Special Health and Wellbeing Board

Date **Thursday 21 January 2016**
Time **10.30 am**
Venue **Conference Room 1 - Council Offices, Spennymoor**

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 3 November 2015 (Pages 1 - 8)
5. Better Care Fund Update - Report of Strategic Programme Manager - Care Act Implementation and Integration, Children and Adults Services, Durham County Council (Pages 9 - 14)
6. North Durham CCG (NDCCG) and Durham Dales, Easington and Sedgefield CCG (DDESCCG) Planning progress update and draft commissioning intentions for 2016-17 - Joint report of Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Chief Operating Officer, North Durham & Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (Pages 15 - 28)
7. Urgent Care Service Integration - Report of Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group (Pages 29 - 44)
8. Durham County Council Cold Weather Plan- Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 45 - 90)
9. County Durham Health Profile 2015 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 91 - 100)
10. County Durham Child Health Profile 2015 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 101 - 110)

11. County Durham Drug Strategy Action Plan 2014-2017 - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 111 - 136)
12. Durham Local Safeguarding Children Board Annual Report 2014-15 - Report of Independent Chair, Durham Local Safeguarding Children Board (Pages 137 - 198)
13. Safeguarding Adults Board Annual Report 2014-15 - Report of Independent Chair, County Durham Safeguarding Adults Board (Pages 199 - 234)
14. Children's Services Update - Report of Head of Children's Services, Children and Adults Services, Durham County Council (Pages 235 - 246)
15. Update from Healthwatch County Durham - Report of Interim Chief Executive, Healthwatch County Durham (Pages 247 - 254)
16. Health and Wellbeing - Area Action Partnership Links - Report of Area Action Partnership Coordinator, Assistant Chief Executive, Durham County Council (Pages 255 - 262)
17. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration
18. 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)

19. Pharmacy Applications - Report of Director of Public Health County Durham, Children and Adults Services, Durham County Council (Pages 263 - 266)
20. 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
13 January 2016

To: The Members of the Health and Wellbeing Board

Durham County Council

Councillors L Hovvels, O Johnson and J Allen

R Shimmin	**Corporate Director of Children and Adult Services, Durham County Council**
A Lynch	**Director of Public Health County Durham, Durham County Council**
N Bailey	**North Durham Clinical Commissioning Group**
Dr D Smart	**North Durham Clinical Commissioning Group**
Dr S Findlay	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
J Chandy	**Durham Dales, Easington and Sedgefield Clinical Commissioning Group**
S Jacques	**County Durham and Darlington NHS Foundation Trust**
A Foster	**North Tees and Hartlepool NHS Foundation Trust**
M Barkley	**Tees. Esk and Wear Valleys NHS Foundation Trust**
C Harries	**City Hospitals Sunderland NHS Foundation Trust**
J Mashiter	**Healthwatch County Durham**

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

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DURHAM COUNTY COUNCIL

At a Meeting of **Health and Wellbeing Board** held in Committee Room 2, County Hall, Durham on **Tuesday 3 November 2015 at 9.30 am**

Present:

Councillor L Hovvels (Chairman)

Members of the Committee:
Councillors J Allen and O Johnson

Apologies:
Apologies for absence were received from Councillors N Bailey, Dr S Findlay, A Foster and S Jacques

1 Apologies for Absence

Apologies for absence were received from N Bailey, Dr S Findlay, A Foster and S Jacques

2 Substitute Members

There were no substitute members.

3 Declarations of Interest

The Chairman declared an interest in Item No. 17.

4 Minutes

The Minutes of the meeting held on 23 July 2015 were confirmed by the Board as a correct record and signed by the Chairman.

5 Better Care Fund Update

The Board considered a report of the Strategic Programme Manager – Care Act Implementation and Integration, Children and Adults Services, Durham County Council that gave an update on the key performance indicators established within the Better Care Fund (BCF), including the requirements of the Better Care Fund Quarter 1 2015/16 return for County Durham, which has already been reported to NHS England (for copy see file of Minutes).

The Corporate Director, Children and Adults Services, DCC highlighted the importance of also monitoring the number of residential and nursing bed days purchased for older people as the long term trend is a downward one.

Resolved:

(i) That the report be noted.

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

6 Care Act and Adult Social Care Transformation Update

The Board considered a report of the Corporate Director, Children and Adults Services, Durham County Council that provided an update on the local and national developments in relation to the implementation of the Care Act 2014 and the transformation of Adult Care services, focussing on changes to deliver Phase 1; the new care and support duties from 1st April 2015. The report also provided an update on the recent announcement by Government to postpone the Phase 2 reforms until 2020 which were due to come into effect from 1st April 2016, which includes the cap on care costs and appeals system (for copy see file of Minutes).

Resolved:

(i) That the report be noted.

(ii) That further updates in relation to Adult Social Care transformation be received.

7 Learning Disability FastTrack Programme / Transforming Care: Next Steps Update

The Board considered a report of the Senior Commissioning Manager, Joint Commissioning and Continuing Health Care and Joint Commissioning Manager, North of England Commissioning Support that gave an update on progress regarding the North East and Cumbria Fast Track programme (for copy see file of Minutes).

The Senior Commissioning Manager advised that the North East have a higher than average number of beds and had been selected as a fast track area. Joint working between CCGs and the local authority are taking place and a regional plan had been developed, as well as local plans. There were three parts to the regional plan – Early Intervention, Crisis Resolution, and Workforce. Beneath the Regional Plan separate localities have submitted their own plan. The Durham plan is to be delivered in partnership with Darlington and focuses upon the development of accommodation based services as an alternative to hospital admission.

The workforce element of the plan aims to encourage robust leadership across all sectors and Positive Behaviour Support (PBS) as the approach for managing challenging behaviours.

A view was expressed by a member of the Board that some independent sector providers charge premiums for care and as such should be responsible for their own leadership programmes.

The Senior Commissioning Manager went on to advise that it was proposed to invest in enhanced community support services and would include more of a 24/7 cover.

The Head of Adult Care, Children and Adults Services, DCC informed the Board that the details around funding were yet to be worked through. She added that she would continue to make representations about the understanding around costings and the challenging timescales. She advised that the principles were sound but that it would take time to get it right and that there were risks associated with a quick turnaround.

The Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust agreed that people with learning disabilities, autism and challenging behaviour should lead as full a life as possible within the community. He also recognised that there would be significant cost pressures on the NHS and local government. The national Clinical Director has provided evidence that shows that proportionately people with learning disabilities were up to 400% higher in the North East than in other parts of the country and a high percentage of those individuals had a mental health need. He advised that TEWV supported the programme but had significant anxieties and emphasised the specific needs of individuals and the financial risks.

The Head of Adult Care, DCC advised that there was a risk register and re-iterated that there were challenges around the programme. She confirmed that the changes were about giving people a better quality of life but that the transformation needs to be implemented carefully and funded adequately.

In relation to the timescale, the Corporate Director of Children and Adult Services asked if NHS England were conscious of some of the risks and the rapid escalation of the work that needs to be carried out. The Associate Director of Clinical Networks and the Clinical Senate, NHS England advised that the Regional Clinical Director was ensuring that people were made aware of the changes. He would take a strong message back to the NHS England Board.

The Director of Primary Care Development and Engagement, DDES CCG said that the CCG fully support the programme especially where changes are affected locally, with primary care at the centre. The Senior Commissioning Manager informed the Board that specific needs of cohorts would be reported locally to each CCG.

In relation to the individuals identified, the Senior Commissioning Manager informed the Board that numbers were fluid and can change with people being admitted and discharged. In terms of projections, she advised that children were being supported at an early stage with care provided in the community, where possible. She went on to explain that the plan would need to be amended from a 5 year to 3 year plan in terms of the timescale to implement changes.

The Senior Commissioning Manager informed the Board that the Regional Scrutiny Committee were looking at the implications of the changes and she said that she would give an update at a future meeting.

The Chairman thanked the Senior Commissioning Manager for her report.

Resolved:

(i) That the plan, in particular the Durham and Darlington Locality Plan which was embedded in the North East and Cumbria Fast Track plan be supported and agreed.

(ii) That the North East & Cumbria Fast Track - proposed trajectories attached at Appendix 5 be noted.

(iii) That regular updates on County Durham's progress in relation to Fast Track implementation be received.

8 Altogether Active - A Physical Activity Framework for County Durham

The Board considered a report of the Corporate Director, Neighbourhood Services, Durham County Council that gave an update of the progress towards the development of a new strategic framework for physical activity. The report sought support for the next steps in the process to launch a consultative version of the framework at the forthcoming Big Tent Engagement Event on 4th November 2015 (for copy see file of Minutes).

The Chairman said that this was an exciting development and had come a long way but added that the messages needed to be simple. The Head of Planning and Service Strategy agreed that it was important to join up services.

The Director of Public Health County Durham said that copies of the strategy would be available at the Big Tent event.

Resolved:

(i) That the progress in the development of a physical activity framework for County Durham 'Altogether Active' be noted and supported.

(ii) That the consultative draft of the framework following its launch on the 4th November at the 'Big Tent' engagement event be formally responded to.

9 County Durham and Darlington Urgent Care Strategy 2015-20

The Board considered a report of the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that asked for endorsement of the County Durham and Darlington Urgent Care Strategy 2015-20 (for copy see file of Minutes).

The Head of Planning and Service Strategy outlined that an easy read version of the Urgent Care Strategy and an extract of key points and how they fit in with other relevant strategies would be welcomed.

The Director of Primary Care Development and Engagement, DDES said that he would take the comments back and explained that patients and the public have been consulted. He advised that the executive summary explains the changes nationally. The Clinical Chair, North Durham CCG added that the main aspects relating to Securing Quality in Health Services (SeQIHS) were to ensure that urgent and non-life threatening care are available in and out of hospital.

The Corporate Director of Children and Adults Services, DCC suggested developing relevant metrics in relation to the eight high impact interventions.

The Corporate Director Children and Adults Services DCC asked if there would be an overarching communication strategy and if so, if a timeline was available. The Director of Primary Care Development and Engagement, DDES advised that each CCG will be working on any proposed changes to urgent care services. The Clinical Chair, North Durham CCG added that there were differences locally and each Patient Reference Group would be involved.

Resolved:

(i) That the County Durham and Darlington Urgent Care Strategy 2015-20 be endorsed.

(ii) That the governance and implementation of the Urgent Care Strategy will be through the System Resilience Group be noted.

10 Winter Plan and System Resilience Update

The Board considered a report of the Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group that provided an update on winter planning and resilience and to outline the processes that the County Durham and Darlington Systems Resilience Group are following to provide assurance and monitor the delivery of approved resilience schemes (for copy see file of Minutes).

The Corporate Director of Children and Adults Services, DCC referred to the summary in Appendix 4 of the list of providers and resilience schemes and said that it was a positive approach and a useful overview.

The Director of Public Health County Durham, DCC outlined that the Council Cold Weather Plan would be aligned with this broader work.

Resolved:

That the report be noted.

11 County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience 2015 - 2020

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council that provided the County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience for agreement (for copy see file of Minutes).

The Head of Planning and Service Strategy, DCC said that there had been significant stakeholder input and as it was such a large document he asked that care be taken when communicating it with young people. The Director of Public Health County Durham, DCC advised that the use of social media in the first year of the Strategy would be used when communicating the key messages to young people.

The Chief Executive of Tees, Esk and Wear Valleys NHS Foundation Trust commended the plan and highlighted the difference in spend for people who access Child and Adolescent Mental Health Services (CAMHS) and have a learning disability in DDES and North Durham CCGs. The Director of Public Health County Durham provided assurance that the plan was evidence based and the comprehensive action plan would ensure that outcomes are improved for children and young people. The Director of Public Health County Durham, DCC also highlighted the increase in spend for services for young people who have eating disorders.

The Chairman asked for a further update in 6 months.

Resolved:

(i) That the work that has taken place to develop the County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience be noted.

(ii) That the County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience be agreed.

12 NHS Health Checks

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council that summarised the findings from the review of the first five years of the NHS Health Check programme; to provide an update on the changes introduced since 2013; ensure that the health check programme commissioned by Durham County Council public health team fulfils the local authority's statutory requirements and to provide a commentary on the current performance of the programme (for copy see file of Minutes).

The Director of Primary Care Development and Engagement, DDES endorsed the work carried out and all of the progress that continues to be made. He said that DDES CCG had been involved from an early stage looking at redeveloping the programme in terms of less bureaucracy, data entry and materials to hand out. A software programme was developed to make the information pack easy to read and understand. They had worked closely with Dr Mike Lavendar, Public Health, to sell the idea to GP surgeries. There was still a lot of work to do and it was recognised that there was a difference in take up in each CCG area. It was also recognised this is an area of work GP Federations could work on collectively.

Resolved:-

(i) That the findings from the evaluation of the first five years of the Health Check programme highlighted in this report and detailed in the attached report at Appendix 2 be noted.

(ii) That the statutory responsibilities for the local authority with regard to the NHS Health Check programme be noted.

(iii) That the developments introduced since 2014 to address the weaknesses identified by the five year review and to ensure that the local authority meets its statutory requirements be noted.

(iv) That the current performance of the programme and the variance between practices be noted.
(v) That the further developments planned to improve the quality of health checks, to increase the coverage of the programme and to reduce the wide variation in coverage between GP practices be noted.

13 Health and Wellbeing of Gypsy Roma Traveller (GRT) Communities

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council that gave an update on the background to the GRT health work and the progress being made following a health needs assessment, the work was a priority in the Health and Wellbeing Strategy (for copy see file of Minutes).

Councillor J Allen recognised the hard work carried out by wardens working with the Gypsy Roma Traveller Communities and how they try to engage people, including the hard to reach. She welcomed the report.

The Director of Primary Care Development and Engagement, DDES CCG asked if health checks were being carried out and the Director of Public Health County Durham advised that most of the Gypsy Roma Traveller communities would be registered with a GP.

The Chairman said that sometimes services would need to be taken to the GRT communities to help to capture their needs. She informed the Board that some Macmillan nurses travelled to Appleby Fair this year to raise awareness of cancer.

Resolved:
(i) That the background to the GRT health work programme be noted.
(ii) That progress being made, be considered.
(iii) That the risks to the sustainability of the work be noted.
(iv) That the evaluation will provide an updated position on the health needs of the GRT community be noted.

14 Joint Health & Wellbeing Strategy 2nd Quarter 2015-16 Performance Report

The Board considered a report of the Head of Planning and Service Strategy, Children and Adults Services that described the progress being made against the priorities and outcomes set within the County Durham Joint Health & Wellbeing Strategy (JHWS) 2015-16 (for copy see file of Minutes).

Resolved:
That the contents of the report and the progress made in relation to the CQC quality premium indicators be noted

15 Exclusion of the public

Resolved:
That under Section 100 A (4) of the Local Government Act 1972, the public be excluded from the meeting for the following item of business on the grounds that it

involves the likely disclosure of exempt information as defined in paragraphs 1 & 2 of Schedule 12A to the said Act.

16 Pharmacy Applications

The Board considered a report of the Director of Public Health County Durham, Children and Adults Services, Durham County Council which provided a summary of Pharmacy Relocation Applications received from NHS England in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 since the last formal meeting of the Board in July 2015 (for copy see file of Minutes).

Resolved:
That the Board note the Pharmacy Relocation Applications received.

17 Any other business

The Director of Primary Care Development and Engagement, DDES CCG advised that units of planning were currently based through DDES, North Durham and Darlington however, guidance had been received that would extend the unit of planning to a bigger footprint. This is likely to include Durham, Darlington and Tees Valley.

Resolved:
That the update be noted and that further information be brought to the board when available.

Health and Wellbeing Board

21 January 2016

Better Care Fund Update

Report of Paul Copeland – Strategic Programme Manager, Care Act and Implementation, Children and Adults Services, Durham County Council

Purpose of the report

1 To provide an update on Quarter 2 2015-16 Better Care Fund (BCF) to the Health and Wellbeing Board.

2 The Better Care Fund Quarter 2 2015-16 return for County Durham to NHS England is available on request.

Background

3 Implementation of the Better Care Fund commenced on 1st April 2015 following approval of the Durham Plan in December 2014. County Durham's allocation from the BCF is £43,735m in 2015-16 which has financed a number of projects and models of service delivery across 7 work programmes.

4 The BCF planning continuum required partners to incorporate 6 key performance indicators in their plans, 4 of which were prescribed nationally (shaded below) and 2 which were agreed locally.

5 The BCF plan was supported locally by a Financial Risk Sharing Agreement produced by partner agencies and approved by the Health and Wellbeing Board.

a.	Permanent admissions of older people (aged 65 yrs.+) to residential / nursing homes per 100,000 population
b.	Percentage of older people (aged 65 yrs.+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
c.	Delayed transfers of care (delayed days) from hospital per 100,000 of the population (average per month)
d.	Number of non-elective admissions to hospitals.
e.	Percentage of carers who are very / extremely satisfied with the support or services they receive.
f.	Number of people in receipt of telecare per 100,000 population

6 The BCF requires that the identified funding is committed in line with the plan to achieve efficiencies with an assurance that expenditure on services does not exceed the budget.

Performance Update

7 Performance against the key indicators can be measured against the position at 2014-15. Quarter 2 2015-16 denotes positive performance in 5 out of 6 indicators. The figure for non-elective admissions indicates an improvement whilst the number of permanent admissions into residential and nursing care homes remain higher than the target for Q2 2015-16.

8 A traffic light system used in the report, where green is on or better than target and red is below target.

Permanent admissions of older people (aged 65 yrs.+) to residential / nursing homes per 100,000 population

INDICATOR	HISTORICAL		LATEST PERIOD	TARGETS 2015-16		PERFORMANCE AGAINST TARGETS
	2013-14	2014-15	JUL-SEPT 2015 (Q2)	Q2	Q4	
Permanent admissions of older people (aged 65 yrs.+) to residential / nursing homes per 100,000 population	736.2	820.9	356.2	337.8	710.4	

9 Between July – September 2015 the rate of older people aged 65yrs. and over admitted on a permanent basis to residential and nursing homes supported by the County Council was 356.2 per 100,000 population. This exceeded the Q2 2015-16 target of 337.8

10 There are a number of factors which have impacted upon the increased number of permanent admissions which include:

- Greater complexity of need in relation to people with dementia
- Increasing number of people with complex health needs requiring nursing home placement

11 Despite the increase in permanent admissions people are being admitted into residential / nursing care much later in their lives and the volume of bed days in residential / nursing care continues to fall.

12 Permanent admissions figures exclude self funders, which is disadvantageous to Durham who provide a larger proportion of state funded support to residents requiring residential / nursing care.

Percentage of older people (aged 65 yrs.+) who were still at home 91 days after discharge from hospital into reablement /rehabilitation services

INDICATOR	HISTORICAL		LATEST PERIOD	TARGETS 2015-16		PERFORMANCE AGAINST TARGETS
	2013-14	2014-15	JUL-SEPT 2015 (Q2)	Q2	Q4	
Percentage of older people (aged 65 yrs.+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	89.4%	89.6%	88.0%	85.7%	85.7%	

13 Between July – September 2015 88.0% of older people aged 65 yrs.+ remained at home 91 days after discharge. This is an improvement on the Q1 2015-16 figure of 86.6% and exceeds the 2015-16 target of 85.7%.

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

INDICATOR	HISTORICAL		LATEST PERIOD	TARGETS 2015-16		PERFORMANCE AGAINST TARGETS
	Q4 2014/15	Q1 2015/16	JUL-SEPT 2015 (Q2)	Q2	Q4	
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	452.3	436	391	807.1	802.3	

14 The number of delayed transfers of care per 100,000 population has decreased further during July – September 2015 when compared to the previous quarter.

15 Durham's rate of (3.6) is lower than the regional (7.4) and national (11.2) figures based upon the number of people per 100,000 of the population. *(Source: ASCOF measures)*

Non Elective Admissions to Hospital

INDICATOR	HISTORICAL		LATEST PERIOD	TARGETS 2015-16		PERFORMANCE AGAINST TARGETS
	Q4 2014-15	Q1 2015-16	JUL-SEPT 2015 (Q2)	Q2	Q4	
Non-elective admissions per 100,000 population (per 3 month period)	2995	2987	2924	3001	2904	

16 Non-elective admissions to hospital are 2.6% below the Q2 2015-16 target figure. The performance element of the BCF for Q2 2015-16 is payable.

