April 2017.

Expected Benefits for Patients

10 We believe these changes to services will:

- Provide care closer to home for our patients providing at least five more sites than we currently do;
- Improve the patient journey and provide better clinical outcomes for the patient;
- Offer familiar services for patients;
- Provide equity across the whole DDES CCG area and a more consistent service;
- Ensure that patients are seen by the right healthcare professional, in the right place and at the right time;
- Offer an alternative to A&E services.

Communications and Engagement

11 Following the Communications and Engagement Plan previously shared with the Board, Phase 1 is now complete. An updated Communications and Engagement Plan for Phase 2 is attached at Appendix 2.

12 Phase 2 material is shared in Appendix 3 as a pocket guide and letter. This information will be received by every DDES household in the second week of March 2017 (over 165K copies) and this will contain a credit card size information card as suggested by the Adults, Wellbeing and Health Overview and Scrutiny Committee.

13 The CCG ‘s Engagement Plan /campaign (Appendix 2) will communicate the changes to the Urgent Care System prior to full implementation on 1 April 2017 to every group that the CCG engaged with pre-consultation.

14 Our Radio advertising campaign promoting the changes in urgent care and what these mean to the general public will launch in the coming weeks.

Urgent and Emergency Care Strategy update

15 The County Durham and Darlington (CDD) Local A&E Delivery Board (LADB) replaced the System Resilience Group (SRG) in September 2016, a transformation that was mandated by NHS England in their correspondence to CCG Accountable Officers in July 2016. The LADB is chaired by Sue Jacques, Chief Officer, County Durham and Darlington Foundation Trust with Stewart Findlay, Chief Clinical Officer, DDES CCG as Vice Chair. The LADB takes a whole system approach to improve A&E performance.

16 As part of the national A&E Improvement Plan, the Emergency Care Improvement Programme (ECIP) Team carried out an intensive whole system diagnostic in November 2016. As a consequence, four key priority areas for improvement across the system have been identified:

a) Leadership
b) Assessment prior to admission
c) Doing today's work today
d) Discharge to assess

17 A dedicated lead from the ECIP Team will work with system leads across County Durham and Darlington to implement the agreed priorities and high impact recommendations linked to the priorities over the next twelve months. A LADB Operations Group has been set up with membership comprising the designated leads for specific aspects of taking forward and implementing the ECIP recommendations.

18 There is to be a national relaunch of the Urgent and Emergency Care (UEC) strategy with the focus being on getting A&E back on track quickly with the required initiatives fully embedded well in advance of winter 2017. The delivery of UEC strategy will also feature in a national Delivery Plan due in March 2017, that will set expectations regarding the implementation of the 5 Year Forward View.

Recommendations

19 The Health and Wellbeing Board is recommended to:

- Note the contents of the report;
- Note that the recommendations by the Adults, Wellbeing and Health Overview and Scrutiny Committee have been incorporated into the Communication and Engagement Plan;
- Support the work taking place in the County Durham & Darlington Local A&E Delivery Board.
- Agree to receive an update at a future meeting.

Contact: Sarah Burns, Director of Commissioning, DDES CCG
Tel: 0191 3713234

Appendix 1: Implications

Finance
There are potential financial implications for existing service providers.

Staffing
There are implications for staff currently employed in the existing urgent care services.

Risk
N/A

Equality and Diversity / Public Sector Equality Duty
Equality impact assessments have been completed as part of the development of alternative service models.

Accommodation
N/A

Crime and Disorder
N/A

Human Rights
N/A

Consultation
A full public consultation was undertaken regarding changes to local urgent care services. This was overseen by the Health and Overview Scrutiny Committee.

Procurement
Formal procurement has taken place

Disability Issues
N/A

Legal Implications
N/A

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URGENT CARE ENGAGEMENT PLAN – January/February/March 2017

This is a list of groups/organisations that the CCG is planning to engage in order to communicate the changes to the urgent care system prior to its full implementation on 1st April 2017.

Group/Locations	Date/Times	Who to attend	Activity planned
Investing in Children	9th February, 5:30 – 7pm (YP Health Group Meeting	Gail Linstead	Attending the young people sessions to ensure that changes to the services are communicated and explained clearly. The young people may also deliver some Agenda Days to gather young people's feedback about the
	2nd March 5:30 – 7pm (Extreme Group)	Gail Linstead	
GRT sites	9th March, 2-3:30pm – GRT Practitioners Meeting	Gail Linstead	GRT Nurse can distribute leaflets/pocket-guide to people living on sites. The New Engagement Lead should also attend a couple of 'mums and toddlers' groups' sessions. The GRT nurse can facilitate attendance and introduce the CCG staff to the sites.
Supermarkets	Dates all confirmed running from 15th March to 30th March 2017	Range off CCG staff with PRG members to support	Stall with leaflets/pocket-guide to distribute Deborah Perry to make arrangements with supermarkets before Christmas.
Durham Deafened Support	22n March – Peterlee 23rd March - Crook	Tina Blabach	To attend two sign language sessions (Peterlee and Crook) to ensure that changes to the services are communicated and explained clearly.

Group/Locations	Date/Times	Who to attend	Activity planned
People's Parliament, Team Meeting	Date to be confirmed	Gail Linstead/Tina Balbach	Attending the team meeting to ensure that changes to the services are communicated and explained clearly. The team could make the leaflet/pocket-guide LD friendly, and they could also disseminate the information to the whole Parliament and other local groups they are involved in.
Bishop Auckland College	Head of Marketing and School Liaison has been contacted, awaiting reply Course Co-ordinator, Level 3 Health & Social Care Date to be confirmed		Stall with leaflets/pocket-guide to distribute
Health Networks	February/March Dales Meeting – 10th Feb 2017 Easington and Sedgefield - TBC	Gail Linstead (where possible)	Information could be distributed electronically through the networks' databases. The three Health Networks could carry some targeted engagement with groups/individuals from the protected characteristics to ensure that the changes are communicated clearly. Firstly, there is a need to understand whether the CCG will continue funding the Health Network in the new financial year. If this is the case, a meeting can be arranged with the three host organisations, David Taylor-Gooby and Gail Linstead in order for them to negotiate how engagement could be developed.

Group/Locations	Date/Times	Who to attend	Activity planned
Healthwatch	GL to attend briefing session on 22nd Feb with the HW Team	Gail Linstead	CCG staff can attend some drop-in sessions across DDES in order to distribute the pocket-guide and the leaflet, and to be available to talk to people and explain the changes to the system.
Urgent Care Centres	March – Dates to be confirmed	Clair White/Lyndsey Jones George/Lisa Trimble	CCG staff to attend urgent care centres to distribute and explain the pocket-guide to patients
PRGs	Dec/Jan Dales – 1st Dec Sedgefield – 15th Dec Easington 20th Dec March:- Dales – 3rd March Easington - 14th March Sedgefield – 15th March	Gail Linstead	Update members on the Local NHS Services Leaflet Brief the members by presenting the pocket-guide
CCG Admin Team	13th March	Gail Linstead	GL to attend an admin team meeting and brief them by presenting the pocket-guide

Group/Locations	Date/Times	Who to attend	Activity planned
AAPs	Teesdale AAP – 18th January 2017 / 15th March 2017 3 Towns AAP – 19th January 2017 / 9th March 2017 GAMP AAP – 17th January 2017 / 14th March 2017 4 Together AAP – 11th January 2017 / 1st March 2017 Weardale AAP – 26th Jan 2017/23rd March 2017 Spennymoor AAP – 19th January 2017 / 16th March 2017 Bishop Auckland and Shildon AAP – 26th January 2017/ 2nd March 2017 East Durham Rural Corridor AAP – 24th January 2017 / 8th March 2017 East Durham AAP – 8th February 2017 –	All CCG AAP reps	5 minutes slot to update groups on Local NHS Services Leaflet 15 minutes slot to present the pocket guide
County Durham Mental Health Network	3rd April 2017	Gail Linstead	Presentation to the service users group on the pocket guide/change of services
Practice Pharmacists Meeting	14th February 2017	Gail Linstead	Presentation on the pocket guide to ensure that pharmacy team are aware of changes and can field any questions from members of the public

Group/Locations	Date/Times	Who to attend	Activity planned
Community Pharmacy Meeting	Date TBC	Gail Linstead/Kate Huddart	Presentation on the pocket guide to ensure that pharmacy team are aware of changes and can field any questions from members of the public
Practice Nurse Meetings	Kim Lawther to confirm March dates	Kim Lawther/Lesley Young/ Pauline Lax	Presentation on the pocket guide to ensure that practice nurse are aware of changes and can field any questions from members of the public
Home Group (Mental Health and LD Housing Provider)	15th February – 11:30am agenda slot	Gail Linstead	Presentation on the pocket guide to ensure that home group are aware of changes and can feed this information back to their services users

Upper Teesdale Agricultural Support (UTASS) sessions have had to be stood down due to capacity/resources. Will inform Diane Richardson (UTASS Co-ordinator), of supermarket stalls that are available where people can attend and also send information on the pocket guide.

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NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Sedgefield Community Hospital
Salters Lane
Sedgefield
TS21 3EE

Tel: 0191 3713222
Fax: 0191 3713223
www.durhamdaleseasingtonsedgefieldccg.nhs.uk
www.facebook.com/ddesccg

6 March 2017

Dear patient,

GETTING CARE RIGHT FOR YOU – A Guide to your Local Health Services

Durham Dales Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is responsible for planning, buying and ensuring the quality of health services in your area.

Last year we consulted with you on the future of urgent care services in your area. We presented a number of options and you told us, following a public consultation last year, that you wanted greater access to urgent care services.

We have listened to what you told us and from 1st April the way you access your health care will change.