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

INDICATOR	HISTORICAL		LATEST PERIOD	ANNUAL TARGET ONLY FOR 2015-16	PERFORMANCE AGAINST TARGETS
	2013-14	2014-15	JUL-SEPT 2015 (Q2)		
Percentage of cares who are very extremely satisfied with the support or services that they receive	47.9%	52.6%	54.4%	48-53%	

17 Durham has a higher rate of carer satisfaction (54.4%) compared to regional (49.1%) and national (41.5%) measures *(Source; ASCOF Measures).*

Number of people in receipt of Telecare 100,000 population

INDICATOR	HISTORICAL		LATEST PERIOD	TARGET (at as 31st March 2016)	PERFORMANCE AGAINST TARGETS
	at 31st March 2014	at 31st March 2015	At 30th Sept 2015		
The number of people in receipt of telecare per 100,000 population	225	292	314	225	

18 The number of people in receipt or more items of telecare equipment remain high at 314 in Q2 2015-16 and exceeds the annual target of 225.

19 There is no national benchmarking data available in relation to telecare equipment.

Recommendations

20 The Health and Wellbeing Board is recommended to:

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

Contact: Paul Copeland – Strategic Programme Manager, Care Act and Integration
Tel 03000 265190

Appendix 1: Implications

Finance
The BCF total for 2015-16 is £43,735m of which £3.214m is performance related

Staffing
No direct implications

Risk
The performance related element of the BCF concerning the non-elective admission target

Equality and Diversity/ Public Sector Equality Duty
Equality Act 2010 requires the Council to ensure that all decisions are reviewed 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 Equality and Diversity

Legal Implications
Any legal requirements related to the BCF Programme and projects are considered and reviewed as necessary

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Health and Wellbeing Board

21 January 2016

North Durham CCG (NDCCG) and Durham Dales, Easington and Sedgefield CCG (DDESCCG) Planning Process Update and Draft Commissioning Intentions 2016/17

Report of Stewart Findlay, Chief Clinical Officer, Durham Dales, Easington and Sedgefield Clinical Commissioning Group and Nicola Bailey, Chief Operating Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups

Purpose of the Report

1. The purpose of this report is to provide an update on the refresh of the North Durham Clinical Commissioning Group (ND CCG) and Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) potential commissioning intentions for 2016/17 (attached at Appendix 2) and provide an overview of the national planning requirements.

Background

2. NHS North Durham CCG has a close working relationship with NHS Durham Dales, Easington and Sedgefield CCG through the County Durham Unit of Planning. The unit of planning includes members from all key partners including Foundation Trusts, Local Authority and public health professionals.

3. The County Durham Unit of Planning has an agreed five year strategic plan that is aligned to the strategic aims of the County Durham Health and Wellbeing Strategy (JHWS).The CCGs contribute to the delivery of the JHWS and this feeds into CCG processes for planning and identifying gaps.

4. CCGs are now required to produce a one year operational plan for 2016/17, and to work with the health and care system to create a Sustainability and Transformation Plan (STP) covering the period October 2016 – March 2021. This will take into account the JHWS.

National Planning Guidance

5. The national planning guidance ““Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21” was issued in late December 2015. This included details of new national requirements to be incorporated into individual CCG commissioning intentions, emerging system changes and financial planning assumptions.

6. The NHS is required to produce two separate but connected plans:

    - A five year Sustainability and Transformation Plan (STP) which is place based and driving the Five Year Forward View (to be submitted in June 2016).
    - A one year Operational Plan for 2016/17 – this will be organisation based but consistent with the emerging STP. This will be submitted by 11th April 2016.

7. The following areas will be priorities or "must dos" for 2016/17:

    - Develop a high quality and agreed STP.
    - Return the system to aggregate financial balance.
    - Develop and implement a local plan to address the sustainability and quality of general practice.
    - Get back on track with access standards for Accident and Emergency (A&E) and ambulance waits.
    - Improve and maintain NHS Constitutional Standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment.
    - Deliver the NHS Constitution 62 day cancer waiting standards, continue to deliver 2 week wait and 31 day cancer standards and make progress in improving one year survival rates and reducing the proportion of cancers diagnosed following an emergency admission.
    - Achieve and maintain the two new mental health access standards – more than 50% of people experiencing a first episode of psychosis will commence treatment with a National Institute for Health and Care Excellence (NICE) approved package of care within two weeks of referral; 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within 6 weeks of referral with 95% treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two thirds of estimated number of people with dementia.
    - Deliver actions set out in local plans to transform care for people with learning disabilities.
    - Develop and implement an affordable plan to make improvements in quality.

8. In addition to this there is a key focus on major transformational change including the Better Health Programme.

9. NHS England has asked that STPs are developed across a wider footprint than the existing planning unit footprints. DDES and ND CCG will be part of a Durham, Darlington and Tees planning footprint which maps to the Better Health Programme work ongoing.

10. Smaller local planning groups will still be required for specific issues such as local authority engagement and joint commissioning.

Process for Identifying Priorities

11. An in-depth data review was undertaken by North of England Commissioning Support (NECS) and presented to CCG leads (finance, quality and commissioning) and Durham County Council leads (planning, public health and commissioning) for each CCG. A long list of key priorities has been identified using a range of local and national data sources.

    This includes:

    - Existing work plan and priorities.
    - Constitutional and performance issues that need to be addressed.
    - Issues identified by the data review (this included the Joint Strategic Needs Assessment (JSNA), public health profiles, NHS Outcomes Atlas, Atlas of Variation, Commissioning for Value, programme budget data, Spend and Outcomes Tool (SPOT) and local data.
    - Activity pressures.
    - New national priorities for 2016/17.

    Only a small number of new areas have been identified by each CCG.

12. Public and stakeholder feedback on services has been captured throughout the year. In addition a number of specific workshops have been held with the public and stakeholders, focussed on developing the potential priorities. Views have also been sought via the CCG's websites and through My NHS.

13. Clinical leads have been allocated to the priority areas as follows:

    DDES:

    - Urgent and emergency care – Dr Stewart Findlay.
    - Long term conditions – Diabetes – Dr Winny Jose, Respiratory – Dr Dilys Waller.
    - Mental health – Dr Kamal Sidhu.
    - Learning disabilities – Dr Cliff Allison, Gillian Findley.
    - End of life – Dr Nari Pindolia, Gillian Findley.
    - Frail elderly – Dr James Carlton.
    - Primary Care – Dr Jonathan Smith.
    - Cancer – Dr Robin Armstrong.
    - Maternity – Gillian Findley.
    - Children – Gillian Findley.
    - Better Health Programme - Dr Stewart Findlay/Dr Neil O'Brien. (North Durham CCG)

14. In addition to this the commissioning delivery team are working with public health leads on the following cross cutting issues:

    - Alcohol – Dr Lynn Wilson, Kirsty Wilkinson.
    - Tobacco – Gill O'Neill, Dianne Woodall.

NDCCG:

- Children – Dr Chandra Anand.
- End of Life Care and Pain Management – Dr Philip LeDune.
- Cancer – Dr Patrick Wright.
- Diabetes – Dr Patrick Ojechi.
- Mental Health – Dr Richard Lilly.
- Frail Elderly and Out of Hospital – Dr Neil O'Brien.
- Urgent and Emergency Care – Dr Jan Panke.
- Better Health Programme – Dr Neil O'Brien.

Process for review and prioritisation – operational plans

15. Members of the commissioning team have met with clinical leads to review the priority areas and identify the key outcomes improvements and discuss what the best approach might be to achieve these improvements.

16. There are several ways that improvements can be achieved in these areas which include:

    - Development of contractual incentives/Commissioning for Quality and Innovation (CQUIN) schemes for major acute/Mental Health providers.
    - Use of contractual levers.
    - Development of enhanced services.
    - Priorities for the Quality Improvement Scheme.
    - Priorities for the Prescribing Scheme.
    - Service reviews.

17. A team of experts from provider management, quality and commissioning are also reviewing the full list of intentions and advising how we might address them.

18. As there is a finite resource in primary, community and secondary care we will be asking the clinical leads to prioritise the areas where we want either primary or secondary care to focus on. This will take place throughout December and be finalised in January.

19. There are a limited number of new areas to focus on. However, the work on out of hospital services linked to the Better Health Programme will be significant and will gather pace during 2016/17. The CCGs will need to ensure that enough capacity available to work on this which may impact on the ability to deliver against all of the areas identified. Again, the clinical leads and executive committees will review this to develop a prioritised plan.

Development of Sustainability and Transformation Plan (STP)

20. The STP is being developed across the Durham, Darlington and Tees (DDT) footprint and will be closely linked to Better Health Programme, the JHWS and the CCGs out of hospital strategy and plans. This work will be supported by NECS. Further details will emerge once the governance structure for the DDT planning footprint has been developed.

21. Some early work has been undertaken in the CCG to look at what the key themes will be for the strategic plan and the out of hospital model for both CCGs. This builds on the work that has been undertaken to date on the development of a strong and sustainable primary care and federated working.

22. STPs will become the single application and approval process for acceptance on to programmes with transformation funding attached from 2017/18 onwards. The Spending Review highlighted that additional dedicated funding will be made available for transformation change over the next five years. This funding is for initiatives such as spread of new models of care, primary care access and infrastructure, technology roll out and to drive clinical priorities (such as diabetes prevention, learning disabilities, cancer and mental health).

Durham Unit of Planning CCG Priorities

23. Durham Unit of Planning priorities are:

    - Mental Health. (including Children and Young People's Transformation Plan)
    - Transformation for Learning Disabilities.
    - Urgent Care. (including Urgent and Emergency Care Vanguard and all age mental health liaison and crisis care)
    - Diabetes.
    - Frail and Elderly.
    - Primary Care Transformation. (Primary Care Strategy and Operating Model)
    - End of Life Care.
    - Better Hospital Programme.
    - Cancer and maternity. (national priorities with more detail expected in winter 2015)

Alignment of Plans

24. The refresh of CCG operational plans will include reflecting Better Care Fund plans including the target reduction in emergency admissions currently captured in activity plans.

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

26. The overarching direction of travel for the local health economy is outlined within the Five Year Forward View. This describes new models of care which focus on integration between settings and across health and social care. This is reflected in the long list of priorities for each CCG.

27. The CCG plans will be closely linked to system-wide transformation work, such as the Better Health Programme and Urgent and Emergency Care Vanguard.

28. The operational plan will also align with the emerging STP.

The Planning Timetable

Stage	Date	Progress
Long list developed	End of November	Complete
Review by clinical leads	End of November/December	Complete
National Planning guidance published	22nd December 2015	Complete
Prioritisation of areas of focus:		
- Clinical Lead	December/January	In progress
- Executive Committees	December/January	In progress
Patient engagement	December/January	In progress
Funding prioritisation (clinical leads and Executive Committees)	January/February 2016	In Progress
Consultation on standard contract and announcement of CQUIN and Quality Premium	January 2016	
Further guidance on STPs issued	January 2016	
Confirmation of the STP Footprint and volunteers for mental health and small DGH trails	29th January 2016	
First submission of draft 16/17 operational plans	8th February 2016	
National tariff S118 consultation	January/February 2016	
Publish national tariff	March 2016	
Executive Committee sign off of Operational plan	By 31st March 2016	
Governing Body sign off of Operational plan	By 31st March 2016	
Council of Members sign off of Operational plan	By 31st March 2016	
National Deadline for signing of contracts	31st March 2016	
Submission of final 16/17 Operational plans aligned with contracts	11th April 2016	
STP Submission	June 2016	
Assessment and Review of STPs	End of July 2016	

29. Both CCG's will need to refresh their outcome trajectories and choose two quality premium indicators. Durham County Council is represented on the planning group where this issue will be discussed. It is recommended that the Health and Wellbeing Board delegate the power of authority to the Corporate Director, Children and Adult Services, Durham County Council, the Chief Clinical Officer, DDES CCG and the Chief Operating Officer, ND CCG & DDES CCG in consultation with the Chair of the Health and Wellbeing Board to sign off the local premium indicators for 2016/17.

Recommendations

30. The Health and Wellbeing Board is recommended to:

- Receive the Planning Progress Update and Draft Commissioning Intentions 2016/17 for comment.
- Note the planning timetable.
- Delegate the power of authority to the Corporate Director, Children and Adult Services, Durham County Council, the Chief Clinical Officer, DDES CCG and the Chief Operating Officer, ND CCG & DDES CCG in consultation with the Chair of the Health and Wellbeing Board to sign off the local premium indicators for 2016/17.

Contact: Donna Bradbury, Commissioning Manager
Tel: 0191 374 6089
Contact: Lorrae Rose, Commissioning Manager
Tel: 0191 374 2760

Appendix 1: Implications

Finance
Clear financial plans in relation to priorities will be developed to support achievement of overall financial balance and this will form part of the strategic plans to be developed. All plans are dependent on the funding available to the CCG.

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

Risk
Individual commissioning priorities will be impact assessed in terms of the risks to mitigate against these. There is a risk that expenditure on contracted services may reduce the amount of funding available to spend on development projects. There are existing financial controls in place to mitigate against this.

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

Accommodation
No implications at this stage.

Crime and Disorder
No implications at this stage.

Human Rights
No implications at this stage.

Consultation
Both CCGs have utilised their own engagement models as part of this process. Stakeholders are involved in the development of these plans via existing stakeholder groups such as Area Action Partnerships, Patient Reference Groups etc. and public and stakeholder engagement events.

Procurement
No implications at this stage.

Disability Issues
No implications at this stage.

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

Any changes to services or pathways may require a formal consultation or for the CCG to go through a procurement process. The CCG has appropriate governance processes in place.

Appendix 2: Long List of Potential Commissioning Intentions 2016/17

Potential 16/17 Commissioning Intention	CCGs	Contribution to Constitutional Standards and other measures	Objective	Policy context and anticipated national priorities 16/17
Urgent and emergency care				
Urgent care review Urgency & Emergency Care Vanguard Primary care weekend opening Systems resilience Durham Urgent Care Transport review	Both Both Both Both Both	Time through Accident & Emergency (A&E) Ambulance handover Ambulance response times Delayed Transfers of Care Reduced A&E attendance and non-elective admissions	Improve the co-ordination of urgent and emergency care services to reduce the pressure on A&E departments and reduce unnecessary admissions. Improve consistency of standards and reduce fragmentation and deliver high quality health and social care to patients.	Vanguard
Out of Hospital Care				
Diabetes new model of care Respiratory nurse project Develop integrated care models for out of hospital community services Vulnerable Adult Wrap Around Services (reactive and proactive) Intermediate Care Plus Care Plan Commissioning for Quality and Innovation Day hospital review Wheelchair services Non-weight bearing patients Frail elderly scheme Holistic commissioning strategy for Continuing Health Care	Both DDES Both DDES Both Both Both Both DDES NDCCG Both	Potential Years of Life Lost Expected 5-10% increase in 75+ population in next 5 years Delayed Transfer of Care Admissions Readmissions Excess Bed Days	To ensure community based services are joined up, responsive and integrated. Providing the right care in the right place at the right time.	

Joint Commissioning & Mental health Children & Young People's Plan Child and Adolescent Mental Health Services review Integrated primary and community – Community Psychiatric Nurse Crisis concordat Crisis services Early Intervention in psychosis Suicide Prevention Implementation Plan Recovery college Special Educational Needs & Disability Autism Dementia	Both Both DDES Both Both Both Both Both Both Both Both Both	% of people followed up within 7 days of discharge from psychiatric inpatient care The proportion of people entering treatment against the level of need in the general population The proportion of people who complete treatment who are moving to recovery Increase numbers of patients on a care programme approach Decreasing the numbers of people subject to the mental health act Decrease in the numbers of young people with 3 or more admissions per year for mental health issues	Improving access at time of crisis Promoting recovery and staying well Reducing suicide and self-harm	Mental health (national priority)
Learning Disabilities Care and treatment Reviews (CTR) National fast track programme Eye care pathway	Both Both DDES/both	All patients to have a CTR within 10 days of admission and review after 6 months	Delivery of care programme approach to empower individuals Right care in the right place, at the right time	Learning disabilities (national priority)
End of life Palliative care consultant Lymphoedema	Both Both	1% of population to be on primary care palliative care registers % of patients that are offered an Anticipatory Care Plan Preferred place of death recorded Preferred place of death achieved Death in usual place of residence	Continuous implementation of the End of Life Strategy Supporting people to die in the place of their choice with the care and support they need	

Primary care GP recruitment Primary care strategy Practice budgets Estates utilisation review		Patient Survey GP Choices Contribution to out of hospital delivery	To develop workforce and infrastructure to delivery care closer to home High quality cost effective primary care	5 Year Forward View
Demand management Outpatient review programme Clinical Support Information Outpatient Parenteral Antibiotic Therapy Community minor orthopaedic surgery Cryotherapy Value based commissioning Ongoing activity and demand management and monitoring	Both Both DDES DDES DDES Both Both	Benchmarked data review including local data and national sources such as NHS Atlas, Commissioning for Value and public health profiles	Implement best practice standards for referral and treatment	
Cancer Implementation of the Macmillan information services review outcomes Macmillan primary care nurse project Review of cancer pathways to improve waiting times and outcomes Radiology initiated follow up (lung pathway)	Both DDES Both Both	Cancer breast symptomatic Cancer 62 days to treatment Cancer mortality	Increase in the number of patients surviving 12 months following treatment and reduction in <75 mortality rates. Improve the proportion of patients diagnosed at an earlier stage. Contributing to the prevention agenda (including smoking cessation).Achieving the 62 day referral to treatment.	Cancer Strategy (national priority)

Improve the recording of stage of disease Implementation of the refreshed health equity audit actions (including smoking cessation)	Both Both		Improving uptake of screening opportunities	
Seven day services	Both	Primary Care Secondary Care Specialist palliative care Hospice inpatient admissions	Improve clinical outcomes and improve patient experience through reducing the risk of morbidity and excess mortality following weekend admission in a range of specialties. Improved quality, efficiency and innovation: • admission prevention; • the speed of assessment, • diagnosis and treatment; • the safety and timing of supported discharge; • reduced risk of emergency readmission; • better use of expensive plant and equipment; • avoidance of waste and repetition; and • service rationalisation to enable safe consultant staffing levels.	Seven day services – 5 Year Forward View

Maternity Developing and implementing maternity specification Maternal mental health Pathway Maternal Obesity	Both Both	National maternity specification Local measures Smoking cessation Smoking at time of delivery	To increase the quality of care for women across the full pathway pre and post-natal pathways.	
Obesity Paediatric obesity pathway Adult tier 3 service review	Both Both		Integrated pathway of care to improve the health wellbeing of obese adults and children	5 Year Forward View (prevention)
Children Paediatric continence review Specialist schools nursing review	Both Both		To commission a tier 2 community service. To implement the outcomes of the review ensuring alignment between the re-procurement and the review of community paediatric services.	
Procurements International Normalised Ratio Podiatry Audiology Home oxygen services	Both Both Both Both		Implementing the outcomes of the procurements on due to expire contracts	
Better Health Programme	Both	Standards and measures currently being discussed.	Contributing to a regional system wide strategic approach to the delivery of the best possible care and outcomes in acute medicine, acute surgery, A&E, critical care, acute paediatrics, maternity and neonatology and out of hospital care.	

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Health and Wellbeing Board

21 January 2016

Urgent Care Service Integration

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

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Board with an update on Durham Dales, Easington and Sedgefield Clinical Commissioning Group's (DDES CCG) review of urgent care services and proposed new service models.

Background

2 A number of factors (both local and national) influenced the CCG's decision to review urgent care services. This report sets out the following:

- The context, both locally, regionally and nationally with required the CCG to carry out a review of services
- Details of existing services and their utilisation
- Stakeholder engagement that has been carried out
- Audits of existing services both from a clinical and patient perspective
- Other factors that influenced the service review

3 This report summarises the case for change and a potential new model for integrated urgent care services in DDES. The sensitivities of any potential changes are recognised and will be part of a full consultation.

Local, Regional and National Context

4 There were a number of factors that initiated the review of urgent care services in DDES and they are described in the following section of this report.

National Context

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

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

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

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

7 In addition to the above there has been a great deal of learning resulting from the challenges experienced throughout the urgent and emergency care system during Winter 2014/15. With this learning from Winter 2014/15 NHS England developed eight High Impact Interventions for urgent and emergency care that are designed to provide focus for local commissioners and providers on elements of the system which are crucial to be in place to ensure effective patient flow and patient experience within urgent and emergency care services.

8 New national standards for commissioning integrated urgent care services were introduced in October 2015 and this builds on the Transforming Urgent and Emergency Care Review published in 2013. An extract from the new national standards is included below:

- The core vision for a more closely Integrated Urgent Care service builds upon the success of NHS 111 in simplifying access for patients

and increasing the confidence that they, local commissioners and the public have in their services.