You will always be seen in your GP surgery or a surgery near you and will no longer visit a Walk In or Urgent Care Centre with an illness. You will not be able to walk into any service without an appointment.

If you are unwell during the day
You will be able to ring up and book urgent same day appointments with a health professional in your GP surgery or a GP Surgery near to where you live. During the hours of 8am-6pm, Monday-Friday you will need to ring your GP surgery, as you do now.

When your GP Surgery is closed
Between 6pm-8am, Monday-Friday and at weekends you should ring NHS 111, where you will be seen based on your need and signposted to the most appropriate service. This could be a GP practice close to where you live, known as a Primary Care Service, or an Out Of Hours service at Peterlee Community Hospital or Bishop Auckland Hospital.

An Out of Hours service, from 8pm-8am Monday-Friday and on weekends will remain and be provided at Peterlee Community Hospital or Bishop Auckland Hospital.

Minor Injury Units
Instead of the Walk In or Urgent Care Centres there will be Minor Injury Units at Bishop Auckland Hospital and Peterlee Community Hospital, 24 hours a day, 365 days a year. These Minor Injury Units will provide X-ray facilities 8am-8pm daily and will treat, for example; broken bones, sprains

and strains, minor burns or scalds. Patients are being advised to call 111 to get an appointment to reduce their waiting times.

Call 999 in a medical emergency when someone is seriously ill or injured and their life is at risk. There are no changes to this service

To summarise – "Talk before you walk"

- There will be no Walk In Centres and you will not be able to access a service without an appointment
- Think GP surgery first through the day between 8am-6pm, Monday-Friday
- When your GP surgery is closed, ring NHS 111. Staff will signpost you to the most appropriate service
- An Out of Hours service, from 6pm-8am, Monday-Friday and on weekends will remain and be provided at Peterlee Community Hospital or Bishop Auckland Hospital
- Minor Injury Units will be at Peterlee Community Hospital or Bishop Auckland Hospital and you should ring 111 to book an appointment.

Please find enclosed a pocket guide called 'What to do if you are unwell' and an information card for your purse or wallet. This guide has been developed in partnership with our patient representatives to help you understand the improvements to urgent care services starting on April 1st 2017 and to provide you with the information of where to go if you are poorly.

If in any doubt, call NHS 111.

Yours sincerely

Dr Stewart M Findlay
Chief Clinical Officer

NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group

Sedgefield Community Hospital,
Salters Lane,
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www.durhamdaleseasingtonsedgefieldccg.nhs.uk

Getting Care Right For You

What do I do if I have a minor injury?

24/7, 365 days a year you can go to a minor injuries unit at:

Bishop Auckland Hospital, DL14 6AD or

24/7

Peterlee Community Hospital, SR8 5UQ.

However, we would advise that you call NHS 111 to get an appointment to reduce your waiting times.

CALL 111

If it's more serious you may need further treatment at a hospital close by.

Minor injury

Examples of minor injuries are:

- Sprains and strains
- Broken bones
- Wound infections
- Minor burns and scalds
- Minor head injuries
- Minor eye injuries
- Insect and animal bites

Medical emergency

Call 999 in a medical emergency, when someone is seriously ill or injured and their life is at risk. This could include:

- Heart attack
- Stroke
- Major trauma (such as a serious road traffic accident, a fall from height or serious head injury)
- Loss of consciousness
- Severe confused state
- Fits that aren't stopping
- Breathing difficulties
- Severe allergic reactions, burns or scalds
- Severe bleeding that cannot be stopped
- Persistent, severe chest pain

When you dial 999 you will be assessed by a trained clinical advisor. You may receive treatment at the scene or be transferred to A&E at the most appropriate hospital.


NHS
Getting Care Right For You
NHS
Durham Dales, Easington and Sedgefield
Clinical Commissioning Group
What to do if you are unwell
Your quick guide to local health services
The NHS belongs to us all.
Let's use it responsibly.
Talk before you walk.
The way you use your NHS matters - using it wisely means we can develop and invest in local services to make your NHS fit for the future.
Help yourself:
Hangover, grazed knee, cough and sore throat. Visit www.nhs.uk. Also download the free NHS child health app.
Pharmacy:
Diarrhoea, runny nose, painful cough and headache. Health and wellbeing, stopping smoking.
Call NHS 111:
Need help fast? Unsure? Not well? Easy, fast health services - keep 999 free for medical emergencies.
Minor injury:
Strains, cuts, sprains and burns. Units at Bishop Auckland Hospital or Peterlee Community Hospital.
24/7
GP practices:
Ring your GP surgery Mon - Fri, 8am - 6pm. Ring NHS 111 between 6pm - 8am and at weekends.
A&E or call 999:
Chest pain, choking, severe blood loss, blacking out, unconsciousness, suspected stroke.