- The offer for the public will be a single entry point - NHS 111 - to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.
- Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The clinicians in the hub will be supported by the availability of clinical records such as 'Special Notes', Summary Care
- Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.
- A plan for online provision in the future will make it easier for the public to access urgent health advice and care. This will increasingly be in a way that offers a personalised and convenient service that is responsive to people's health care needs when:

    - They need medical help fast, but it is not a 999 emergency.
    - They do not know whom to contact for medical help.
    - They think they need to go to A&E or another NHS urgent care service.
    - They need to make an appointment with an urgent care service.
    - They require health information or reassurance about how to care for themselves or what to do next.

Put simply:

"If I have an urgent need, I can phone a single number (111) and they will, if necessary, arrange for me to see or speak to a GP or other appropriate health professional – any hour of the day and any day of the week"

County Durham and Darlington Context

9 The County Durham and Darlington System Resilience Group, which is a sub group of the Health and Wellbeing Board, has developed the County Durham and Darlington Urgent Care Strategy 2015-20 and has overall responsibility for the capacity planning and operational delivery across the health and social care system for urgent and emergency care. The local System Resilience Group (SRG) will be responsible for overseeing the implementation of the Urgent Care Strategy locally.

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

11 In line with the National vision, the local vision for urgent and emergency care across County Durham and Darlington that has been developed is:

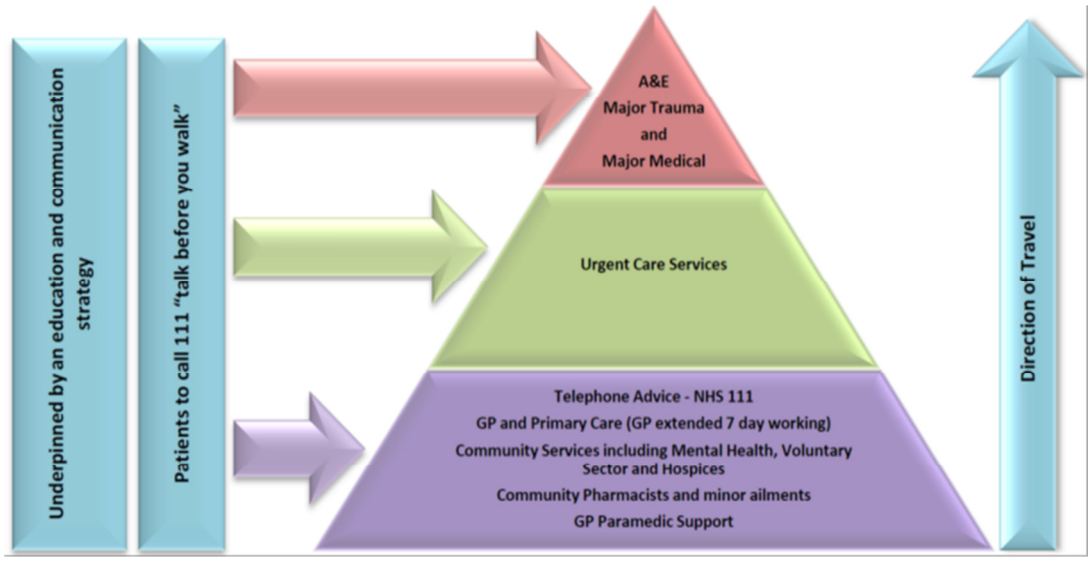
'Patients are seen by the right health/social care professional, in the right setting, at the right time, to the highest quality and in the most efficient way providing the best outcome for the patient.'

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

13 To implement the vision, the identified actions have been aligned to seven objectives:

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

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



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

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

17 The final draft of the strategy has been endorsed through all three Clinical Commissioning Group Executive Meetings, Governing Body Meetings, Health Overview and Scrutiny Committees for County Durham and Darlington and the County Durham Health and Wellbeing Board

DDES Context

18 Alongside the County Durham and Darlington Urgent Care Strategy development the CCG has been reviewing local urgent care provision for almost two years. Very detailed work has been undertaken to understand the usage of services locally which are different to those in place across the rest of Durham and Darlington. The aim of this work has been to understand:

- If these services best meet the needs of the local population given that services have been in place now for several years
- How the services in DDES support delivery of improved outcomes for patients
- If the services help to support the national strategy and standards for out of hours services
- If the services represent value for money
- If services need to change or improve

Services Available in DDES

19 There are currently three Urgent Care Centres (UCCs) and one Walk-In Centre (WIC) within the DDES CCG area. The UCCs located at Bishop Auckland and Peterlee currently operate 24 hours a day, every day of the year and are GP led. The Seaham service operates from 8am to 6pm, Monday to Friday and is nurse led.

20 In addition, a WIC service is provided under a contract with Intrahealth that operates from 8am to 8pm, 7 days a week, at Healthworks, Easington which is GP led.

21 The list of facilities available at each of the DDES sites is shown below:

	Bishop Auckland UCC	**Peterlee UCC**	**Seaham UCC**	**Healthworks WIC**
GP led	✓	✓		✓
Nurse led			✓	
Ability to "Walk In"	✓	✓	✓	✓
Appointment Required				
Appointment Available	✓	✓	✓	✓
Open 8am – 6pm	✓	✓	✓	✓
Open 6pm – 8am	✓	✓		
Open 6pm – 8pm (teatime surge)	✓	✓		✓
Open Monday to Friday	✓	✓	✓	✓
Open Saturday & Sunday	✓	✓		✓
X ray services	✓ (9am-9pm)	✓ (to 7pm)		
Durham Dales location	✓			
Easington location		✓	✓	✓
Sedgefield location				

22 Primary Care services currently offer extended opening hours on a Saturday in a hub model with support to vulnerable patients at risk of admission to hospital throughout the whole weekend period.

23 Urgent and Emergency Care Services in County Durham and Darlington have evolved in response to evidence based practice and guidelines, along with relevant NHS policy changes. Over time this has resulted in the development of numerous services that can appear to the patient as unrelated, each with different names and access points. This has created a complicated system with multiple connections and complex patient flows. Patients and health and social care professionals can find it challenging to navigate around these services efficiently.

24 In County Durham and Darlington there has been a continued rise in demand for Urgent and Emergency Care across the whole system, from increasing attendances at Emergency Departments to increased demand on the GP In and Out of Hours Services. County Durham and Darlington has an increasingly ageing population, and there is a continued rise in all long term conditions. In the future, managing this demand may become unsustainable within the current configuration of health and social care systems. As technology and clinical techniques advance, so do the expectations of the public in being able to access health and social care services in more convenient and flexible ways.

25 Continuing to work to refine the already stretched hospital centric and urgent care systems will only have limited success in meeting the growing demands. Fundamentally there is a need to reduce the overall demands through addressing the underlying reasons for the patient accessing an urgent and emergency care service. This requires alignment of services, working collaboratively together to provide one simpler, safer and more effective system, delivering an improved seamless patient experience, improved quality and safety and better value for the taxpayer.

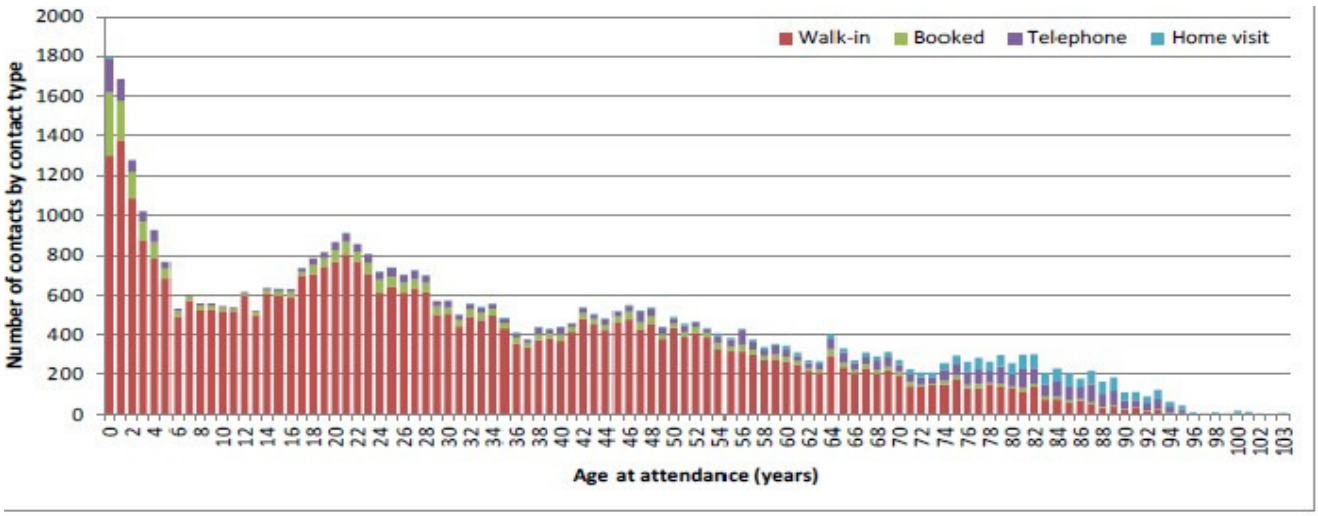
Use of Services Across DDES

26 Detailed analysis has been undertaken based on attendances at the four services during 2013/14. The key highlights are:

- There were 137,763 attendances across the four centres
- During the hours of 8am and 8pm, Monday to Friday there are an average of 5.7 attendances per practice in UCCs (including Healthworks) – this varies by practice as below

Locality	08:00 – 18:00	18:00 – 20:00	08:00 – 20:00
Dales	3.78	1.31	5.09
Easington	9.08	1.50	10.58
Sedgefield	2.47	0.98	3.46
DDES	5.71	1.31	7.01

- The closer a practice is to an UCC the more attendances there are for that practice population
- There are peaks in attendances at certain times of the day and day of week i.e.
    - Mid-morning between 10am and 12 noon
    - Early evening from 4pm – 8pm
    - Weekends between 10am and 12 noon
- The age profile of patients is similar at all four centres



Engagement

27 Engagement has been undertaken with a range of stakeholders to better understand the services delivered and the needs and preferences of the population.

Engagement with Patients and Other Stakeholders (including providers)

28 In July 2014, DDES CCG in partnership with an external Experience Led Commissioning (ELC) team, formed a local ELC team to carry out an engagement exercise to help understand how patients and the public use and perceive urgent care and what matters to them when they access these services.

29 Engagement work was undertaken in the DDES CCG area with the following groups of people:

- Parents of young children (under five years)
- People living with long term health issues
- People with mental health issues
- People in good health

30 The local ELC team also spoke to front line teams in urgent care settings. There were five main reasons that people said they use urgent care centres:

- They want immediate reassurance
- They perceive their condition as “in between GP and A&E”
- They believe they can’t see their GP soon enough
- It is out of hours
- Because there is free transport to urgent care centres out of hours

31 Both people and front line staff said that urgent care centres are mainly used because people cannot get an appointment to see their GP during the day. Front line staff added that during the day, the majority of patients attend urgent care centres with problems that could have been resolved at their GP practice, and that during the out of hours period urgent care services are used more appropriately.

32 The outcomes of the ELC exercise were that:

- The process for making GP appointments should be improved
- Direct access to x-ray and fracture clinics would improve services
- Having the ability to request diagnostic tests for non-urgent should be considered
- There is a need for more joined up thinking around;
    - Triage (across urgent care centres, GP practices and NHS 111)
    - Policies and procedures
    - Access to clinical records
    - Accessing specialist advice (a second opinion)
- NHS 111 needs to be joined up and part of any new system thinking
- What matters to people and delivers a 'great' urgent care experience would be if services are;
    - Welcoming
    - Supporting
    - Reassuring
    - Building confidence
    - Informing and educating people how to self-care
    - Listening and understanding

33 The key message was that patients would prefer to see their own GP where possible and that they would like new and innovative ways of contacting their GP.

34 The outcomes of the ELC exercise underpinned DDES CCGs decision to carry out further work around integrating urgent care services.

Engagement with Member Practices

35 As information has been collated it has been shared with member practices on a regular basis via the DDES wide management meeting

Service Visits

36 Visits to all four of the services were undertaken by members of the Executive Committee, commissioning team and on occasion members of the Governing Body. The aim of the visits was to visit the site, observe the services in operation and talk to staff.

The visits were informative and allowed CCG staff to ask questions to aid their understanding of service operation.

Service Audits

37 There was a large volume of quantitative data available on all four services, but further analysis and audit was required to better understand service utilisation.

38 Further audits were carried out in February 2015 to help understand:

- Numbers and demographics of those accessing urgent care and walk-in centres by DDES CCG patients
- Proportion of symptoms and ailments that patients present at urgent care, that could be safely dealt with, assessed and treated in primary care
- Current capacity in primary care, to help understand or challenge public perception that patients are unable to access appointments and as a result feel they have no choice but go to A&E

Clinical Audit of UCC and WIC attendances

39 The first audit was carried out by DDES GP Practices of UCC and WIC attendances *(Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an urgent care centre or a walk-in centre)*

- 36 out of 41 practices in DDES CCG took part in the audit
- In total, 5,338 UCC attendances were reviewed (4.90% sample of the approximate120,000 predicted UCC attendances)
- The top reason for attending urgent care was due to an injury (15.5% of the total) and this was also the final or main diagnosis of the attendance (16.1% of the total)
- Most patients had the symptoms for 0-1 weeks prior to their attendance at urgent care (63.0% of the total)
- Prescribing of medicines was the top treatment stated by practices (44.3% of the total)
- In total there were 394 cases where the patient had received an x-ray
- In 59.2% of UCC attendances no follow up was required
- 69.7% of UCC attendances could have been seen in primary care instead
- Appointments were available in GP practices when the UCC attendances took place in67.6% of cases

Audit carried out by Healthwatch regarding patients experience in an UCC or WIC *(Note: 'urgent care centre [UCC]' has been used to describe all activity whether at an urgent care centre or a walk-in centre)*

- Healthwatch reviewed 151 patients, at Bishop Auckland, Peterlee, Seaham and Healthworks UCCs
- 91.4% of these were from DDES CCG
- The top reason for attending urgent care was patient choice: "I chose to come here"
- 84.1% (127 patients) of patients stated they had used their own transport to get to the UCC
- The top reason for attending urgent care was due to an injury (14.6% of the total)
- 29.1% patients would have gone to A&E had the UCC been unavailable

Other Factors to be Considered

40 A range of other factors were given consideration when reviewing existing services.

Duplication of Services

41 There are more services available in DDES than in the rest of County Durham and Darlington, particularly during GP practice opening hours.

42 In one case there is a nurse led urgent care centre in the same building as two GP practices with the same opening hours. The patient reference group contacted the CCG in 2015 raising concerns about duplication of service and asking the CCG to consider having services open when GP practices are not to avoid duplication and extend access.

Seven day working

43 The national policy direction is to move towards seven day working. It is unlikely that GP practices will be required to open 8am to 8pm seven days a week. It is possible that there will be changes to the national GP contract which may impact on the way that services are delivered.

The Impact of Weekend Working in Primary Care

44 Previous extended opening pilots have suggested that there is not sufficient demand for GP services to open every practice at weekends. The current model across DDES is to provide access for all the whole population via a hub model (practices opening on behalf the population from a number of other practices).

45 Demand for urgent care services has decreased significantly since these services were introduced. When comparing activity for April to August 2015

to the same period last year activity is 8% lower at the three UCCs (Bishop Auckland, Seaham and Peterlee) and 23% lower at Healthworks.

46 This downward trend in demand has never been seen before as activity has previously increased year on year.

Cost of Services

47 Benchmarking work was undertaken to compare the cost of services in DDES with those commissioned in other areas. This exercise suggested that cost were higher in DDES than in other areas.

Procurement Issues

48 The contracts to provide UCC and WIC centre have expired, but have been renewed on a rolling yearly basis whilst the review has been undertaken. The law requires the CCG to re- procure contracts when they expire.

49 It is appropriate that a review of patient need and service outcomes is undertaken before a service is re-procured to ensure that the model is still appropriate and is cost effective.

Potential Future Models

50 All of the information included in this report has been shared with the member practices at the monthly DDES wide management meeting as it has become available.

51 A discussion on the proposed future model for urgent care service took place at the three locality meetings in July and August 2015. The discussion included the commissioning leads from each practice and the PRG chair for that locality. A follow up workshop took place in October 2015 with the clinical locality leads and proposed new service models were developed. The models were based on the information previously mentioned in this report, but summarised below:

- There are multiple services for patients to access in DDES, particularly during the day
- There are peaks in demand for services (mid-morning and 4-8pm)
- Patients would prefer to see their own GP where possible
- Appointments are available in the majority of cases where patients have attended UCC/WIC services
- Services must be more closely linked and integrated (including 111 services)
- Patients perceive the UCC/WICs to be between A&E and GP services when this is not always the case

52 The following tables summarises the preferred model for each localities:

Potential future service model for integrated urgent care services

Times	Easington	Sedgefield	Durham Dales
In hours (U/C and WIC)	Primary care model delivered by a number of hubs Triage at front desk	Urgent care provided by patient's own GP practice Patients should be seen by appointment only Triage at front desk	Urgent care provided by patient's own GP practice Patients should be seen by appointment only Triage at front desk
6pm – 8pm	GP practice hub based model	GP practice hub based model	GP practice hub based model
Weekends	Primary care extended opening via a hub based model	Primary care extended opening via a hub based model	Primary care extended opening via a hub based model
Out of Hours	All calls triaged through 111 Consideration be given to transport issues	All calls triaged through 111 Consider transport issues OOH	All calls triaged through 111 Consider transport issues OOH
Minor Injuries	Hubs to treat minor injuries Rapid access to x-ray facilities	Hubs to treat minor injuries Rapid access to x-ray facilities	Rapid access to x-ray facilities Majority of injuries to be managed in primary care Rapid access to secondary care for second opinion regarding fractures

53 Key Points

- All three localities felt that access to transport services was an important consideration given issues with rurality and or lack of access to personal transport
- In hours it is felt that patient need can be better met by the patient's own GP practice or practices operating a hub model – the clinician seeing the patient would have access to the full patient record and could treat the patient holistically rather than just for their presenting complaint
- Extended access to a GP practice between 6-8pm on weeknights will be available to the whole population
- Extended access to primary would continue at weekends although further consultation with the public would be necessary to understand the key times this should be available.
- Patients should be triaged and scheduled to be seen as appropriate
- The mandatory GP out of hours service would be commissioned from 8pm in the evening and across the weekend
- Significant engagement with the general public needs to take place to ensure they have all of the information they need about accessing urgent care services

The models were presented back to the DDES wide management meeting in November 2015 and supported. The models were also supported by the CCG Council of Members in December 2015.

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Summary and Next Steps

54 A new model of urgent care is being developed for DDES which has been designed based on an extensive service review and engagement exercise. As the model proposes a significant change to the current service it is expected that a formal public consultation would be required.

55 A detailed consultation and engagement plan is in development and discussions with existing providers and their staff would take place in January 2016 to inform them of the proposals and allow them to input into the consultation/engagement process.

56 At a meeting on 12th January the DDES CCG Governing Body supported the recommendations to:

- Further development of the proposed new service models for urgent care as set out in this paper
- Develop a consultation/ engagement model with the public in respect of these new proposed models

57 A paper will be presented to the Health Overview and Scrutiny Committee on 19th January.

Recommendations

58 The Health and Wellbeing Board is recommended to:

- Note the contents of the report
- 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

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

Accommodation

Crime and Disorder

Human Rights

Consultation
Engagement has been carried out via the Experience Led Commissioning programme.

Clinical engagement has taken place via the DDES wide management meeting (including PG chairs) and the clinical locality leads

Any significant service change would require formal consultation. Advice will be sought from the Health and Overview Scrutiny Committee

Procurement
Any service changes may require a formal procurement exercise to be undertaken.

Disability Issues

Legal Implications

Health and Wellbeing Board

21 January 2016

Durham County Council's Cold Weather Plan

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

Purpose of the Report

1 The purpose of this report is to update the Health and Wellbeing Board on Durham County Council's Cold Weather Plan (attached at Appendix 2) which seeks to reduce excess winter deaths and cold related ill health.

Background

2 The plan sets out the Council's actions to mitigate the impact of cold weather on the population's health and well-being through an approach to winter preparedness. It builds on previous years' plans, taking into account the shifts which have taken place in health and social care structures and seeks to strengthen community engagement and resilience. The plan incorporates a series of appendices that highlight key local actions, interventions and resources that will be used to provide assurance on delivery against the objectives.

3 The plan for winter 2015/16 has been reviewed to incorporate recent National Institute for Health and Care Excellence (NICE) guidance, updated contact details and the updated national Cold Weather Plan produced by Public Health England. The plan links with the Severe Weather Plan produced by the Council which is a year round action orientated document outlining how the organization will respond to a range of emergency weather conditions including storms, snow, flooding or heat. The interface with the Clinical Commissioning Groups (CCGs) system resilience plan is being explored.

4 Cold-related ill health and excess winter deaths (EWD) is a multi-faceted issue. The causes of EWD are complex, and no single agency or service can tackle the issue alone. The factors that increase the risk of ill health and death from the cold can be categorised as follows:

- Population factors
- Housing factors
- Economic factors
- Behavioural factors
- Other contributing health factors

5 By working in partnership and bringing together expertise from a range of disciplines and services, the County Durham Cold Weather Plan aims to make a significant difference in reducing excess winter deaths, and cold-related illnesses, in County Durham by addressing their root causes and by focusing on the county's most vulnerable residents.

6 The plan will be appended to the NHS system resilience plan as part of the approach to managing demand and keeping vulnerable residents independent longer.

Recommendations

7 The Health and Wellbeing Board is recommended to:

- Note the contents of this report.
- Note the Cold Weather Plan incorporates the new NICE guidance and is exploring the interface with the NHS system resilience plan.

Contact*:* Tim Wright, Public Health Portfolio Lead
Tel: 03000 267673

Appendix 1: Implications

Finance
No implications

Staffing
No implications

Risk
No implications

Equality and Diversity / Public Sector Equality Duty
The plan has a dual function to cover the whole population as well as targeting vulnerable individuals.

Accommodation
No implication

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
No implications

Disability Issues
There is a focus on those vulnerable individuals.

Legal Implications
No implications

APPENDIX 2

Cold Weather Plan

October 2015

CONTENTS

Executive Summary

This plan sets out Durham County Council's actions to mitigate the impact of cold weather on the population's health and well- being through a council-wide approach to winter preparedness. It builds on previous years' plans, taking into account the shifts that have taken place in health and social care structures and seeks to strengthen community engagement and resilience. The plan incorporates a series of appendices that highlight key local actions, interventions and resources that will be used to provide assurance on delivery of against the objectives.

The plan links with the Severe Weather Plan produced by Durham County Council which is a year round action orientated document outlining how the organization will respond to a range of emergency weather conditions including storms, snow, flooding or heat.

Cold-related ill health and excess winter deaths (EWD) is a multi-faceted issue. The causes of EWD are complex, and no single agency or service can tackle the issue alone. The factors that increase the risk of ill health and death from the cold can be categorised as follows:

- Population factors
- Housing factors
- Economic factors
- Behavioral factors
- Other contributing health factors

By working in partnership and bringing together expertise from a range of disciplines and services, the Weather Plan aims to make a significant difference in reducing excess winter deaths, and cold-related illnesses, in County Durham by addressing their root causes and by targeting the county's most vulnerable residents.

Section 1 – Introduction

1.1 Context

The Cold Weather Plan aims to mitigate the impact of cold weather on the health and wellbeing of residents with a particular focus on those most vulnerable .Previous winters have had significant periods of severe and sustained cold weather. This has highlighted the need to have effective plans in place.

A cross service DCC Severe Weather Planning Group was initially established in 2011 (see appendix 6 for current membership and appendix 7 for the terms of reference). This Excess Winter Death Plan was focused on measures to identify and contact those most vulnerable to ensure they were safe and had appropriate support arrangements in place during any prolonged cold spell. The action plan was subsequently amended to include appropriate communication protocols and locally appropriate interventions.
Recent further amendments, including a name change, were made to ensure alignment with the Cold Weather Plan for England[1]

The Cold Weather Plan is linked to Durham County Council's Severe Weather Plan. It is a year round plan with designated actions at level 0 being assessed throughout the year. These actions are complemented with the Cold Weather Alerts, operational between 1st November and 31st March. The latter are based on the Met Office data released on a "need to know" basis. All staff will be informed through the monthly newsletter and the document placed on the CAS Intranet site. There is a need for greater alignment with NHS planning processes and this has been raised with both the CCGs and NHS England and this has been included in the current action plan.

1.2 Scope of a Cold Weather Plan

Aim
The Cold Weather Plan aims to mitigate the impact of cold weather on the health and wellbeing of residents with a particular focus on those most vulnerable.

Objectives

- to identify those most at risk from cold weather
- to develop and deliver the Department of Health recommended practical and effective key interventions to reduce the risk of excess winter deaths
- to systematically offer the key interventions to those people most at risk from the cold weather

[1] PHE, LGA, Met Office, NHSE, 2014, Cold Weather Plan for England: Making the case: why long term strategic planning for cold weather is essential to health and wellbeing.

- to develop and deliver key communications that minimise the impact of cold weather on the residents of County Durham, in response to a:
    - Level 1: Winter preparedness cold weather alert
    - Level 2: Alert and readiness cold weather alert
    - Level 3: Severe weather action cold weather alert
    - Level 4: Emergency Response (Local action)

- To ensure access to emergency interventions is available for those people identified as most vulnerable, in response to a:
    Level 1: Winter preparedness cold weather alert
    Level 2: Alert and readiness cold weather alert
    Level 3: Severe weather action cold weather alert
    Level 4: Emergency Response (Local action)

Section 2 – Impact of factors on excess winter deaths and ill health

2.1 Effects of cold on health and healthcare services

The impact of cold weather on health produces direct and indirect effects. The former include an increase in heart attacks and strokes, accounting for 40% of excess winter deaths, respiratory disease, approximately one third of all deaths, influenza, falls and injuries and hypothermia. Indirect effects include an increase incidence of depression and carbon monoxide poisoning risk if boilers, coking or heating equipment is badly maintained.

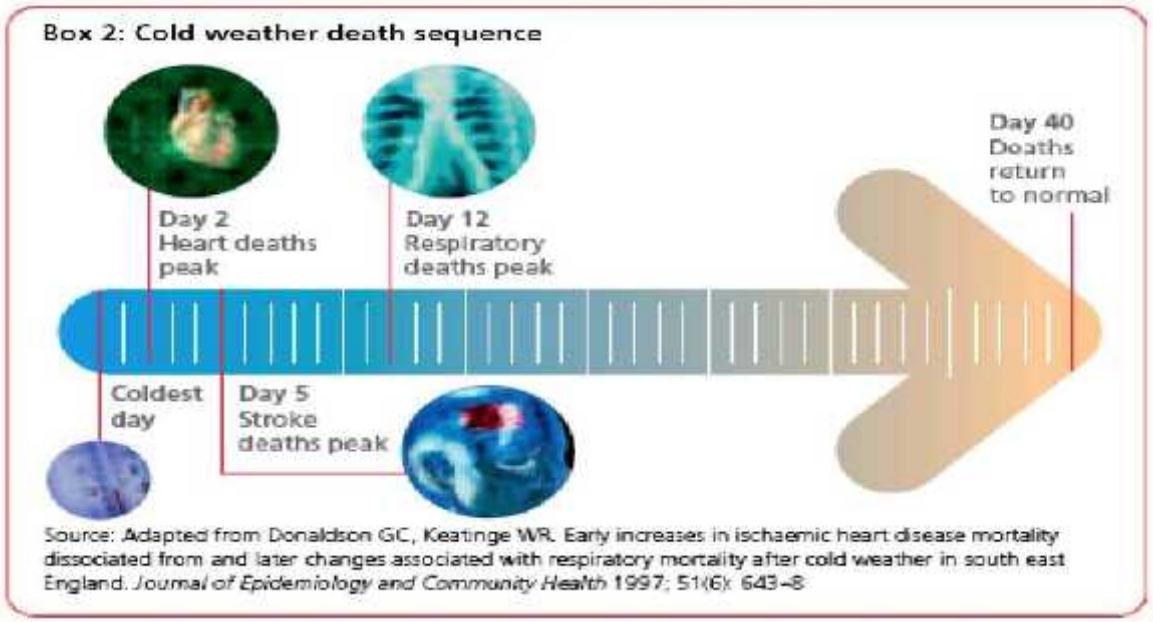
Every year mortality rises by 19% in the winter months in England. This amounts to an average of 27,000 'excess' winter deaths or about 1,560 more people per week dying between December and March compared with the rest of the year.

Table 1.1 The effect of temperature on health

Temperature	Effect
18°C (65˚F)	Heating homes to at least 18 degrees C (65F) in winter poses minimal risk to health of a sedentary person, wearing suitable clothing.
Under 16°C (61˚F)	May diminish resistance to respiratory diseases
9–12°C (48–54˚F)	May increase blood pressure and risk of cardiovascular disease
5 -8°C (41˚F)	Mean outdoor temperature threshold at which increased risk of death
5^{o}C	Poses a high risk of hypothermia.

Table 1.2: The effect of related winter conditions on health

Moderate outdoor temperatures of between 4-8 degrees C are related to the greatest health burden in terms of cold related ill health. This requires an increased emphasis on year-round (level 0) and winter preparedness and action (level 1) to protect "at risk" population groups.



2.1.1 Cardiovascular disease

Indoor temperatures of 12°C or less can cause a constriction in the blood vessels resulting in a rise in blood pressure. Thickening of the blood further increases the risk of clots. If these clots form in the heart and brain vessels, they can lead to heart attack and stroke. A 1°C lowering of temperature in the living area of an older person is associated with a rise of 1.3 mmHg in their systolic blood pressure, due to cold extremities and a lower core body temperature.[2]

2.1.2 Respiratory illnesses

People tend to spend more time indoors when the weather is cold and where they are more likely to be in close proximity to one another. This can aid the spread of infection. Exposure to cold indoor or outdoor temperatures suppresses the immune system; diminishes the lungs' capacity to fight off infection; and increases constriction of the airways which stimulates mucus production. These factors are associated with an increased risk of bronchitis and pneumonia.

[2] Woodhouse, P.R., Khaw, K.T and Plummer, M. 1993 Seasonal Variation of blood pressure and its relationship to ambient temperature in an elderly population. Journal of Hypertension 11 (11). 1267-74 quoted in Cold Weather Plan for England, p.8

It is estimated that GP visits for respiratory illness increase by up to 19% for every 1°C drop below 5°C of the mean temperature[3]. When a house is damp as well as cold, mold is likely to occur. This increases the risk of respiratory illness, particularly asthma.
Home energy efficiency measures have been shown to significantly reduce absence from school in children due to asthma, and recurrent respiratory infections[4].

2.1.3 Influenza

Seasonal flu vaccinations[5] can provide protection and are offered, free of charge, to those in the following groups:

- people aged 65 or over
- all children aged 2 – 4 and children in school year 1 and 2
- people with serious medical conditions (including children over six months of age) such as:
    - *chronic respiratory disease, such as severe asthma, chronic obstructive
    - *pulmonary disease (COPD) or bronchitis
    - *chronic heart disease, such as heart failure
    - *chronic kidney disease at stage 3, 4 or 5
    - *chronic liver disease
    - *chronic neurological disease, such as Parkinson's disease or motor neurone disease
    - *diabetes
    - *a weakened immune system due to disease (such as HIV/AIDS) or treatment (such as cancer treatment)
- pregnant women (at any stage of pregnancy)
- everyone living in a residential or nursing home
- everyone who cares for an older or disabled person
- household contacts of anyone who is immune-compromised
- all frontline health and social care workers

2.1.4 Other infectious diseases

Cold weather is also associated with an increase in the prevalence of other respiratory infections, such as respiratory syncytial virus. In addition, other infectious diseases such as bacterial infections and viral gastroenteritis (winter vomiting disease) – also have a seasonal pattern and may increase in winter.

[3] Hajat, S., Kovats, R.S. and Lachowycz, K., 2007 Heat related and cold related deaths in England and Wales: who is at risk? Occupational and Environmental Medicine 64 (2): 93-100, quoted in Cold Weather Plan for England, p.9

[4] Howden-Chapman, P., Matheson, A., Crane, J. et al, 2007 Effects of insulating existing houses on health inequality; cluster radomised study in the community. British Medical Journal 334: 460, quoted in Cold Weather Plan for England p. 9

[5] Public Health England, 2014: Flu plan, Winter 2014/15, quoted in Cold Weather Plan for England, p.9

2.1.5 Low weight gain in infants

Evidence shows there is a relationship between living in cold homes and poor infant weight gain, attributed to the fact that children living in colder homes need greater calorific intake to fulfil growth potential.[6]

2.1.6 Hypothermia

Hypothermia is a potentially fatal lowering of core body temperature caused by exposure to cold. One study shows incidence peaks of hypothermia in patients attending emergency departments, over 65 years, from relatively deprived postcodes, which coincided with periods of cold weather. Of the 5% showing core temperature below 35ºC, more than one third of the patients died.[7] Deaths directly caused by hypothermia represent only a small proportion of the total amount of excess winter deaths.

2.1.7 Injuries and falls

Winter weather and cold homes affect mobility and increase the likelihood of falls and injuries – especially in frail and elderly people – because:

- symptoms of arthritis worsen in cold, damp houses
- strength and dexterity decrease as temperatures drop, increasing the risk of non-intentional injuries
- snow and icy conditions increase the risk of trips and falls outdoors[8]

In England, the number of emergency hospital admissions, due to falls on snow and ice, varies considerably from one winter to another. A recent study showed that the weekly rate of emergency hospital admissions for falls on snow and ice is inversely related to the mean weekly temperature.[9]

In the harsh winter of 2009/10, the rate of hospital admissions related to falls was particularly high for older people. The cost of emergency admissions that winter was estimated at £42m – with true healthcare costs estimated at being considerably higher.

2.1.8 Mental health and wellbeing

Damp, cold housing is associated with an increase in mental health problems, such as depression and anxiety. Living in these homes can affect people's ability to go about their daily lives. Some become socially isolated as they are reluctant to invite friends or family to a cold house, while others seek refuge elsewhere as an alternative to staying in.

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[6] Liddell, C. and Morris, C., 2010, Fuel poverty and human health: A review of recent evidence, quoted in Cold Weather Plan for England, p.10.

[7] Pedley, D.K.,, Patterson, B. and Morrison, W., 2002 Hypothermia in elderly patients presenting to Accident & Emergency during the onset of winter. Scottish Medical Journal 47; 10-11, quoted in Cold Weather Plan for England, p.10

[8] Department of Health, 2007, Health and Winter Warmth –Reducing Health Inequalities, quoted in Cold Weather Plan for England, p.10

[9] Beynon, C., Wyke, S., Jarman, I et al, 2011. The cost of emergency hospital admissions for falls on snow and ice in England during winter 2009/10: a cross sectional analysis. Environmental Health 10;60, quoted in Cold Weather Plan for England, p.10

Cold housing can also negatively affect children's emotional wellbeing and resilience. It can be difficult for children to study or do homework in a cold house, which affects educational and long-term health and work opportunities. Studies have suggested that more than one in four adolescents living in cold housing are at risk of developing mental health problems, compared with one in 20 adolescents who have always lived in warm housing.[10]

A questionnaire linking proxies for fuel poverty to Common Mental Health Disorders (CMD) showed that 10% of those with CMD reported not being able to keep their home warm enough in winter, compared with just 3% without CMD. Of those with CMD, 15% said they had mold in their home, compared with 8% with no CMD.[11]

2.1.9 Carbon monoxide poisoning

Cases of carbon monoxide (CO) poisoning increase in winter because people may use malfunctioning or inappropriate appliances to heat their homes. Approximately 40 people die each year in England from CO poisoning; sixteen people died from CO poisoning from faulty household appliances from April 2011 to March 2012[12]. During cold weather, people may also try to reduce ventilation inside the house. Incorrectly installed, poorly maintained and poorly ventilated cooking and heating appliances (such as those using oil, gas, coal, wood or paraffin) are the main sources of carbon monoxide poisoning in the home. CO poisoning symptoms include:

- headache
- dizziness
- disorientation
- memory loss
- fainting
- coma
- death.

2.1.10 The impact of cold weather on health and social care services

The major impact of cold weather on the NHS and social care is increased admissions to hospital, subsequent strain on emergency services and fallout on social care. These often result from a high demand for beds and difficulties in discharging patients all of which may be compounded by staff shortages due to illness.

The main categories of admissions are cardiovascular, respiratory and infectious diseases, as well as weather-related accidents. This is compounded with extended periods of in-patient episodes, either due to medical complications or a delay in discharging patients because of lack of suitable accommodation.

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[10] Liddell, C. 2008, Policy Briefing: The Impact of Fuel Poverty on Children, Belfast: Ulster University & Save the Children, quoted in Cold Weather Plan for England, p11

[11] Harris, J., Hall, J, Meitzer, H., Jenkins, R., Oreszczyn, T., and McManus, S, 201 Mental health and housing conditions in England, National Centre for Social Research, quoted in Cold Weather Plan for England, p. 11

[12] The Carbon Monoxide and Gas Safety Society, 2012, UK deaths caused by accidental Carbon Monoxide poisoning between 1/9/95 and 31/8/12, quoted in Cold Weather Plan for England, p.11

The annual cost to the NHS of treating disease due to cold private housing is reported to be over £850 million[13]. This does not include additional spending by social care, or economic losses through absences from work.

2.2 Excess winter mortality

There are a number of methods used to define excess winter death.
The Office for National Statistics (ONS) calculates winter deaths (deaths occurring in December to March) minus the average of non-winter deaths (deaths occurring in the preceding August to November plus deaths occurring in the following April to July divided by two). This estimate is published on an annual basis in November each year and is available by region and age-group.
There are around 25,000 excess winter deaths each winter in England. The number of extra deaths occurring in winter depends on temperatures, levels of disease (particularly influenza) in the population and other factors.

An extension of this calculation is the Excess Winter Deaths Index (EWDI). This takes the number of excess winter deaths as calculated by ONS and divides it by the average of non-winter deaths on a three year rolling basis. This is published by age-group at local authority level allowing comparison between local authorities and examination of trends over time.

Public Health England also undertakes weekly mortality surveillance which aims to detect and report acute significant excess mortality above usual seasonal levels in a timely fashion. Excess mortality is defined as a significant number of deaths reported over that expected for a given point in the year, allowing for weekly variation in the number of deaths. This information is used to guide an urgent response to a public health threat such as an influenza epidemic or temperature extremes. Information is published in a winter health watch bulletin on a weekly basis on the PHE website

Climate change does not mean an end to cold winters in England. Our climate is, in part, influenced by natural variations including changes in the amount of energy we receive from the sun, volcanic eruptions and natural cycles such as El Niño. Such variations will mean that, despite the warming climate, we may still experience very cold winters, although such cold weather is likely to become less frequent. Winter morbidity and mortality will likely remain an issue, particularly if our population becomes less well adapted to cold conditions. The National Adaptation Programme report sets out actions to adapt to climate change for a number of sectors, including the health and social care system

2.3 Who is most at risk?

There are a number of factors that increase the risk of ill health from cold. These include:

[13] Department of Health, 2010, Winter Kills in 2009 Annual Report of Chief Medical Officer

2.3.1 Population

- Older age: especially those over 75 years old or those living on their own who are socially isolated. Older people are more vulnerable to cold, partly because of an increased likelihood of suffering from pre-existing chronic illness, and partly because of a reduction in fat to retain body heat. They may be more vulnerable to indoor cold because of the increased time they spend at home and a higher prevalence of fuel poverty. However, it should be noted that the health of people of all ages is affected by cold homes
- chronic and severe illness: including heart conditions, circulatory disease, asthma, COPD, depression and anxiety, diabetes and arthritis
- children under the age of five are vulnerable to the cold due to immature thermoregulation and a high dependency level
- homeless people/street sleepers are vulnerable to the cold due to exposure to outdoor temperatures, and other factors which increase vulnerability to cold, such as social isolation, smoking, substance dependencies, mental illness and chronic and respiratory diseases which are more prevalent in this population.

2.3.2 Housing/economic factors

Fuel poor homes are less likely to be warm, dry homes. Fuel poverty is caused by a combination of fuel costs, poor home energy efficiency and low household income. These drivers of fuel poverty are strongly associated with cold homes, and have a strong effect on the risk of poor health outcomes. The prevalence of fuel poverty in this country varies according to region, household composition, tenure type and whether or not the house is connected to the mains gas network (as this is the cheapest method of heating the home). Private sector housing continues to be over-represented in the numbers of fuel poor households with owner occupier properties being the most likely to be fuel poor, followed by homes in the private rental sector.