Health and Wellbeing Board

16 March 2017

Transforming Care for People with Learning Disabilities (Fast Track Plan)

Report of Louise Okello, Senior Commissioning Manager, Joint Commissioning and Continuing Health Care, North of England Commissioning Support

Purpose of the Report

1 The purpose of this report is to update the Health and Wellbeing Board on progress regarding the North East and Cumbria Fast Track programme, a report was last received by the Board in November 2015.

Background

2 During the 1990s and 2000s there were many resettlement programmes for people with learning disabilities. However, there is still an over reliance on hospital settings for the care of people with learning disabilities and/or autism. Following the Winterbourne View scandal and the Sir Stephen Bubb Report, the transformation programme was developed. Since then the national plan Building The Right Support (Link) has been published which sets out the vision and ambition for achieving better care and life opportunities for people with a learning disability.

3 By improving community infrastructure, supporting the workforce, avoiding crisis, with earlier intervention and prevention, we will be able to support people in the community so avoiding the need for hospital admission. This will result in systematic closure of learning disability in-patient hospital beds over the next five years across the North East and Cumbria.

4 The Transforming Care guidance highlights the importance of local partnership working between commissioners from local government and the NHS with an emphasis on the oversight and support of Health and Wellbeing Boards.

5 Nationally, the Learning Disabilities Transforming Care Programme aims to reshape services for people with learning disabilities and/or autism with a mental health problem or behaviour that challenges, to ensure that more services are provided in the community and closer to home rather than in hospital settings. This arose as a result of Sir Stephen Bubb's review of the Winterbourne View concordat.

Progress to Date

6 Since the plan was accepted “in principle” by local Health and Wellbeing Boards across the region, work has been ongoing to implement the recommendations and the following progress is expected to be achieved by March 2017.

7 The North East and Cumbria Transforming Care Programme Board (NE +C) has committed to reducing the number of beds by 42 by the end of March 2017. The trajectory for achievement of this is now being monitored across North East and Cumbria on a monthly basis.

8 Whilst there have been some concerns that the NE +C are admitting too many people to institutional care, NHS Trusts have confirmed that bed closure trajectories will be achieved by March 2017.

9 In terms of current activity, the total number of beds commissioned in County Durham are highlighted below:

CCG	CCG Commissioned Patients Total	Specialised Commissioned Total
Durham Dales Easington and Sedgefield CCG	8	10
North Durham CCG	11	15

10 NHS England (NHSE) have acknowledged that whilst good progress has been made there is still much to do to ensure that, where it is appropriate, people are cared for in the community and closer to home. The level of scrutiny linked with this programme of work is intense with weekly updates to the Secretary of State.

11 As part of the ongoing monitoring programme NHSE have asked the Senior Responsible Officer for the North East and Cumbria programme to closely scrutinise the following areas:

a. Community and post-admission Care and Treatment Reviews (CTRs) being completed for individual patients;
b. Achievement of planned discharge dates;
c. Resolution of any financial dispute cases;
d. A clear focus on the patients who have been in hospital for five years and moves towards discharges, where appropriate;
e. Review of cases where patients have been readmitted to identify any lessons learned.

12 The enhancement of intensive home support services to intervene early when individuals experience behavioural challenges, so avoiding crisis, is essential if hospital admissions are to be avoided. This provision needs to be available on an out of hours basis ensuring responsive specialist interventions can be delivered in a person’s home, wherever that may be.

13 From a County Durham perspective so far there have been some very positive examples of individuals being supported through enhanced joint working between the community provider and the specialist team from Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). The October Transforming Care Board supported in principle; the proposed service models for community services that will support reduced admissions, and reduced readmissions and facilitate discharges for current in-patients. The proposal for a Secure Outreach and Transitions Team (SOTT) has been submitted to Regional Leadership Group (NHSE) for agreement. The SOTT is based on the nine principles of the National Service Model and has been developed by the Forensic Services at TEWV and Northumberland and Tyne and Wear NHS Foundation Trust and with experts by profession, and a series of co-production events with service users and carers. The CCGs are reviewing the community proposals as part of the current contract negotiations.

Communication and Engagement

14 Within the previous update, reference was made to a presentation which was scheduled for the Regional Overview and Scrutiny Committee. This took place in January 2016 and an update presentation is scheduled early 2017.

15 The Regional Overview and Scrutiny Committee, whilst understanding of the need to improve the service offer to people with a learning disability, expressed concern regarding issues relating to bed availability and potential costs to Local Government. Information relating to such concerns is outlined in paragraphs 19-21 of this report.

16 A Confirm and Challenge Group, comprised of service users and carers, sits beneath the Transforming Care Board. Its role being to champion co-production and ensure the needs and views of users and carers are appropriately represented in relation to new service models.

17 Local implementation groups are also expected to evidence engagement with users and carers. It should be noted that any changes to an individual service user's care and treatment arrangements will be subject to usual Care Act assessment processes which mandate engagement with those directly affected.

18 The Transforming Care Programme is also part of the Sustainability and Transformation Plan (STP) for both North East footprints.