The Hills Review[14] gave recognition to the role fuel poverty (living in low temperature households) has as a contributor to a number of incidents of ill health, including excess winter deaths. The Institute of Health Equity[15] further highlighted the association between living in a cold home and higher rates of illness and death, estimating that “excess winter deaths in the coldest quarter of housing are almost three times as high as in the warmest quarter”.
Evidence indicates that we could prevent many of the yearly excess winter deaths through warmer housing, with an emphasis on “level 0” year-round strategic commissioning and planning services.

2.3.3 Energy inefficient housing

There have been significant improvements to building regulations over the last decade, and a push to improve the energy efficiency of older homes. However, there are still many homes in England that fall well below modern standards of insulation and heating. Furthermore, older people – who are more likely to be at risk of ill health from a cold, damp home – are also more likely to be living in a home that fails to provide a reasonable degree of thermal comfort or living in a home that is not centrally heated. Evidence shows that over 26% of homes occupied by people over 60 years of age fail to meet the decent homes standard[16].[17] Living in houses with

[14] Hills, J, 2012, Getting the Measure of Fuel Poverty. The Final Report of the Fuel Poverty Review. Centre for Analysis of Social Exclusion
[15] Institute of Health Equity, 2011, The Health Impacts of Cold Homes and Fuel Poverty
[16] Department for Communities and Local Government, 2012, English Housing Survey 2010 to 2011: Household report

mould increases the risk of respiratory diseases becoming worse in cold weather. Living in deprived circumstances will reduce the person's ability to heat their home affordably and stay warm.

2.3.4 Behavior

Excess winter mortality is higher in England (average 19% increase) than in most other European countries, including much colder ones (Germany 11%, Finland 10%, France 13%)[18]. This difference may in part be due to the variation in behavioural patterns across Europe, both institutional and individual. Reasons may include:

- In countries such as England where comparatively milder winters are more common, people adapt less effectively to very cold weather.
- Inability to adapt behavior to stay warm. Some illnesses and conditions, such as mental illness, dementia and learning disabilities can reduce the person's ability to self-care.
- Not claiming benefits. Each year several billion pounds of benefits go unclaimed. In 2007/08, about £6 billion to £12 billion of benefits overall were left unclaimed in England. During that same year, the total amount of housing benefit alone that was left unclaimed was between £1,780 million and £3,410 million. The number of people that were entitled to, but not receiving housing benefit, was estimated to be between 680,000 and 1.18 million. There are many different reasons why people do not claim the income they are entitled to. The additional income could make a significant difference to the ability of vulnerable people to heat their homes more affordably.
- Not accepting help offered.

2.4 Local Picture

The latest reporting against the Public Health Outcomes Framework indicators (2015), that the three year pooled excess winter deaths index for County Durham (Aug 2010 – Jul 2013, all ages) was not significantly different to England or other north east local authorities. Over this period there were 944 excess deaths in County Durham

Hospital admission data is collected but it is rare for a patient's condition to be associated with their living conditions. Thus the influence of a cold, damp home is not captured. Public Health England has just started to explore how this may be done in future. In addition the way fuel poverty has changed so that it is now based on a definition of Low Income High Costs (LIHC)[19]. It is estimated that in County Durham 11.5% of the households are fuel poor.

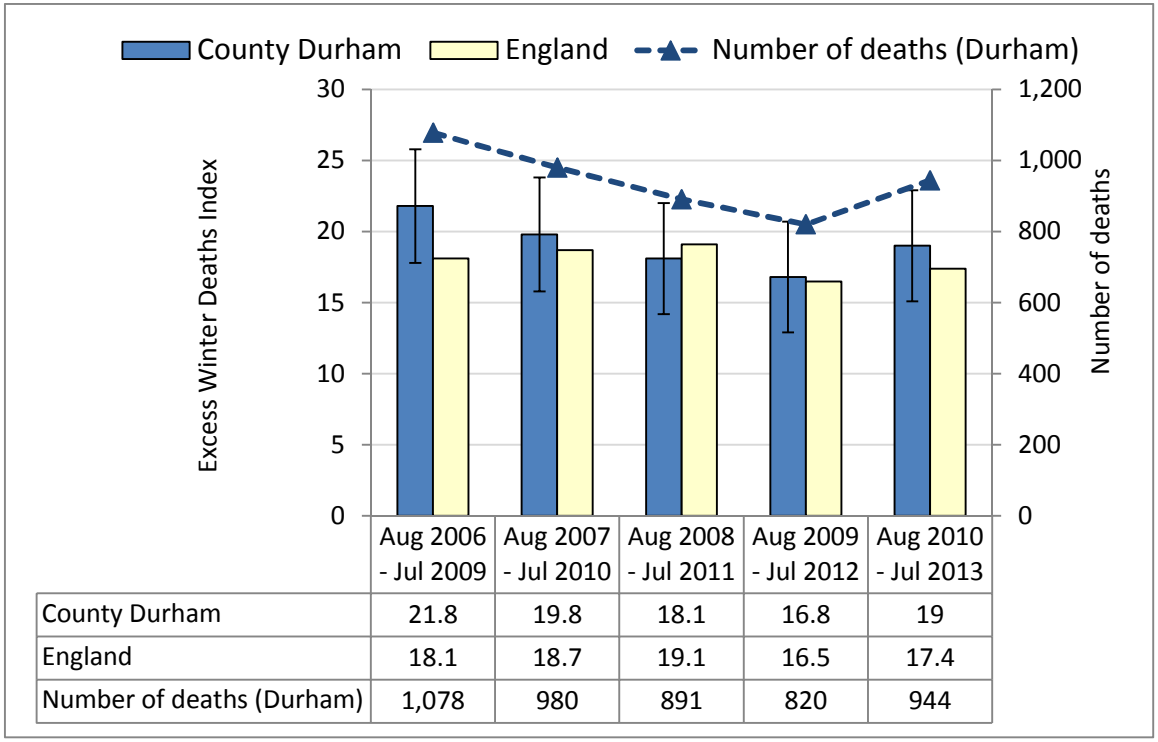
[17] Age UK, 2013, Later Life in the UK August 2013
[18] Healy, J., 2003 Excess winter mortality in Europe: a cross country analysis identifying key risk factors , BMJ
[19] ONS, 2015, 2013 sub-regional fuel poverty data: low income high cost indication

Figure 3.1 Excess Winter Deaths Indices Source: Public Health Outcomes Framework, PHE. December 2015.

PHOF Indicator		Period	Number of excess deaths	Excess Winter Deaths Index (EWDI)		
			County Durham		North East	England
4.15i	Excess Winter Deaths Index (Single year, all ages)	Aug 2012- Jul 2013	364	21.2	20.7	20.1
4.15ii	Excess Winter Deaths Index (Single year, ages 85+)	Aug 2012 – 2013	149	24.9	28.6	28.2
4.15iii	Excess Winter Deaths index (3 years, all ages)	Aug 2010 – Jul 2013	944	19.0	16.0	17.4
4.15iv	Excess Winter Deaths Index (3 years, ages 85+)	Aug 2010 – Jul 2013	396	23.9	21.6	24.1

Not significantly different to England

Figure 3.2 Excess Winter Deaths Index, 3 years, all ages, 2006-09 to 2010-13
Source: Public Health Outcomes Framework, December 2015.



	Aug 2006 - Jul 2009	Aug 2007 - Jul 2010	Aug 2008 - Jul 2011	Aug 2009 - Jul 2012	Aug 2010 - Jul 2013
County Durham	21.8	19.8	18.1	16.8	19
England	18.1	18.7	19.1	16.5	17.4
Number of deaths (Durham)	1,078	980	891	820	944

The Excess Winter Deaths Index (EWDI) in County Durham has been falling over time, although the period 2010-13 saw an increase on 2009-12. Between 2006-2009 and 2010-13 the Index fell by almost 13% (from 21.8 to 19). Although County Durham's Index is higher than England, the difference is not statistically significant.

For the period 2006-2009 there were a total of 1,078 excess winter deaths at an average of 359 per year (all ages). For the period 2010-2013 the number of deaths was 944, at an average of 315 per year.

Section 3 – Policy framework and evidence base

3.1 Policy context

3.1.1 Healthy Lives, Healthy People

The Public Health White Paper[20] provides a response to Marmot's Fair Society, Health Lives and adopts a life course approach to address the social determinants of health including fuel poverty.

3.1.2 Public Health Outcomes Framework 2013-16

Underpinning the White Paper is an Outcomes Framework within which two indicators relate directly to this plan, fuel poverty (1.17) and excess winter deaths (4.15). However, as the Cold Weather Plan for England emphasizes 'action to reduce the harm from cold can be linked to many more outcome framework indicators connected to the wider determinants of health, such as poverty, educational achievement and social isolation.' (p.27). Thus action to mitigate the impact of cold related ill health cuts across the domains as follows:

- Domain 1 –Improving the wider determinants of health (1.01 Children in poverty, 1.03 Pupil absence, 1.09 Sickness absence rates, 1.17 Fuel poverty, 1.18 Social isolation)
- Domain 2 –Health improvement, (Diet, 2.23 Self-reported wellbeing, 2.24 Falls and injuries in the over 65s')
- Domain 3 – Health protection, (Population vaccine coverage, 3.05 Public sector bodies with board approved sustainable development management plans, 3.07 Comprehensive, agreed inter-agency plans for responding to public health incidents and emergencies.)
- Domain 4- Healthcare public health and preventing premature mortality, (4.03 – Mortality from all causes considered preventable, 4.04 Under 75 mortality rate from cardiovascular diseases (including heart disease and stroke), 4.07 Under 75 mortality from respiratory diseases.4.08 Mortality rate from communicable diseases, 4.11 Emergency readmissions within 30 days of discharge from hospital, 4.13 Health related quality of life for older people, 4.14 Hip fractures in people aged 65 and over,4.15 Excess winter deaths.)

3.1.3 NHS Outcomes Framework (NOF) 2015-2016

Measures to reduce cold-related harm also meet indicators in four out of the five domains of The NHS Outcomes Framework (NOF) 2014-2015:

- Domain 1 – Preventing people from dying prematurely;
- Domain 2 - Enhancing quality of life for people with long term conditions;
- Domain 3 – Helping people to recover from episodes of ill health or following injury; and
- Domain 5 – Treating and caring for people in a safe environment and protect them from avoidable harm.

[20] White Paper: Healthy Lives, Healthy People: Our strategy for Public Health in England, 2011, Department of Health

3.1.4 Adult Social Care Outcomes Framework 2015/16

Cold related illness and death will also impact on three domains of the Adult Social Care Outcomes Framework 2015/16:

- Domain 1 – Enhancing quality of life for people with care and support needs;
- Domain 2 - Delaying and reducing the need for care and support; and
- Domain 4 - Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

3.1.5 Cutting the Cost of keeping Warm: A Fuel Poverty Strategy for England[21]

Following the Hills Review, the Government changed the definition of fuel poverty to one of 'low income, high cost (LIHC)'. Households are deemed fuel poor if 'they have required fuel costs that are above the median level and were they to spend that amount they would be left with a residual income below the official poverty line.' This means that in England in 2011 there were 2.39 million fuel poor households. In addition, the report describes a 'fuel poverty gap' (£1.05 billion or £438 per fuel poor household) the difference between a household's modelled fuel bill and what their bill would be if they were no longer fuel poor. The Strategy emphasizes the role the NHS and Social Care Sector can play in tackling fuel poverty.

3.1.6 Local plans and strategies

- County Durham Housing Plan 2015-20 highlights the fuel poverty and measures to address it as outlined in the Affordable Warmth Strategy.
- County Durham Climate Change Strategy. The strategy recognizes the impact of energy inefficient homes as a key contributor to carbon levels and proposes and cross references actions from the Affordable Warmth Strategy.
- Affordable Warmth Strategy. Outlines a range of measures to address fuel poverty locally including the role of Warm Up North. The strategy also recognizes the impact of cold homes for those living with an underlying health condition.
- Joint Strategic Needs Assessment (JSNA). The issue of excess winter deaths is highlighted as an area requiring local action.
- Joint Health & Well Being Strategy. Action to reduce the impact of excess winter morbidity and mortality are included in this document.

3.2 Evidence

The Health Inequalities National Support Team identified nine key interventions that, if implemented, can help mitigate the impact of cold weather. These are:

- Assessment for affordable warmth interventions, including energy efficiency, household income and fuel cost.
- Regular review of benefits entitlement and uptake.
- Annual flu and pneumococcal vaccination.
- Provision of an annual medication review (every six months if taking four+ medicines).

[21] Department for Energy and Climate Change, 2015, Cutting the Cost of Keeping Warm: A Fuel Poverty Strategy for England

- Provision of an annual medicines utilisation review (MUR) and follow-up support for adherence to therapy.
- Implementation of a personal brief health interventions plan that includes advice and support to stop smoking, sensible drinking, healthy eating, adequate hydration and daily active living.
- Assessment and support programme to prevent falls.
- Assessment for appropriate assistive technologies, for example alarm pendants to call for help.
- Help to develop a personal crisis contingency plan (e.g. including a buddy scheme, if there are no close friends or family to watch for danger signs and provide someone to call).

Many of these actions were subsequently captured in the Cold Weather Alerts

A recently released NICE guideline[21] makes recommendations on how to reduce the risk of death and ill health associated with living in a cold damp home. The guideline outlines the case for year round planning where a focus is on prioritizing those most vulnerable, shaping and influencing decisions about how homes are improved and outlining a case for research, implementation and evaluation.

NICE defines vulnerability in terms of people with cardiovascular conditions, respiratory conditions such as COPD and asthma, mental health conditions, those with disabilities, those aged 65 and older, households with young children (0-5 years), pregnant women and those on low income. Both the national and local Cold Weather Plan are consistent with NICE recommendations regarding a single point of contact services that often tailor solutions to which all who come into contact with vulnerable people can use.

The guideline has 12 recommendations with responsibility for each shared by a combination of national and local organisations.

Public Health commissioned the North East Public Health Observation[22] (NEPHO) to undertake a local evaluation study to establish a baseline picture for both excess winter deaths and hospital admissions. It then reviewed the data after three years. The key findings from the study corroborate the Office of National Statistics review of excess winter deaths[23]. These include:

- Fluctuations are evident in excess winter deaths and admission rates over time and between areas of the county.
- Significantly increasing emergency admissions to hospitals. County Durham has lower emergency admission rates than the north east but higher than the England average.
- Older males particularly those over 85 years have the highest emergency admission rate within County Durham. This could be due to a range of factors including males being less likely to access primary care services.
- COPD has the highest readmission and multiple emergency admission rates of the conditions considered.

[21] NICE (2015) Excess winter death and mortality and the health risks associated with cold homes
[22] Office National Statistics (2010) Excess winter mortality in England and Wales, 2009/10 (provisional) and 2008/09 (final). Statistical Bulletin
[23] NEPHO (2011) Rights to Warmth in County Durham: Evaluation of excess winter deaths and admission dates

3.3 Cold Weather Alerts

The Met Office in association with the Department of Health operates a Cold Weather Health Watch system throughout the winter from 1 November to 31 March. There are different thresholds for the cold weather health watch. Only one of the three thresholds needs to be breached for a warning to be issued. The thresholds are:

- Mean temperatures below 2 degrees Celsius for 48 hours or longer
- Heavy snow
- Widespread ice

Level 0 – Year round planning and intervention
It has been recognized by the National Health Inequalities Team and then within the Cold Weather Plan, that a year round approach is required to address excess winter deaths and life quality issues. Best practice suggests a partnership approach to both needs assessment and commissioning, planning and implementing interventions. Ensuring ownership by Joint Health and Well Being Boards via the Joint Strategic Needs Assessment and Joint Health and Well Being Strategies is a critical first step.

Level 1 - Winter action and preparedness (Green)
This is the minimum state of vigilance during the winter. During this time social and healthcare services will ensure that there is ongoing awareness and preparedness.

Level 2 – Severe winter weather is forecast - Alert and readiness (Yellow)
Triggered by the Met Office as soon as the risk is 60% or above for any of the three thresholds to be breached. This is an important stage for social and healthcare services who will be working to ensure readiness and swift action to reduce harm from a potential period of cold weather.

Level 3 – Response to severe winter weather – Severe weather action (Amber)
Triggered by the Met Office when we are experiencing weather which breaches any of the three thresholds. This stage requires social and healthcare services to target specific actions at high-risk groups.

Level 4 – Major incident – Emergency Response (Red)
Reached when a period of cold weather is so severe and/or prolonged that its effects extend outside the health and social care system. A level 4 warning would be issued on advice from, or in collaboration with, our Government partners. At this level, the health effects may occur among the fit and healthy, and not just in high-risk groups.

4. Governance

4.1 Review arrangements

The Cold Weather Plan will be reviewed annually in May by the Severe Weather Planning Group. This review will include a debriefing of last year's planning arrangements to identify any lessons learned and which should be included within the plan. A further refresh of the plan will be completed annually in September.

A debriefing and plan review will also be undertaken after any incident requiring the activation of this plan.

4.2 Assurance Arrangements

Both NHS England and the Urgent Care Board require assurances that this plan is robust and linked to wider health and social care systems. This has been provided by the Consultant in Public Health on an annual basis at the Board Meetings. The Plan also includes a testing table that will detail when and how it has been tested. The 2015 version of the Cold Weather Plan was agreed at Public Health SMT on 5th August 2015 and signed off by the Severe Weather Planning Group on 13th October 2015.

The attached appendices provide both national and local information to assist front line staff and commissioned providers to implement interventions to address cold weather.