Challenges

19 The Transforming Care Programme needs to be acknowledged in the backdrop of extreme financial pressures both in the NHS and Adult Social Care. The Health and Wellbeing Board will recall that in the previous update specific reference was made to the potential risks associated with dowry allocations which were limited only to a small cohort of learning disabled people. Concerns were also expressed regarding the lack of clarity on dowry allocations.

20 Representations have been made on the financial barriers to delivering on the new Transforming Care programme, particularly from the North East Region, led by Adult Social Care in County Durham. Limited capital funds have been made available and regional representatives are in discussions regarding the funding and affordability of individual care dowry payments. In addition, no additional revenue has been released to establish core provision in the community.

Recommendations

21 The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Agree to support officers in continuing to lobby for the financial position of the Transforming Care Programme to be reviewed.
- Agree to receive a further update to a future Health and Wellbeing Board meeting.

Contact:	**Donna Owens, Commissioning Manager for Learning Disabilities in the Durham and Tees Area, North of England Commissioning Support**
Tel:	**0191 374 4168**

Appendix 1: Implications

Finance

Potential shortfall in funding arrangements. Management of the financial consequences of supporting more people in community settings including:

- Funding released from decommissioning inpatient services is less than the amount required for community based provision.
- Dowries and funding allocations insufficient with resultant potential consequences to Local Authorities.
- Potential to destabilise existing provider services.

Staffing

Potential inability to recruit a skilled flexible workforce who can deliver evidence-based care including subsequent significant training and re-skilling demands.

Risk

Failure to deliver the agreed bed reduction trajectory. The focus on "bed closures" associated with the Fast Track programme may detract from the broader system-wide transformation that is needed to achieve the safe and sustainable reduction in the number of people in an inpatient setting. New community-based support will require a significant lead in time.

Equality and Diversity/Public Sector Equality Duty

No immediate implications although there is a potential impact on the rights of individuals who remain in hospital longer than expected due to a lack of appropriate infrastructure in community provision.

Accommodation

Accommodation for alternative assessment and treatment provision will be required.

Crime and disorder

The Fast Track plan aims to support people who have risky criminal behaviour in their local communities.

Human rights

No immediate implications although there is a potential impact on the rights of individuals who remain in hospital longer than expected due to a lack of appropriate infrastructure in community provision.

Consultation

Consultation with individual service users and their carers will take place as part of Community Treatment Reviews. Implications of staff currently employed in in-patient settings. Consultation will need to be undertaken with affected staff.

Procurement

Potential procurement activity required for new models of delivery.

Disability issues

Accommodation will need to be fit for purpose for people with a learning disability.

Legal implications

Potential TUPE (Transfer of Undertakings [Protection of Employment]) implications.

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Health and Wellbeing Board

16 March 2017

Motor Neurone Disease Charter

Report of Andrea Petty, Strategic Manager Policy, Planning and Partnerships, Durham County Council

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Board with details of:

- The Motor Neurone Disease (MND) Charter (Appendix 2).
- Evidence of how the County Durham Health and Wellbeing Board meet the needs of people with MND and any areas for further development.

Background

2 The MND Charter is part of a campaign initiated by the MND Association. They describe the MND Charter as a statement of the respect, care, and support that people living with MND and their carers deserve.

3 MND is a fatal, rapidly progressing disease that affects the brain and spinal cord. It can leave people locked in a failing body, unable to move, talk and eventually breathe. A person's lifetime risk of developing MND is up to one in 300. It kills around 30% of people within 12 months of diagnosis, more than 50% within two years. It affects people from all communities. It has no cure.

4 Nationally, the prevalence of people living with MND at any one time is approximately seven in every 100,000 people.

5 The MND Association believe that what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity. The MND Charter is intended to serve as a tool to help make this happen by supporting organisations to meet their responsibilities towards people with MND and their families and carers.

6 There are five commitments in the charter and evidence as to how the charter commitments are met and areas for further development are outlined below.

Commitments and areas for further development

7 **Commitment 1**: People with MND have the right to an early diagnosis and information:

- An early referral to a neurologist;
- An accurate and early diagnosis, given sensitively;
- Timely and appropriate access to information at all stages of their condition.

8 GP's across the county are able to identify symptoms and signs of neurological problems. Plans are also in place to review neurology guidelines in line with the clinical guidelines programme of work.

9 Support, information, guidance and advice to people who have, or are in the process of a diagnosis is available from a variety of information sources such as health and social care staff and Locate. Locate is a free online resource offering a wealth of information, advice, and services to help people live independently and find the right care and support to meets their needs.

10 In addition, health and social care professionals currently attend forums with the regional clinics regarding ongoing patients/clients and the ongoing research work they undertake in relation to the condition. This work will continue to take place to develop any further links.

11 **Commitment 2:** People with MND have the right to high quality care and treatments:

- Access to co-ordinated multidisciplinary care managed by a specialist key worker with experience of MND;
- Early access to specialist palliative care in a setting of their choice, including equitable access to hospices;
- Access to appropriate respiratory and nutritional management and support, as close to home as possible;
- Access to the drug Riluzole;
- Timely access to NHS continuing healthcare when needed;
- Early referral to Social Care services;
- Referral for cognitive assessment, where appropriate.

12 Occupational Therapy staff form part of coordinated multidisciplinary teams (MDT) and already attend quarterly forums with the regional clinic and the MDT to discuss current clients and identify links and networks with other services.

13 End of life care is a key priority for the County Durham Health and Wellbeing Board and is identified as a strategic objective in the Joint Health and Wellbeing Strategy as follows:

> "Support people to die in the place of their choice with the care and support that they need"

14 A Palliative and End of Life Care plan is now in place to deliver high quality sustainable services and improvements for patient and carer experience for people diagnosed with a life limiting condition. There are a number of services commissioned by CCG's as part of the strategy which enable care closer to home including the Marie Curie Planned Nursing service and the response service which can support people with MND.

15 Referrals for people with MND for Continuing Healthcare (CHC) assessments are made in a timely manner if this need is identified in liaison with the CHC coordinator and support from other members of the MDT. A simple and timely process for referral to social care services is in place which can sustain the best possible quality of life.

16 Ongoing education for health and Social Care professionals in order to reflect advances in best practice is a potential area for development. There is an opportunity across both CCGs to use the protected learning time for GP's for further training and within the local authority, work will take place to look to incorporate good practice briefings into the training budgets.

17 **Commitment 3:** People with MND have the right to be treated as individuals and with dignity and respect:

- Being offered a personal care plan to specify what care and support they need;
- Being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting;
- Getting support to help them make the right choices to meet their needs when using personalised care options;
- Prompt access to appropriate communication support and aids;
- Opportunities to be involved in research if they so wish.

18 All service users are involved in developing their own personal care and support plan. Personalised care is central to the care processes and full use is made of individual budgets and direct payments in support of service

users' needs and choices. The cases of people with MND are kept 'open' in recognition of the probability of rapid deterioration and therefore the need for further social care support. Occupational Therapists (OTs) will support service users to access appropriate equipment and communication aids in conjunction with NHS colleagues. The OT service will look at equipment on the commercial market if it is felt that something bespoke will meet the client needs and these clients are often referred to the NHS environmental controls service who can provide electronic assistive technology equipment on loan to severely disabled people enable them to live more independently in their homes.

19 The OT service will actively continue to improve their skills and knowledge to meet the needs of specialist client groups

20 **Commitment 4:** People with MND have the right to maximise their quality of life:

- Timely and appropriate access to equipment, home adaptations, environmental controls, wheelchairs, orthotics and suitable housing;
- Timely and appropriate access to disability benefits.

21 The OT service and the Housing providers in Durham recognise that MND is a rapidly progressive disease and work together to provide the best possible outcomes within the accommodation resources available to support the client. Fast track to adaptations can be offered should the need arise.

22 Specialist and non-specialist wheelchair provision is commissioned by CCG's and provided by County Durham and Darlington NHS Foundation Trust across the County. Ensuring timely access to the service is monitored as part of the contract.

23 A welfare rights service is in place within County Durham which ensures that service users with MND will have timely advice about disability benefits and broader welfare information.

24 Identified Social Care professionals will continue to work jointly with housing providers and ensure they are aware of the housing options available and the housing role.

25 **Commitment 5:** Carers of people with MND have the right to be valued, respected, listened to and well supported:

- Timely and appropriate access to respite care, information, counselling and bereavement services.
- Advising carers that they have a legal right to a Carer's Assessment of their needs, ensuring their health and emotional well-being is recognised and appropriate support is provided.

- Timely and appropriate access to benefits and entitlements for carers.

26 Each carer has a right to their own Carers Assessment and Care and Support Plan. Durham County Carers Support Service and The Bridge Young Carers Service are support services who offer information, advice and support to Carers. The services can signpost carers to welfare and benefits advice and help to access respite services and carers' breaks.

27 Identified Social Care professionals will continue to develop links with specialist health teams relating to MND and ensure they work together to access appropriate services in a timely manner for clients and their carers.

Recommendations

28 The Health and Wellbeing Board is recommended to:

- Note how member organisations of the Health and Wellbeing Board meet the commitments to the MND Charter as outlined in this report
- Agree to adopt the MND Charter using it as a tool to progress the care and support of people with MND in the county
- Agree to receive an update on the progress of charter commitments of the Health and Wellbeing Board at a future meeting.

Contacts:	**Jenny Warren, Strategic Commissioning Manager**
Tel:	**07786027189**
	Denise Hopper, Principal Occupational Therapist
	03000 262185

Appendix 1: Implications

Finance
Not applicable

Staffing
Not applicable

Risk
Not applicable

Equality and Diversity / Public Sector Equality Duty
Under the Equality Act 2010 a person is classified as disabled if they have a physical or mental impairment which has a substantial and long-term effect on their ability to carry out normal day-to-day activities.