APPENDIX	DETAILS	USE	BY WHOM	WHEN
1	The Cold Weather Plan for England, 2015, PHE/NHSE	It provides advice to help prevent the major avoidable effects on health during periods of cold weather. Includes a series of action cards forming a checklist for commissioners/providers at levels 1-4 as well as year round actions.	Social Care, Commissioners and providers	Year round Alerts November – March
2	Children and Adult Services (CAS) Actions 2015/16	To inform and influence planning and delivery of local services. To identify local actions linked to the Cold Weather Plan for England and particularly the Cold Weather Alerts.	Public Health Social Care Commissioners Social Care Providers CAS front line staff	Year round as well as interventions in response to level 1-4 in cold weather alerts
3	Local Service Information linked to nine key interventions highlighted in the National Health Inequalities support team and endorsed in Cold Weather Plan	To assist deliver of local interventions	Social Care provides CAS Frontline staff NHS staff	Can be used to support clients at each of four levels plus year round plan
4	Customer Service Teams Scripts for Cold Weather enquiries	Information on a range of local services providing advice to local residents. This could be existing service users or those who are not eligible for social care services. The appropriate recording and reporting/ escalation procedure will be followed	Social Care Direct First Contact Customer Services	Information can be used at each of the alert levels 1-4
5	Severe Weather Planning Group – list of membership	Names and job titles of the group's members		
6	Cold Weather Plan – terms of reference	To provide an overview of the role and function of the Group.		
7	CAS responsibilities following a level 3/4 alert. Includes flowchart, email alerts	Process and procedure for dissemination of cold weather alerts between 1st November and 31st March	Commissioners Providers CAS frontline staff	Met Office alert at level 3 or 4
8	Top tips for keeping warm and well; Age UK and NHS	Information leaflet to complement Keep Warm Keep Well leaflet produced by HM Government	Frontline staff and Service Providers	Targeted use during alert period 1st

		www.nhs.uk/keepwarmkeepwell www.gov.uk/government/publications/keep-warm-keep-well-leaflet-gives-advice-on-staying-healthy-in-cold-weather		November – 31st March

Appendix 1 – The Cold Weather Plan for England 2015, PHE/NHSE

The Cold Weather Plan gives advice to help prevent the major available effects on health during periods of Cold Weather. It includes a series of action cards forming a checklist for Commissioning, Providers and individuals at Levels 1-4 as well as other year round actions

https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england

Appendix 2 - Cold Weather Plan Actions 2015/16

Objective 1: Develop and deliver the nine recommended practical and effective key interventions to reduce the risk of excess winter deaths

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
1.1	Assess current provision of nine key Interventions (listed on page 15) to identify any gaps in provision against good practice within Cold Weather Plan	Nick Springham	Oct 2015				Current provision described in Appendix 3
1.2	Undertake a baseline audit of NICE guideline, identifying any gaps and produce action plan to address them	Tim Wright	August 2015				Audit undertaken and results discussed with members of both Fuel Poverty and Severe Weather Planning Groups
1.3	Ensure closer integration with NHS Winter Residence Planning System	Anna Lynch/ Tim Wright					CCGs/NHSE linkages identified Systems baseline group invitation received
1.4	Warm and Healthy item programmes commissioned by Public Health until March 2017	Tim Wright	Ongoing				Quarterly PIs provider continues to deliver well against PIs

Objective 2: Systematically offer the key interventions to those people most at risk from the cold weather

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
2.1	Develop processes to ensure that key workers know how to access interventions for vulnerable people.	Tim Wright	Oct 2015				CAS frontline staff informed via monthly newsletter and updated Cold Weather Plan on CAS Intranet
2.2	Develop information with details of how to access nine key interventions with key contacts.	Tim Wright	Oct 2015				

Objective 3: Develop and deliver key communications that minimise the impact of cold weather on the residents of County Durham in response to the three cold weather alert levels

Level 1: Winter and action programme (1 November to 31 March)

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
3.1	County Durham News Winter edition.	Karen Stewart	Oct 15				Reviewed and circulated via winter edition of Durham County News
3.2	Produce media articles (including website, press release and magazine articles) produced for public, staff and VCS for a range of winter weather situations and agreed by Severe Weather Task Group and Corporate Communications	Karen Stewart	Nov 2015				Articles produced and shared with corporate communications. Information placed on Durham Voice for VCS. This to be repeated in November annually. Three Stay Well this Winter Roadshows organised by PHE, visited St Cuthberts Walk, Chester le Street 11-12/11/15; Thames Centre Newton Aycliffe 13-14 / 11/15 and Byron Place, Seaham 16-17/11/15
3.3	Produce a briefing for elected members and corporate directors.	Karen Stewart	By Nov 2015				To be circulated annually
3.4	Ensure carers are targeted with appropriate message to help those most vulnerable.	Karen Stewart	Nov 2015				Stay well this Winter messages via social media (Carers' Echo Twitter)
3.5	Publication and promotion of awareness raising messages for staff. For example:- • Awareness raising and be prepared messages • Safe Winter Driving Hot Topic • Winter Weather Action Hot Topic • Inclement Weather Guidance	Karen Stewart	Nov 2015				Health and Safety briefings for staff circulated on winter issues via intranet and staff bulletins

3.6	Publication and promotion of awareness raising messages and be prepared messages through VCS and CVS magazines and groups.	Karen Stewart	Nov 2015				Information sent to all AAP co-ordinators for distribution within their localities.
3.7	Actively involve AAPs in dissemination of community resilience messages.	Karen Stewart	Oct 2015				National winter planning guide messages shared with AAP co-ordinators
Level 2 – Severe weather is forecast – alert and readiness							
3.8	Communication messages escalated to the public around being prepared and who to contact if struggling as a result of the severe winter weather.	Karen Stewart	Following a Level 2 Met Office Alert				To go live when level 2 occurs. Alerted via CCU cascade. KS to confirm to Consultant in Public Health that action completed.
3.9	Communication messages escalated for VCS around being prepared and who to contact if they are aware of people who are struggling as a result of the severe winter weather. (in line with National Action Cards)	Karen Stewart	Following a Level 2 Met Office Alert				See above
Level 3 – Response to severe winter weather – Severe weather action							
3.10	Cascade of standard email (see appendix 8) by CCU to Cold Weather Escalation Group for circulation to frontline staff.	CCU Duty Officer	Following level 3 Met Office Alert				To go live when level 3 occurs led by Public Health communications and marketing
3.11	Prepared scripts will be made available to Customer Service Teams (including SCD, First Contact and Social Care Direct) to deal with queries from the public.	Carole Lee	Following a Level 2 Met Office Alert				To go live when level 2 occurs. Alerted via CCU cascade. KS to confirm to Consultant in Public Health that action completed.
3.12	Severe Weather Task Group will meet twice weekly following a Level 2 Met Office Alert to coordinate actions and identify any new actions needed.	Nick Springham	Following a Level 3 Met Office Alert				Group to be convened by Consultant in Public Health
3.13	Communication messages escalated for VCS around being a good neighbour and who to contact if they are aware of people who are struggling as a result of the severe winter weather. (in line with National Action Cards)	Karen Stewart	Following a Level 3 Met Office Alert				To go live when level 3 occurs led by Public Health communications and marketing.

3.14	Communication messages escalated for The public around being a good neighbour and who to contact if struggling as a result of the severe winter weather (in line with National Action Cards).	Karen Stewart	Following a Level 3 Met Office Alert				As above
3.15	Communication messages escalated for staff around what to look out for when visiting people and who to contact if aware of people struggling as a result of the severe winter weather (in line with National Action Cards).	Karen Stewart	Following a Level 3 Met Office Alert				As above
Level 4 – Major Incident – Emergency response							
3.16	Level 3 actions will continue as detailed above.	Karen Stewart	Following a Level 4 Met Office Alert				To go live when level 4 occurs led by Public Health communications and marketing

Objective 4: Ensure access to emergency interventions is available for those people identified as most vulnerable, in response to the three cold weather alerts

Level 1: Winter preparedness and action programme (1 November – 31 March)

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
4.1	Severe Weather Task Group meets monthly from October 2015 to March 2016 to review the winter weather situation.	Nick Springham	October 2015				Meetings arranged

Level 2: Severe winter weather is forecast -Alert and readiness cold weather alert

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
4.2	Severe Weather Task Group twice weekly meeting following a Level 2 Met Office Alert to coordinate actions and identify any new actions needed.	Nick Springham	Following a Level 2 Met Office Alert				Meetings to be convened by Consultant in Public health
4.3	Prepared scripts will be adapted and made available to Customer Service Teams (including SCD, First Contact and Social care Direct) to deal with queries from the public.	Nick Springham	Following a Level 2 Met Office Alert				As above
4.4	Customer Services Teams will have information in relation to systematic interventions available to help deal with the effects of cold temperatures when no emergency measures are needed	Nick Springham	Following a Level 2 Met Office Alert				See above
4.5	Details of emergency measures available across the county will be updated and made available to customer service teams. This includes details relating to: • Snow clearance • Affordable warmth	Nick Springham	Following a Level 2 Met Office Alert				As above

Level 3: Response to severe winter

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
4.6	Prepared scripts will be utilised by Customer Service Teams to deal with queries from the public.	Customers Service Team	Following a Level 3 Met Office Alert				Go live as necessary
4.7	Customer Services Teams will have information in relation to systematic interventions available to help people deal with effects of cold temperatures when no emergency measures are needed	Customers Service Team	Following a Level 3 Met Office Alert				As above
4.8	Severe Weather Planning Group will meet twice weekly following a Level 3 Met Office Alert to coordinate actions and identify any new actions needed	Nick Springham	Following a Level 3 Met Office Alert				As above
4.9	Emergency measures activated as required via contact through Customer Services routes.	Nick Springham	Following a Level 3 Met Office Alert				As above

Level 5 – Major incident – Emergency Response - Local action

Task No	Action	Lead Officer	Timescale	Performance RAG			Update Report
5.0	Level 3 actions will continue as detailed above.	Nick Springham	Following a Level 4 Met Office Alert				Go live as necessary
5.1	Cascade of standard email (see appendix 8) by CCU to Cold Weather Escalation Group for circulation to	CCU Duty Officer	Following Level 4 Met Office Alert				As above

Appendix 3 – Local service information linked to key interventions

Key Interventions	Delivered by	Where	How Accessed
Assessment for affordable warmth interventions, including energy efficiency, household income and fuel cost	Warm Homes Scheme, DCC	Countywide	Via professionals or self referral Contact 03000 261079 - Sue Carr
	Warm and Healthy Homes, Housing and Regeneration, DCC • Energy Saving advice and health/insulation scheme • Benefit entitlement checks • Home fire safety check • Fuel debt advice • Access to emergency fund	Countywide	Via Health and Social Care professionals Contact 03000 261079 – Sue Carr
	Welfare assistance scheme to help with short term support/help for residents to live independently.	Countywide	03000 267 900 http://www.durham.gov.uk/welfareassistance
	Keep Warm, Keep Well campaign – information packs Age UK County Durham	Countrywide	Contact: Advice and Information Team, Age UK County Durham Tel: 0191 374637
	Surviving Winter Campaign – grants available to pay for relief items, e.g. blankets, distribution of hot meals	Countrywide	Contact: County Durham Community Foundation Christine Rackley Tel: 0191 3786340
	Managing Money Better Scheme Helps people save money on their energy bills	Countrywide	Tel: 03000 5000933
	County Durham Socialist Clothing Bank Twice a month on a Tuesday between 12 and 2pm – Brandon Welfare Hall – free to those on benefits, are sanctioned, homeless and low wages		07707 031 625
Regular reviews of benefit entitlement and uptake	Warm and Healthy Homes, Housing and Regeneration, DCC	Countywide	Via Health and Social Care professionals Contact 03000 261079 – Sue Carr
	Welfare Rights Service	Countywide	Via Health and Social Care professionals

Key Interventions	Delivered by	Where	How Accessed
	Age UK County Durham	Countywide	Self-referral via Age UK – Advice and Information Team 0191 374 6367 Lead Contact – Harriet Gibbon
	Citizen Advice County Durham	Countywide	Self-referral via local offices :- Advice line : 03444 111 444 Debit advice line : 0300 3232000 Reception :03000 3231000
Annual flu and pneumococcal vaccination	GP practices and Pharmacies	Countywide	Led by NHS England. Accessed via GP surgeries and Pharmacies
Provision of annual medication review (every six months if taking four + medicines)	GP practices and Pharmacists	Countywide	Accessed via GP surgeries and pharmacies
Provision of an annual medicines utilisation review (MUR) and follow up support for adherence to therapy	GP practices and Pharmacists	Countywide	Accessed via GP surgeries and pharmacies
Assessment and support programme to prevent falls	County Durham and Darlington Foundation Trust Community Falls Service Age UK County Durham	Countywide	Via health and social care professionals or self-referral Lead Contact: Wendy Lyons (Community Falls Team) Tel: 0191 333 3233 Lead Contact: Helen Sams (Age UK County Durham)
Snow Clearance **DCC Highways:** In addition to maintenance programme for priority routes and mainstream bus services there are additional criteria in place to respond to specific emergency situations including:	DCC Highways Customer Services	Countrywide	DCC Customer Services 0300 123 7070 Lead Contact - David Payne DCC Highways Highways Action Line 03000 261000 Lead Contact – Brian Kitching

Key Interventions	Delivered by	Where	How Accessed
▪ Urgent medical care ▪ Funerals ▪ Difficulties accessing mainstream services Ensuring fuel supplies (oil, lpg)			
Assessment for appropriate assistive technologies e.g. alarm pendants to call for help	Care Connect	Countywide	Open access service – self referral or via professional/friend/family 03000 262 195 Care.connect@durham.gov.uk
Help to develop a personal crisis contingency plan	Personal Winter Plan leaflet http://content.durham.gov.uk/PDFRepository/Personal- Winter-Plan.pdf	Countywide	Distributed to every household via County Durham News Winter Edition Lead contact: Karen Stewart
Implementation of personal brief health intervention plan	Frontline health and social care staff via brief advice on lifestyle factors, referral to NHS choices	Countrywide	Referral to NHS Choices http://www.nhs.uk/LiveWell/Winterhealth/Pages/Winterhealthhome.aspx
	Access to food • Food Co-ops o Wellbeing for Life o Horden Community Centre and Nursery o Hasell Mencap • Food Emergency East Durham (FEED) project (food pracels distributed via a network of volunteers to those in crisis situations) • Durham Foodbank • Please note that faith and community groups will respond across areas by providing delivery of hot meals and/or luncheon groups • Foodcycle is a national charity which has recently been set up in Durham and provides free meals for those who need it	Easington Colliery Horden Haswell East Durham Countrywide Various Sanctuary, 21 Saddler Street, Durham DH1	0191 5274156 Every Thursday 11.00 a.m.–1.00 p.m. 03000 260000 Every Wednesday 9.00 a.m–2.00 p.m. 0191 5260987 Every Thursday & Friday 11.0 – 2.00 Malcolm Fallow 0191 5693511 Malcolm.fallow@eastdurhamtrust.org.uk www.eastdurhamtrust.org.uk Peter MacLellan 0191 303 7559 durhamcpmail@gmail.com www.durham.foodbank.org.uk Various Tel: 0207 3778771 Wednesday at 6.00 p.m. www.foodcycle.org.uk

Key Interventions	Delivered by	Where	How Accessed
		3NU	
	Emergency Food Shopping Service	Urgent emergency support only	Care Connect : Berni Malone 03000 262195
	Surviving Winter Campaign – grants available between October 2015 and March 2016 to pay for relief items, e.g. hot mails via luncheon club	Local Community Groups	County Durham Foundation 0191 3786340
	Silver Talk – volunteer run telephone service		0800 093 092
	Health Buddies – trained volunteer befrienders for up to six months e.g. shopping, attending social events, health appointments. Coxhoe, Trimdon, Fishburn, Sedgefield.	Pioneering Care Partnership	01325 321 234 Healthbuddy@.pcp.uk.net

Appendix 4 - Script for Customer Service Teams (Social Care Direct, First Contact/Customer Services)

Severe Weather Related Enquiries 2015/16

Throughout this period of severe weather, it is expected that SCD/Customer Services and CAS will receive a number of weather related enquiries regarding various issues.

If the caller is an existing service user, then the normal process should be followed regarding referrals.

Where the cause of the person's problem is the weather i.e. unable to leave the home or unable to get visitors because of the snow, and the caller is not an existing service user, please explore the following areas and redirect as appropriate:-

Medication
Check if the person has sufficient medication to last until the weather is expected to improve. Suggested timeframe is 48 hours.

If not, then redirect the caller to GP surgery or pharmacy who will be able to arrange a delivery. If the caller does not know details of surgery/pharmacy of during out of hours refer to Non-Emergency Urgent Care – 111 number.

If urgent note that Non-Emergency Urgent Care – 111 number and Highways Service have access to 4x4 vehicles and can respond to emergencies (access via CRM)

Any Urgent Medical Appointments
For example dialysis, chemotherapy - redirect caller to GP surgery or call 111 the non- emergency healthcare number.

Customer Relationship Management (CRM) on 03000 261000 have access to 4x4 vehicles and can respond to non-medical emergencies e.g. funerals

Heating
Check that the person is warm enough and if there are any heating related issues e.g. boiler broken, fire not working, and no fuel.

These issues should be referred to the Housing Provider in the first instance.

Details of Registered Traders scheme can be provided for urgent and non-urgent repairs 03000 261 016

An urgent referral can be made to the Warm Homes Team 03000 261079 who can react to emergencies

Food
If the person is ringing to say they have no food in the house, then please check the following:

- Determine what food if any they have in the home.

- Have they any friends/family/neighbours that can assist?
- Can they or family/friend make an order over the internet, e.g. Asda, Tesco etc.?
- Is there a nearby shop who can deliver some food?
- Can they contact a community group for help? See below
- Are they a Care Connect customer if so Tel 03000 262 195 to advise situation
- As a last resort if the person is in urgent need of emergency shopping – Tel: 03000 262195 for Care Connect Emergency Shopping Service

Food banks

Food banks can support families or individuals with the provision of emergency food for those people in a crisis situation

- Durham Food bank: 0191 303 7559
- FEED project – East Durham 0191 569 3511
- Food4U – Consett: 07923420719 between 10am – 12pm or emergency number 07926810732

CVS contact details for local community groups

- Durham Community Action (DCA) 01388 742040
- East Durham Trust 0191 569 3511

Link2 Dial a Ride Service is available if people need to get to shops for food

Minibus will pick people up at the door and travel to a shopping area within five miles of your home

Eligibility:

- Have a disability
- Personal mobility problems
- No bus services within one hour of when you want to travel or requires a change of bus

To book ring – 03000 269999

In any of the above circumstances, if the person would normally be independent and able to get out of the house alone to resolve the above issues, then please ring CRM on 03000 261000 and inform then that there is a vulnerable person unable to get out of the home and there is an urgent need. Gritting and clearing of snow will be prioritised in emergency situations.

Before taking a referral and requesting an assessment, please check that the person actually wants an assessment and make every effort to determine the urgency of the situation.

Guidance checklist for Customer Services (CAS/SCD for information)

Response	Required Action
The householder confirms that all is fine	None
The householder/caller advises there is a problem with attending urgent medical appointments due to snow (for example dialysis, maternity unit, chemotherapy)	Contact Neighbourhood Services to provide urgent gritting for access to emergency appointments If timescales not suitable for urgent gritting redirect caller to GP surgery for assistance or call 111 the non-emergency healthcare number
The householder advises they are struggling with staying warm	Check that the person is warm enough and if there are any heating related issues e.g. boiler broken, fire not working, no fuel. These issues can be referred to Housing Provider, or Warm Homes Team 03000 261079 Details of Registered Traders scheme can be provided for non-urgent repairs
The person advises they have difficulty with reducing medication supplies	Check if the person has sufficient medication to last until the weather is expected to improve. Suggested timeframe of 48hours. If not, then redirect the caller to GP surgery or pharmacy who will be able to arrange a delivery. Advise to contact their pharmacy/surgery or non-emergency Urgent Care 111 number immediately if situation more urgent Advise Neighbourhood Services to arrange for gritting and include route if possible Advise Neighbourhood Services if area can be covered by volunteer scheme

The person advises they have no food or drink as the result of being unable to get out of the house	If the person is ringing to say they have no food in the house, then please check the following: o Determine what food if any they have in the home. o Have they any friends/family/neighbours that can assist? o Can they or family/friend make an order over the internet, e.g. Asda, Tesco etc.? o Is there a nearby shop who can deliver some food? o Can they contact a community group for help? local CVS may be able to advise on this: • Durham Community Action (DCA) 01388 742010 • East Durham Trust 0191 5693511 Are they a Care Connect customer if so Tel 03000 262 195 to advise situation
The person advises they are running out of food due to frailty/lack of mobility	Food banks can support families or individuals with the provision of emergency food for those people in a crisis situation o Durham Food bank: 0191 303 7559 o FEED project – East Durham: 0191 569 3511 Food4U – Consett: 07923420719 between 10am – 12pm or emergency number 07926810732
Concerns raised about person's overall wellbeing and care	Refer to Social Care Direct Urgent Care – 111 service Consider a referral to Care Connect Service

Appendix 5 - Severe Weather Planning Group Membership

Name	Job Title
Nick Springham (Chair)	Consultant in Public Health
James Anderson	Contact Centre Co-Ordinator
Linda Bailes	Team Leader, Governance/Policy & Procedure
Peter Bodo	Civil Contingencies Officer
Susan Carr	Housing Regeneration Officer
Andy Coulthard	Area Action Partnership Co-Ordinator
Cliff Duff	Senior Housing Develop & Delivery Officer
Denise Elliott	Strategic Commissioning Manager Older People/Physical Disability Sensory Impairment
Julie Harvey	Telecare Care Connect Control/CCTV Manager
Paul Jenkins	Public Health and Housing Team Leader
Su Jordan	CCU Programme Office Manager
Vicky Kirtley	Contact Centre Co-Ordinator
Brian Kitching	Policy & Asset Manager
Neil Laws	Public Health & Housing Manager
Carole Lee	Team Manager - Social Care Direct
Stephen McDonald	Senior Sustainability & Climate Change Officer
Jackie Mckimm	Team Coach, Neighbourhood
Neil Pace	Home Improvement Agency Senior Team Leader
Stephen Ragg	Durham Association of Partnership and Town Councils Executive Officer
Maureen Snowball	Telecare Care Connect Response Manager
Karen Stewart	Marketing Officer (Public Health)
Tim Wright	Public Health Portfolio Lead
Bernie Malone	Care Connect CCTV Business Development Manager
Linda Ogilvie	Care Connect and CCTV Manager, Regeneration & Economic Development
Melanie Close	Telecare Locality Co-Ordinator
Michael Duffy	Commissioning Policy & Planning Officer

Penny Rouse	Personal Assistant
Victoria Murray	Customer Relations Team Manager

Appendix 6 - Responsibilities for Children and Adult Services

During Office Hours:

Cold weather alerts will only be escalated within CAS at Level 3 or above, when received either from the Civil Contingencies Duty Officer or directly from the Met Office. Automated Met Office alerts are set up to be sent directly to the CAS emergency planning email address, to ensure that the cold weather alerts will always be escalated when required. The emergency planning email address is accessible to several members of the Service Support team and is monitored regularly throughout the day to ensure that messages are picked up during working hours.

On receipt of a level 3 or level 4 alerts from the met office the CCU Duty Officer will cascade the information to

emergencyplanningrotas@durham.gov.uk
Nick.springham@durham.gov.uk
anna.lynch@durham.gov.uk
adam.farrell@durham.gov.uk
tim.wright@durham.gov.uk
Christine.edgar@durham.gov.uk
Lynn.hall@durham.gov.uk
Linda.ogilvie@durham.gov.uk
Julie.harvey@durham.gov.uk
Mary.readman@durham.gov.uk

Cold weather alerts at level 3 or above will then be escalated during office hours by the Public Health Team using a standard email (see paragraph 5 below) to emergency planning rota, Social Care Services, Strategic Commissioning Managers and Education listed below;

Emergency Planning Rota
emergencyplanningrotas@durham.gov.uk

Commissioning Services Team – Providers:
Louise.Lyons@durham.gov.uk
CAS.commissioning@durham.gov.uk
Denise.Elliott@durham.gov.uk
David.Shipman@durham.gov.uk

County Durham Care & Support Management Team
Gillian.rochford@durham.gov.uk
Karen.Vasey@durham.gov.uk
Les.Shaw@durham.gov.uk
Debbie.Richardson@durham.gov.uk
Theresa.Thomas@durham.gov.uk

Education Management Team
Sheila.palmerley@durham.gov.uk
Caroline.O'Neill@durham.gov.uk

On receipt of these escalation emails, Social Care Service Managers and Strategic Commissioning Managers should ensure they keep themselves informed of the current situation with the weather and use this information as a basis for advice and decision making when considering whether additional services need to be commissioned for vulnerable people in the community.

The Strategic Commissioning Service Managers will use their lists of in-house and independent sector providers to cascade cold weather guidance. Service providers are required to take care to keep themselves informed of the current situation with the weather and should use the “Cold -Health Watch” system for guidance. Strategic Commissioning and Social Care Managers should ensure that service managers, as appropriate, are provided with cold weather guidance, reference materials and alerts to ensure they are fully informed of their responsibilities, and should also liaise with partnership agencies such as the NHS to ensure that a coordinated social care, and health care response to a cold weather occurrence is given.

Social Care Managers will update the Emergency Duty Team (EDT) of any arrangements in response to the cold weather prior to the EDT coming on duty. The Emergency Duty Team will keep the on call EDT Duty Manager informed of the situation.

It may also be necessary for Public Health colleagues in consultation with Strategic Commissioning Managers to issue press releases to the public to make them aware of the health and social care services available to them should they require them as a result of a cold weather alert.

Strategic Commissioning Managers should keep records of any decisions taken on whether to commission additional services in response to a cold weather along with delegation details and financial records. Financial implications of a cold weather occurrence are as yet unknown. However, any costs for additional services commissioned will have to be absorbed within the current service budget allocations.

Out of Hours: Inclusive of Weekends & Bank Holidays

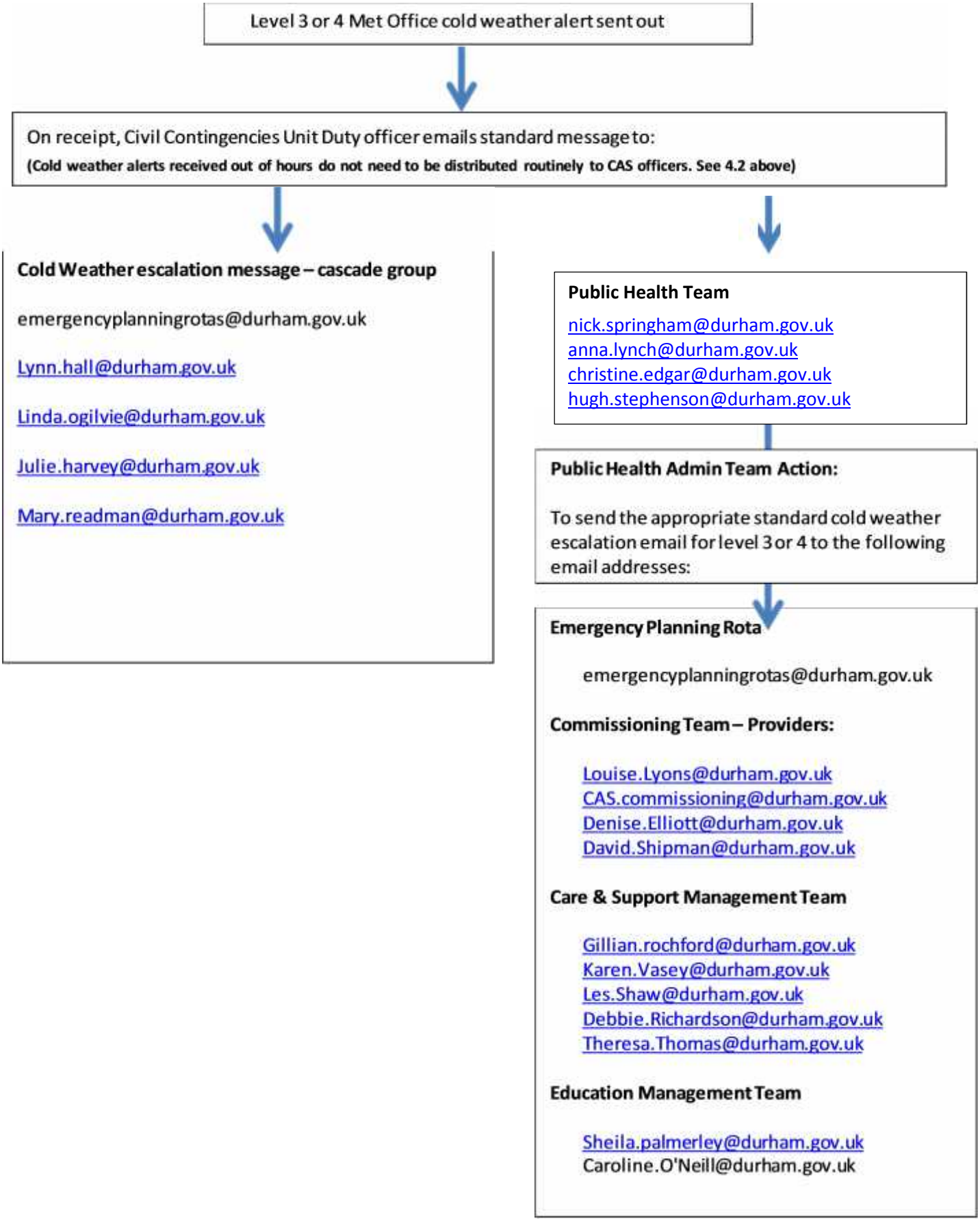
Cold Weather alerts received out of hours do not need to be distributed routinely to CAS officers.

The CCU Duty Officer does NOT need to alert the on call CAS Emergency Coordinator of any escalation to level 3 or above and regional probability of cold weather out of hours UNLESS the situation develops into an emergency incident.

If it is likely that the situation will develop into an emergency incident the CCU Duty Officer will advise the CAS Emergency Coordinator to inform the Emergency Duty Team of the situation over the weekend/Bank Holiday to prepare them for possible increases in service requests.

In the event of a major incident being declared, all existing emergency policies and procedures will apply.

Cold Weather Alert Flowchart / Activation



CAS Standard Escalation Emails

Email title: Cold Weather Alert Level3 – Cold Weather Action

Dear Colleagues

We have received a cold weather alert which has changed the National Alert Level to 3. As this is a national alert scheme it may be that it is not appropriate to this area – this message is sent out automatically and those who are required to act upon it should exercise their judgement according to the situation. Please refer to the attached alert for details of the regional probability of cold weather in the North East. Please be vigilant in monitoring the situation through media coverage and guidance.

Please read The Cold Weather Plan.pdf and attached guidance for full details of the responsibilities of the Local Authority and Social Care Services.

Local social services may wish to:

- Continue to distribute advice to people at risk and managers and staff of care homes;
- Ensure that health and social care staff are aware of risk and protective factors and consider, there appropriate, daily visits/phone calls for high-risk individuals living on their own who have no regular daily contacts;
- Advise social care or informal carers (families and friends), to contact the GP if there are concerns about an individual's health
- Ensure that Department of Health advice reaches private and local authority funded residential and nursing care home managers as soon as cold weather starts.

Hospital and care, residential and nursing homes must:

- Continue to communicate public health media messages
- Communicate alerts to staff and make sure that locally agreed actions take place, especially those to protect vulnerable service users
- Implement local plans for contacting the vulnerable. Consider daily visits/phone calls for high risk individuals living on their own who have no regular contacts
- Ensure carers are receiving appropriate advice and support
- Implement plans to deal with surge in demand
- Ensure key partners, including managers of care, residential and nursing homes are aware of the alerts and can access the Department of Health and other advice
- Ensure that organisations and staff are prompted to signpost vulnerable clients onwards (e.g. for energy efficiency measures, benefits or related advice)
- Support local community organisations to active community emergency plans
- Active business continuity arrangements and emergency plans as required
- Consider how to make best use of available capacity, for example by using community beds for at risk patients who do not need an acute bend and enabling access to step down care and reablement
- Work with partner agencies (e.g. transport) to ensure road/pavement gritting preparations are in place to allow access to critical services and pedestrian hotspots

If you have any questions regarding this alert please do not hesitate to contact the Public Health Team for advice.

Email Title: Cold Weather Alert Level 4 – Emergency

Dear Colleagues

We have received a cold weather alert which has changed the National Alert Level 3 to 4. As this is a national alert scheme it may be that it is not appropriate to this area – the message is sent out automatically and those who are required to act upon it should exercise their judgement according to the situation. Please see the attached alert for details of the regional probability of cold weather in the North East. Please be vigilant in monitoring the situation through media coverage and guidance.

A National Alert Level 4 is declared in the event of severe or prolonged cold weather affecting sectors outside health and social care, such as power or water shortages, and/or whether the integrity of health and social care systems are threatened. At this level, illness and death may occur among the fit and healthy, and not just in high-risk groups and will require a multi sector response at national and regional levels.

Please read The Cold Weather Plan.pdf and attached guidance for full details of the responsibilities of the Local Authority and Social Care Services.

For information, specific actions include:

- Continue action as per level 3 unless advised to the contrary
- Implementation of national emergency response arrangements by central government

In the event of a major incident being declared, all existing emergency policies and procedures will apply.

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Health and Wellbeing Board

21 January 2016

County Durham Health Profile 2015

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

Purpose of the Report

1. The purpose of this report is to provide the Health and Wellbeing Board with a summary of the County Durham Health Profile 2015 and compare indicators against the previous profile (2014). The indicators used in the profile do not necessarily represent the most recently available performance data, as it is not performance management tool. It presents a snapshot in time, and all indicator time periods are dated. This report does not look at specific actions (current or planned) to address any of the issues highlighted within the profiles. These details are included in the relevant routine updates that are presented to the Health and Wellbeing Board.

Background

2. Health profiles provide a snapshot of health and wellbeing in County Durham. Produced annually using key indicators, these profiles enable comparison locally, regionally and nationally. When published they are incorporated into the Joint Strategic Needs Assessment for County Durham. They are designed to help local commissioners and providers across the health and social care system understand the health needs of their population, in order to work collaboratively in partnership to improve health and reduce health inequalities. By using the profiles local organisations can work in partnership to plan and commission evidence-based services based on local need.

Health Profile summary

3. The health and well-being outcomes of an area are greatly shaped by a wide variety of social, economic and environmental factors (such as poverty, housing, ethnicity, place of residence, education and environment). It is clear that improvements in health outcomes cannot be made without action in these wider determinants. Health inequalities are disparities between population groups that are systematically associated with these socio-economic and environmental factors. Such variations in health are avoidable and unjust.

4. There is a clear social gradient to many health outcomes. The more deprived an area is, the poorer health outcomes that would be expected. Overall the health and wellbeing people living in County Durham is generally worse than the England average, as are the levels of deprivation. County Durham is the 62nd most deprived local authority in England (out of 326) and as such would be expected to have lower than average health outcomes (ID2010).

5. Of the 32 indicators included in the 2015 summary spine chart:

- 5 are significantly better than the England average.
- 7 are not significantly different to the England average.
- 18 are significantly worse than the England average.
- Significance was not tested for breastfeeding initiation or suicide. The values for both these indicators are worse than the England average and have deteriorated since the previous reported period.

Significantly better than England	Not significantly different than England	Significantly worse than England
Statutory homelessness	GCSE achieved (5A*-C inc maths and english)	Deprivation
Violent crime	% of physically active adults	Children in poverty
Drug misuse	Obese adults	Long term unemployment
Acute sexually transmitted infections	Incidence of malignant melanoma	Smoking at time of delivery
Incidence of TB	Excess winter deaths (3 year pooled)	Obese children (year 6)
	Infant mortality	Alcohol-specific stays (under 18)
	Killed and seriously injured on roads	Teenage conceptions (<18)
		Smoking prevalence
		Excess weight in adults
		Hospital stays for self-harm
		Hospital stays for alcohol related harm
		Recorded diabetes
		Hip fractures in 65s and over
		Life expectancy - male
		Life expectancy - female
		Smoking related deaths
		<75 mortality rate: CVD
		<75 mortality rate: Cancer

6. Overall, since the previous profile was published:

- 10 indicators have improved.
- 6 have experienced no real change.
- 16 have deteriorated.

7. Of the 18 indicators that are significantly worse than the England average:

- 6 have improved since the previous profile.
- 5 have not changed since the previous profile.
- 7 have deteriorated since the previous profile.

Significantly worse outcomes than England, improved from the previous profile	Significantly worse outcomes than England, no change from the previous profile	Significantly worse outcomes than England, worse than previous profile
Children in poverty	Deprivation	Obese children (year 6)
Long term unemployment	Smoking at time of delivery	Smoking prevalence
<75 mortality rate: CVD	Teenage conceptions (<18)	Hospital stays for self-harm
Alcohol-specific stays (under 18)	Excess weight in adults	Hip fractures in 65s and over
Hospital stays for alcohol related harm	Recorded diabetes	Life expectancy - female
Life expectancy - male		Smoking related deaths
		<75 mortality rate: Cancer

8. Of the 12 indicators that are not significantly worse than the England average:

- 4 have improved since the previous profile.
- 1 had not changed since the previous profile.
- 7 have deteriorated since the previous profile1.

Not significantly worse outcomes than England, improved from the previous profile	Not significantly worse outcomes than England, no change from the previous profile	Not significantly worse outcomes than England, worse than previous profile
Drug misuse	Obese adults	Statutory homelessness
Incidence of TB		GCSE achieved (5A*-C inc maths and english)
Acute sexually transmitted infections		Violent crime
Infant deaths		Incidence of malignant melanoma
		% of physically active adults
		Excess winter deaths
		Killed & seriously injured on roads
		Breast feeding initiation[1]
		Suicide rate[1]

Key findings from the profile

9. Health in summary

- The health of people in County Durham is varied compared to the England average.
- Deprivation is higher than the national average and about 22.7% (20,100) children live in poverty.
- Life expectancy for men and women is lower than the England average.

10. Living longer

- Life expectancy is 7.0 years lower for men and 7.5 years lower for women in the most deprived areas of County Durham.

[1] Rates of breastfeeding initiation and suicide are worse than the England average, and have increased since the previous profile but the level of significance was not tested.

11. **Child health**

- In Year 6, 21.3% of children (1,038) are classified as obese, worse than the England average.
- The rate of alcohol-related hospital stays among under 18s was 69.9 per 100,000 population, worse than the England average. This represents70 stays per year.
- Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average.

12. **Adult health**

- In 2012, 27.4% of adults were classified as obese.
- The rate of alcohol-related harm hospital stays was 788 per 100,000, worse than the England average. This represents4,053 stays per year.
- The rate of self-harm hospital stays was 287.7 per 100,000, worse than the England average. This represents 1,471 stays per year.
- The rate of smoking related deaths was 381 per 100,000, worse than the England average. This represents 1,117 deaths per year.
- Estimated levels of adult excess weight , smoking and physical activity are worse than the England average.
- The rate of hip fractures is worse than the England average.
- Rates of sexually transmitted infections and TB are better than the England average.

13. **Local priorities**

- Priorities in County Durham include tackling health inequalities, improving mental health and wellbeing, and children's health.

14. The attached table summarises the 2015 County Durham Health Profile, benchmarks against the England average using a dark blue/amber/light blue scheme to show whether the local measure is significantly different to the England average as shown below. Progress over time (against the previous profile in this instance) is shown via a white or black box.

County Durham Health Profile 2015 summary

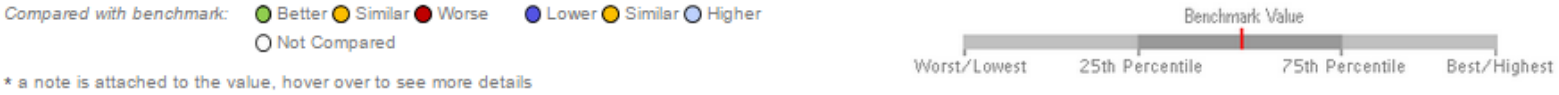
No.	Indicator	Rate or %	2015 Health Profile				2014 Health Profile			
			2015 HP		Sig* worse than England?	Period & Source	2014 HP		Sig* worse than England?	Period & Source
			Measure	No.			Measure	No.		
1	Deprivation	%	28.7	148268	Yes	2012	28.8	148312	Yes	ID2010
2	Children in poverty	%	22.7	20075	Yes	2012	23	20405	Yes	2011
3	Statutory homelessness	CR/1000	0.9	198	No	2013/14	0.1	24	No	2012/13
4	GCSE achieved (5A*-C inc maths and english)	%	57.6	3027	No	2013/14	63.1	3450	No	2012/13
5	Violent crime	CR/1000	8.2	4204	No	2013/14	6.8	3504	No	2012/13
6	Long term unemploment	CR/1000	10.1	3327	Yes	2014	14.7	4825	Yes	2013
7	Smoking at time of delivery	%	19.9	1049	Yes	2013/14	19.9	1045	Yes	2012/13
8	Breast feeding initiation	%	57.4	3006	No	2013/14	58.9	3098	Yes	2012/13
9	Obese children (year 6)	%	21.3	1038	Yes	2013/14	21	986	Yes	2012/13
10	Alcohol-specific stays (under 18)	CR/1000	69.9	70	Yes	2011/12-2013/14	81.5	82	Yes	20010/11-2012/13
11	Teenage conceptions (<18)	CR/1000	33.8	293	Yes	2013	33.7	291	Yes	2012
12	Smoking prevalence	%	22.7	n/a	Yes	2013	22.2	n/a	Yes	2012
13	Physically active adults	% 16+	51.4	248	No	2013	52.2	n/a	No	2012 (APS)
14	Obese adults	% 16+	27.4	n/a	No	2012 (APS)	27.4	n/a	No	2012 (APS)
15	Excess weight in adults		72.5	970	Yes	2012 (APS)	72.5	970	Yes	2012 (APS)
16	Incidence of malignant melanoma	DASR/100,000	17.3	80	No	2010-12	15.3	82	No	2009-2011
17	Hospital stays for self harm	DASR/100,000	287.7	1471	Yes	2013/14	269.5	1374	Yes	2012/13
18	Hospital stays for alcohol related harm	DASR/100,000	788	4053	Yes	2013/14	794	4069	Yes	2012/13
19	Drug misuse	DASR/100,000	6.4	2155	No	2011/102	7	2376	No	2010/11
20	Recorded diabetes	%	6.9	30506	Yes	2013/14	6.8	29680	Yes	2012/13
21	Incidence of TB	CR/1000	1.9	10	No	2011-2013	2.1	4	No	2010-2012
22	Acute sexually transmitted infections	CR/100,000	611	2050	No	2013	645	3309	No	2012
23	Hip fractures in 65s and over	DASR/100,000	674	662	Yes	2013/14	636	617	Yes	2012/13
24	Excess winter deaths	Ratio	19	314	No	01.08.10-31.07.13	16.8	273	No	01.08.09-31.07.12
25	Life expectancy - male	Years	78	n/a	Yes	2011-2013	77.9	n/a	Yes	2010-2012
26	Life expectancy - female	Years	81.3	n/a	Yes	2011-2013	81.5	n/a	Yes	2010-2012
27	Infant deaths	DASR/100,000	3.2	18	No	2011-2013	3.9	23	No	2010-2012
28	Smoking related deaths	DASR/100,000	381.3	1117	Yes	2011-2013	372	1075	Yes	2010-2012
29	Suicide rate	DASR/100,000	13.4	68	No	2011-2013	11.3	57	N/A	2010-2012
30	<75 mortality rate: CVD	DASR/100,000	88.8	413	Yes	2011-2013	91.3	420	Yes	2010-2012
31	<75 mortality rate: Cancer	DASR/100,000	166.6	782	Yes	2011-2013	164	762	Yes	2010-2012
32	Killed & seriously injured on roads	DASR/100,000	38.5	198	No	2011-2013	37.5	192	No	2010-2012

	Indicator has improved from previous profile
	Indicator has not changed from previous profile
	Indicator has deteriorated from previous profile

Yes	Indicator value is significantly worse than England
No	Indicator value is not significantly worse than England

County Durham Health Profile 2015 spine chart

15. The chart below shows how health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below and the indicator definitions are attached as appendix 2.