Accommodation
Not applicable

Crime and Disorder
Not applicable

Human Rights
Not applicable

Consultation
Not applicable

Procurement
Not applicable

Disability Issues
The Health and Wellbeing Board has been requested to adopt the MND Charter as a method of supporting people with MND, and their carers, in County Durham.

Legal Implications
Not applicable

mnda
motor neurone disease
association

CHAMPION THE CHARTER ON YOUR DOORSTEP

themndcharter

Achieving quality of life, dignity and respect for people with MND and their carers

The MND Charter is a statement of the respect, care and support that people living with motor neurone disease (MND) and their carers deserve, and should expect.

We believe that everyone with a connection to MND, either personally or professionally, should recognise and respect the rights of people with MND as set out in the Charter, and work towards the Charter's vision of the right care, in the right place at the right time.

About MND:

- MND is a fatal, rapidly progressing disease that affects the brain and spinal cord.
- It can leave people locked in a failing body, unable to move, talk and eventually breathe.
- A person's lifetime risk of developing MND is up to one in 300.
- It kills around 30% of people within 12 months of diagnosis, more than 50% within two years.
- It affects people from all communities.
- It has no cure.

Therefore, what matters most is that people with MND receive a rapid response to their needs and good quality care and support, ensuring the highest quality of life as possible and the ability to die with dignity. The MND Charter serves as a tool to help make this happen.

MND is a devastating, complex disease and particularly difficult to manage. We believe that if we get care right for MND we can get it right for other neurological conditions, and save public services money in the long run. But more importantly, we can make a positive difference to the lives of people with MND, their carers and their loved ones.

1 People with MND have the right to an early diagnosis and information

THIS MEANS:

- An early referral to a neurologist.
- An accurate and early diagnosis, given sensitively.
- Timely and appropriate access to information at all stages of their condition.

There is no diagnostic test for MND – it can only be diagnosed by ruling out other neurological conditions. People with MND can be halfway through their illness before they receive a firm diagnosis.

GPs need to be able to identify the symptoms and signs of a neurological problem and refer directly to a neurologist in order to speed up diagnosis times for MND.

Appropriate tests must be carried out as soon as possible to confirm MND. The diagnosis should be given by a consultant neurologist with knowledge and experience of treating people with MND[1]. The diagnosis should be given sensitively, in private, with the person with MND accompanied by a family member/friend and with time to ask questions. A follow-up appointment with the neurologist should be arranged soon after diagnosis.

At diagnosis people with MND should be offered access to appropriate information and should be informed about the MND Association. Appropriate information should be available at all stages of the person's condition in a language of their choice.

2 People with MND have the right to high quality care and treatments

THIS MEANS:

- Access to co-ordinated multidisciplinary care managed by a specialist key worker with experience of MND.
- Early access to specialist palliative care in a setting of their choice, including equitable access to hospices.
- Access to appropriate respiratory and nutritional management and support, as close to home as possible.
- Access to the drug riluzole.
- Timely access to NHS continuing healthcare when needed.
- Early referral to social care services.
- Referral for cognitive assessment, where appropriate.

People with MND may need care provided by health and social care professionals from up to 20 disciplines. This clearly needs co-ordination to work effectively. Co-ordinated care can improve the quality of life of people with MND and provide value for money for the NHS by preventing crises and emergency hospital admissions. The care should be co-ordinated by a specialist key worker with experience of MND who can anticipate needs and ensure they are met on time. Ongoing education for health and social care professionals is important to reflect advances in healthcare techniques and changes in best practice.

A third of people with MND die within 12 months of diagnosis. Early access to specialist palliative care[2] soon after diagnosis is therefore vital and should be available in a setting of the person's choice. Some hospices give preferential access to people with a cancer diagnosis. It is important that access is based on need, not diagnosis, so that people with MND have equitable access to hospice care. Hospices can

provide high-quality respite care, which can benefit both the person with MND and their carer.

As MND progresses, the respiratory muscles and muscles of the mouth and throat may be affected. People with MND may therefore need respiratory and nutritional support. It is important that these services are available as close to the person's home as possible so that travelling is minimised and support is available quickly.

In 2001 the National Institute for Health and Care Excellence (NICE) recommended riluzole as a cost-effective drug for people with MND. GPs can be reluctant to prescribe riluzole on cost grounds, despite its NICE-approved status, or to monitor for side effects during its use. However, it is vital that people with MND have ongoing access to this important treatment.

As the disease progresses, people with MND may need more intensive health care. It is important that people with MND have timely access to NHS continuing healthcare when they need it.

People with MND are likely to need help with getting up, washing, dressing and preparing food as the disease progresses. Access to social care services is therefore important to maintain quality of life. People with MND may also need access to cognitive assessment, as up to half of people with the disease experience changes in cognition.

3 People with MND have the right to be treated as individuals and with dignity and respect

THIS MEANS:

- Being offered a personal care plan to specify what care and support they need.
- Being offered the opportunity to develop an Advance Care Plan to ensure their wishes are met, and appropriate end-of-life care is provided in their chosen setting.
- Getting support to help them make the right choices to meet their needs when using personalised care options.
- Prompt access to appropriate communication support and aids.
- Opportunities to be involved in research if they so wish.

Everyone with MND should be offered a personal care plan[3] to specify what care and support they need. The plan should be regularly reviewed as the disease progresses and the person's needs change.

People with MND should be offered the opportunity to develop an Advance Care Plan[4] to make clear their wishes for future care and support, including any care they do not wish to receive. The plan should be developed with support from a professional with specialist experience and may include preferences for end-of-life care.

Some people with MND will need support to help them make the right choices to meet their needs when using personalised care options, such as personal budgets.

As the disease progresses, some people with MND will experience difficulty speaking. It is important that people with MND can access speech and language therapy to help them maintain their voice for as long as possible. However, as the disease progresses, people with MND may need access to communication aids including augmentative and alternative communication (AAC)[5]. The ability to communicate is a basic human right. For people with MND, communication support and equipment are vital in order to remain socially active and to communicate their wishes about their care, especially during hospital stays and other medical environments.

Many people with MND value the opportunity to be involved in research as it provides hope that one day an effective treatment will be developed. Everyone with MND who wishes to should be able to participate in research as far as is practicable.

4 People with MND have the right to maximise their quality of life

THIS MEANS:

- Timely and appropriate access to equipment, home adaptations, environmental controls, wheelchairs, orthotics and suitable housing.
- Timely and appropriate access to disability benefits.

People with MND may find their needs change quickly and in order to maximise their quality of life, they may need rapid access to equipment, home adaptations, wheelchairs and suitable housing. These needs should be anticipated so that they are met in a timely way. This is particularly true of wheelchairs which are important for maximising independence and quality of life.

People with MND need timely and appropriate access to disability benefits to help meet the extra costs of living with a disability. Information on appropriate benefits needs to be readily accessible in one place and easily understandable.

5 Carers of people with MND have the right to be valued, respected, listened to and well supported

THIS MEANS:

- Timely and appropriate access to respite care, information, counselling and bereavement services.
- Advising carers that they have a legal right to a Carer's Assessment of their needs[1], ensuring their health and emotional well being is recognised and appropriate support is provided.
- Timely and appropriate access to benefits and entitlements for carers.

Caring for someone with MND is physically and emotionally demanding. Carers need to be supported in order to maintain their caring role. Every carer should have their needs assessed and given timely and appropriate access to respite care, information, counselling and bereavement services. It is important to support the emotional and physical needs of the carer in a timely way so that they can continue their caring role.

Carers should also have timely and appropriate access to benefits and entitlements to help manage the financial impact of their caring role.

[1] Recomendation in the NICE guideline on MND.

[2] Specialist palliative care – palliative care is the active holistic care of patients with progressive illness, including the provision of psychological, social and spiritual support. The aim is to provide the highest quality of life possible for patients and their families. Specialist palliative care is care provided by a specialist multidisciplinary palliative care team.

[3] Personal care plan – a plan which sets out the care and treatment necessary to meet a person's needs, preferences and goals of care.

[4] Advance care plan – a plan which anticipates how a person's condition may affect them in the future and, if they wish, set on record choices about their care and treatment and/or an advance decision to refuse a treatment in specific circumstances so that these can be referred to by those responsible for their care or treatment (whether professional staff or family carers) in the event that they lose capacity to decide or communicate their decision when their condition progresses.

[5] Augmentative and Alternative Communication (AAC) – is used to describe the different methods that can be used to help people with speech difficulties communicate with others. These methods can be used as an alternative to speech or to supplement it. AAC may include unaided systems such as signing and gesture as well as aided systems such as low tech picture or letter charts through to complex computer technology.

"Many people with MND die without having the right care, not having a suitable wheelchair, not having the support to communicate.

We have got to set a standard so that people like us are listened to and treated with the respect and dignity we deserve.

We have got to stop the ignorance surrounding this disease and have to make sure that when a patient is first diagnosed with MND, they must have access to good, co-ordinated care and services.

One week waiting for an assessment or a piece of equipment is like a year in most people's lives, because they are an everyday essential to help us live as normal a life as possible and die with dignity"

Liam Dwyer, who is living with MND

For more information:

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Email: campaigns@mndassociation.org

Telephone: 020 7250 8447

We are proud to have the following organisations supporting the MND Charter:

Royal College of General Practitioners

Association of British Neurologists

Royal College of Nursing

Chartered Society of Physiotherapy

College of Occupational Therapists

Royal College of Speech & Language Therapists

British Dietetic Association

MND Association
PO Box 246 Northampton NN1 2PR
www.mndassociation.org

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