* a note is attached to the value, hover over to see more details

Indicator	Period	Co Durham		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Deprivation	2013	148,268	28.7%	32.5%	20.4%	83.8%		0.0%
Children in poverty (under 16s)	2012	20,075	22.7%	23.6%	19.2%	37.9%		5.8%
Statutory homelessness	2013/14	198	0.9	1.3	2.3	12.5		0.0
GCSE achieved (5A*-C inc. Eng & Maths)	2013/14	3,027	57.6%	54.6%	56.8%	35.4%		79.9%
Violent crime (violence offences)	2013/14	4,204	8.2	8.3	11.1	27.8		2.8
Long term unemployment	2014	3,327	10.1	12.5	7.1	23.5		0.9
Smoking status at time of delivery	2013/14	1,049	19.9%	18.8%	12.0%	27.5%		1.9%
Breastfeeding initiation	2013/14	3,006	57.4%	60.3%	73.9%	-	-	-
Obese children (Year 6)	2013/14	1,038	21.3%	21.1%	19.1%	27.1%		9.4%
Alcohol-specific hospital stays (under 18)	2011/12 - 13/14	210	69.9	65.8	40.1	105.8		11.2
Under 18 conceptions	2013	293	33.8	30.6	24.3	44.0		7.6
Smoking prevalence	2013	-	22.7%	22.3%	18.4%	30.0%		9.0%
Percentage of physically active adults	2014	247	55.5%	53.6%	57.0%	44.9%		76.8%
Obese adults	2012	-	27.4%	25.9%	23.0%	35.2%		11.2%
Excess weight in adults	2012	970	72.5%	68.0%	63.8%	75.9%		45.9%
Incidence of malignant melanoma	2010 - 12	240	17.3	17.0	18.4	38.0		4.8
Hospital stays for self-harm	2013/14	1,471	287.7	268.2	203.2	682.7		60.9
Hospital stays for alcohol related harm	2013/14	4,053	788	844	645	1,231		366
Prevalence of opiate and/or crack use	2011/12	2,155	6.4	9.9	8.4	25.0		1.4
Recorded diabetes	2013/14	30,506	6.9%	6.5%	6.2%	9.0%		3.4%
Incidence of TB	2011 - 13	30	1.9	5.3	14.8	113.7		0.0
New STI (exc Chlamydia aged under 25)	2014	1,914	572	669	829	3,190		230
Hip fractures in people aged 65 and over	2013/14	662	674	651	580	838		354
Excess winter deaths (three year)	Aug 2010 - Jul 2013	944	19.0	16.0	17.4	34.3		3.9
Life expectancy at birth (Male)	2011 - 13	-	78.0	78.0	79.4	74.3		83.0
Life expectancy at birth (Female)	2011 - 13	-	81.3	81.7	83.1	80.0		86.4
Infant mortality	2011 - 13	54	3.2	3.3	4.0	7.6		1.1
Smoking related deaths	2011 - 13	3,351	381.3	371.9	288.7	471.6		167.4
Suicide rate	2011 - 13	204	13.4	10.6	8.8	-	-	-
Under 75 mortality rate: cardiovascular	2011 - 13	1,239	88.8	88.9	78.2	137.0		37.1
Under 75 mortality rate: cancer	2011 - 13	2,347	166.6	169.5	144.4	202.9		104.0
Killed and seriously injured on roads	2011 - 13	594	38.5	33.0	39.7	119.6		7.8

Recommendations

16. The Health and Wellbeing Board is recommended to:

- Note the report for information.
- Note that the findings are utilised and inform the planning of services provided for people living in County Durham by DCC and partners and also those services that are commissioned.
- Note that the poor outcomes identified in the profile are being addressed by the relevant strategies and plans developed by partners including the Joint Health & Wellbeing strategy, mental health strategies, tobacco control plan, health weight framework etc.

Contact: Michael Fleming, Public Health Epidemiologist
Tel: 03000 267664

Appendix 1: Implications

Finance:
None

Staffing:
None

Risk:
None

Equality and Diversity / Public Sector Equality Duty:
Health status is heavily impacted by deprivation, low income, educational attainment, employment etc.

Accommodation:
None

Crime and Disorder:
None

Human Rights:
None

Consultation:
The detail in this report will be captured in the JSNA.

Procurement:
None

Disability Issues:
None

Legal Implications:
None

Indicator notes

1. % people in this area living in 20% most deprived areas in England, 2013.
2. % children (under 16) in families receiving means-tested benefits & low income, 2012 .
3. Crude rate per 1,000 households, 2013/14.
4 % key stage 4. 2013/14
5. Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14
6. Crude rate per 1,000 population aged 16-64, 2014
7. % of women who smoke at time of delivery, 2013/14
8. % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14
9. % school children in Year 6 (age 10-11), 2013/14
10. Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled)
11. Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013
12. % adults aged 18 and over who smoke, 2013
13. % adults achieving at least 150 mins physical activity per week, 2013
14. % adults classified as obese, Active People Survey 2012
15. % adults classified as overweight or obese, Active People Survey 2012
16. Directly age standardised rate per 100,000 population, aged under 75, 2010-12
17. Directly age sex standardised rate per 100,000 population, 2013/14
18. The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14
19. Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12
20. % people on GP registers with a recorded diagnosis of diabetes 2013/14
21. Crude rate per 100,000 population, 2011-13, local number per year figure is the count
22. All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013
23. Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14
24. Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13
25. Male life expectancy, at birth, 2011-13
26. Female life expectancy, at birth, 2011-13
27. Rate per 1,000 live births, 2011-13
28. Directly age standardised rate per 100,000 population aged 35 and over, 2011-13
29. Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13
30. Directly age standardised rate per 100,000 population aged under 75, 2011-13
31. Directly age standardised rate per 100,000 population aged under 75, 2011-13
32. Rate per 100,000 population, 2011-13

Health and Wellbeing Board

21 January 2016

County Durham Child Health Profile 2015

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

Purpose of the Report

1. The purpose of this report is to provide the Health and Wellbeing Board with a summary of the County Durham Child Health Profile 2015 and compare indicators against the previous profile (2014). The indicators used in the profile do not necessarily represent the most recent performance data, as it is not a performance management tool. It presents a snapshot in time, and all indicator time periods are dated. This report does not look at specific actions (current or planned) to address any of the issues highlighted within the profiles. These details are included in the relevant routine updates that are presented to the Health & Wellbeing Board and Children & Families Partnership.

Background

2. Child Health Profiles provide a snapshot of child health and wellbeing in County Durham. Produced annually using key indicators, these profiles enable comparison locally, regionally and nationally. When published they are incorporated into the Joint Strategic Needs Assessment for County Durham. They are designed to help local commissioners and providers across the health and social care system understand the health needs of their population, in order to work collaboratively in partnership to improve health and reduce health inequalities. By using the profiles local organisations can work in partnership to plan and commission evidence-based services based on local need.

3. Each profile is available as a 4-page PDF report available at http://www.chimat.org.uk/resource/view.aspx?RID=242297

4. Further relevant information relating to County Durham is available using the Public Health England (PHE) Children and Young Peoples Benchmarking tool at http://fingertips.phe.org.uk/profile/cyphof/data#page/1/gid/8000025/pat/6/par/E12000001/ati/102/are/E06000047

Child Health Profile summary

5. The health and well-being outcomes of an area are greatly shaped by a wide variety of social, economic and environmental factors (such as poverty, housing, ethnicity, place of residence, education and environment). It is clear that improvements in health outcomes cannot be made without action in these wider determinants. Health inequalities are disparities between population groups that are systematically

associated with these socio-economic and environmental factors. Such variations in health are avoidable and unjust.

6. There is a clear social gradient to many health outcomes. The more deprived an area is, the poorer health outcomes that would be expected.

7. Overall the health and wellbeing of children in County Durham is generally worse than the England average, as are the levels of child poverty.
County Durham is the 62nd most deprived local authority in England (out of 326) and as such would be expected to have lower than average health outcomes (ID2010).

8. Of the 32 indicators included in the 2015 summary spine chart:

- 5 are significantly better than the England average.
- 15 are significantly worse than the England average.
- 9 show no significant difference to the England average (a further 2 weren't tested for significance and 1 had no data supplied).
- Overall, 14 indicators have improved since the previous profile, 14 deteriorated, 3 experienced no change, 1 was a new indicator and 1had no data supplied.

Significantly better than England	Significantly worse than England
MMR immunisation (one dose, 2 years)	Children with a good level of development (end of reception)
Dtap/IPV/hib vaccination (2 years)	Not in education, employment or training (16-18)
Children in care immunisations	Children living in poverty (under 16 years)
Family homelessness	Children killed or seriously injured in road traffic accidents
A&E attendances (age 0-4 years)	Obese children (4-5)
	Obese children (10-11)
	Teenage conception rates (<18)
	Teenage mothers (<18)
	Hospital admissions due to alcohol specific conditions
	Hospital admissions due to substance misuse (15-24)
	Smoking at time of delivery
	Breastfeeding initiation
	Hospital admissions due to injury in children (0-14)
	Hospital admissions due to injury in young people (15-24)
	Hospital admissions as a result of self-harm

NB. Breastfeeding initiation is lower in County Durham than the England average, has increased since the previous profile. The level of significance was not tested.

9. Of those 15 indicators significantly worse than the England average:

- 6 have improved since the previous reporting period
- 9 have not improved since the previous reporting period (including 2 that showed no change).

Significantly higher than England, not improved from previous period	Significantly higher than England, but improved from previous period
Breastfeeding initiation	Children with a good level of development (end of reception)
Children killed or seriously injured in road traffic accidents	Children living in poverty (< 16)
Obese children (age 4-5)	Not in education, employment or training (16-18)
Obese children (age 10-11)	Teenage conception rates (<18)
Teenage mothers (age <18)	Hospital admissions due to alcohol specific conditions
Smoking at time of delivery	Hospital admissions due to substance misuse (15-24)
Hospital admissions due to injury in children (0-14)	
Hospital admissions due to injury in young people (15-24)	
Hospital admissions as a result of self-harm	

10. Key findings from the profile

- The health and wellbeing of children in County Durham is generally worse than the England average.
- Infant and child mortality rates are similar to the national average.
- The level of child poverty is worse than the England average, with 22.7% of children under 16 years living in poverty.
- Children in County Durham have worse than average levels of obesity: 10.7% of children aged 4-5 years and 21.4% of children aged 10-11 years are classified as obese.
- Measles, Mumps and Rubella (MMR) immunisation rates are better than the England average. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is better than the England average.
- County Durham has a similar rate of children in care to England. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

11. The attached table in Appendix 2 summarises the 2015 County Durham Child Health Profile, benchmarks against the England average using a dark blue/amber/light blue scheme to show whether the local measure is significantly different to the England average as shown below. Progress over time (against the previous profile in this

instance, some longer term trends are available on request) is shown via a white or black box.

12. The full child health profile is attached for information as Appendix 3.

Recommendations

13. The Health & Wellbeing Board is recommended to:

- Note the report for information.
- Note the health profile is used in the planning of services provided for children and young people living in County Durham by Durham County Council and partners and also those services that are commissioned.
- Note that the poor outcomes identified in the profile are being addressed by the relevant strategies and plans including the Children & Young People's Plan, the Joint Health & Wellbeing Strategy, Children and Young People Mental Health and Emotional Wellbeing Resilience Plan, Alcohol Harm Reduction Strategy, Healthy Weight Framework etc.

Contact:	**Michael Fleming, Public Health Epidemiologist**
Tel:	**03000 267664**

Appendix 1: Implications

Finance:
None

Staffing:
None

Risk:
None

Equality and Diversity / Public Sector Equality Duty:
None

Accommodation:
None

Crime and Disorder:
None

Human Rights:
None

Consultation:
None

Procurement:
None

Disability Issues:
None

Legal Implications:
None

Appendix 2: County Durham Child Health Profile 2015 summary

		Indicator	Measure	Polarity - what's best?	2015 Profile				
					Period	No. per year	Value	England ave.	Improvement from previous period?
Preventable mortality	1	Infant mortality rate (less than 1 year)	Rate/1,000 live births	Lower	2011-13	19	**3.3**	4.1	**Yes**
	2	Child mortality rate (age 1-17 years)	DASR/100,000*	Lower	2011-13	10	**10.4**	11.9	**No**
Health protection	3	MMR immunisation (one dose, by age 2)	%	Higher	2013/14	5,746	**97.2**	92.7	**Yes**
	4	Dtap/IPV/ hib vaccinations (by age 2)	%	Higher	2013/14	5,835	**98.7**	96.1	**Yes**
	5	Children in care immunisations	%	Higher	2014	410	**100**	87.1	**No change**
	6	New sexually transmitted infections (inc chlamydia)	Rate/1,000	Lower	2013	2,177	**3,193.5**	3,432.7	**New indicator**
Wider determinants of health	7	Children achieving a good level of development at the end of reception	%	Higher	2013/14	3,090	**56.7**	60.4	**Yes**
	8	GCSE achievement (5A*-C inc maths & english)	%	Higher	2013/14	3,028	**57.6**	56.8	**No**
	9	GCSE achievement (5A*-C inc maths & english) for children in care	%	Higher	2014	-	**-**	12	**No data**
	10	Not in education, employment or training (age 16-18)	%	Lower	2013	1,250	**7.1**	5.3	**Yes**
	11	First time entrants to the youth justice system	Rate/100,000	Lower	2013	211	**473.5**	440.9	**Yes**
	12	Children living in poverty (age < 16 years)	%	Lower	2012	20,075	**22.7**	19.2	**Yes**
	13	Family homelessness	Rate/1,000	Lower	2013/14	121	**0.5**	1.7	**Yes**
	14	Children in care	Rate/10,000	Lower	2014	605	**60**	60	**Yes**
	15	Children killed or seriously injured in road traffic accidents	Crude rate/100,000	Lower	2011-13	22	**25.3**	19.1	**No**
Health improvement	16	Low birthweight	% <2,500 grams	Lower	2013	396	**7.3**	7.4	**No**
	17	Obese children (age 4-5 years)	%	Lower	2013/14	583	**10.7**	9.5	**No**
	18	Obese children (age 10-11 years)	%	Lower	2013/14	1,058	**21.4**	19.1	**No**
	19	Children with one or more decayed, missing or filled teeth	%	Lower	2011/12	-	**27.2**	27.9	**No**
	20	Teenage conception rates (age <18 years)	Rate/1,000	Lower	2013	293	**33.8**	24.3	**Yes**
	21	Teenage mothers (age <18 years)	%	Lower	2013/14	113	**2**	1.1	**No change**
	22	Hospital admissions due to alcohol specific conditions	Crude rate/100,000	Lower	2011/12-13/14	70	**69.9**	40.1	**Yes**
	23	Hospital admissions due to substance misuse (age 15-24 years)	DASR/100,000*	Lower	2011/12-13/14	65	**94.7**	81.3	**Yes**
	24	Smoking at time of delivery	%	Lower	2013/14	1,049	**19.9**	12	**No change**
	25	Breastfeeding initiation	%	Higher	2013/14	3,006	**57.4**	73.9	**No**
Prevention of ill-health	26	Breastfeeding prevalence at 6-8 weeks	%	Lower	2013/14	1,546	**28.5**	-	**No**
	27	A&E attendances (age 0-4 years)	Crude rate/100,000	Lower	2013/14	10,605	**368.1**	525.6	**Yes**
	28	Hospital admissions due to injury in children (0-14 years)	Crude rate/100,000	Lower	2013/14	1,389	**168.4**	112.2	**No**
	29	Hospital admissions due to injury in young people (15-24 years)	Crude rate/100,000	Lower	2013/14	1,387	**201.7**	137.7	**No**
	30	Hospital admissions for asthma (age <19 years)	Crude rate/100,000	Lower	2013/14	213	**200.3**	197.1	**Yes**
	31	Hospital admissions for mental health conditions	Crude rate/100,000	Lower	2013/14	89	**88.8**	87.2	**No**
	32	Hospital admissions as a result of self-harm	DASR/100,000*	Lower	2013/14	508	**523.5**	412.1	**No**

	Significantly worse than England
	Not significantly different to England
	Significantly better than England
	Significance not tested

Public Health England

Child Health Profile

June 2015

County Durham

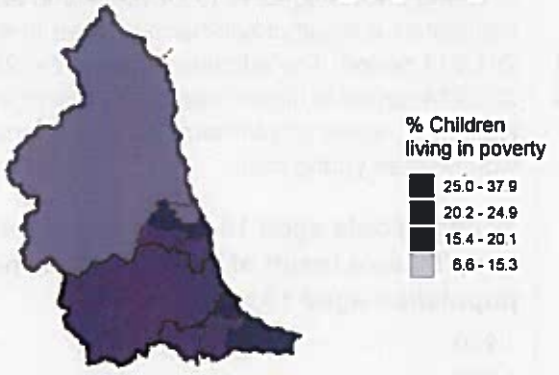
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	North East	England
Live births in 2013			
	5,388	28,961	664,517
Children (age 0 to 4 years), 2013			
	28,800 (5.6%)	151,800 (5.8%)	3,414,100 (6.3%)
Children (age 0 to 19 years), 2013			
	114,100 (22.1%)	594,200 (22.8%)	12,833,200 (23.8%)
Children (age 0 to 19 years) in 2020 (projected)			
	116,200 (21.9%)	595,100 (22.3%)	13,325,100 (23.6%)
School children from minority ethnic groups, 2014			
	2,298 (3.8%)	27,895 (8.9%)	1,832,995 (27.8%)
Children living in poverty (age under 16 years), 2012			
	22.7%	23.6%	19.2%
Life expectancy at birth, 2011-2013			
Boys	78.0	78.0	79.4
Girls	81.3	81.7	83.1

Children living in poverty

Map of the North East, with County Durham outlined, showing the relative levels of children living in poverty.



Contains Ordnance Survey data

Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2012-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 22.1% of the population of County Durham. 3.8% of school children are from a minority ethnic group.

The health and wellbeing of children in County Durham is generally worse than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is worse than the England average with 22.7% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in County Durham have worse than average levels of obesity: 10.7% of children aged 4-5 years and 21.4% of children aged 10-11 years are classified as obese.

The MMR immunisation rate is better than the England average. The immunisation rate for diphtheria, tetanus, polio, pertussis and Hib in children aged two is better than the England average.

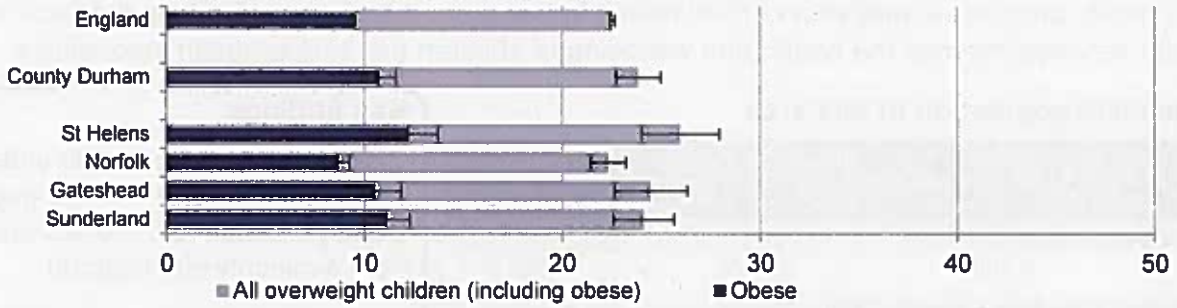
There were 605 children in care at 31 March 2014, which equates to a similar rate to the England average. A higher percentage of children in care are up-to-date with their immunisations compared with the England average for this group of children.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

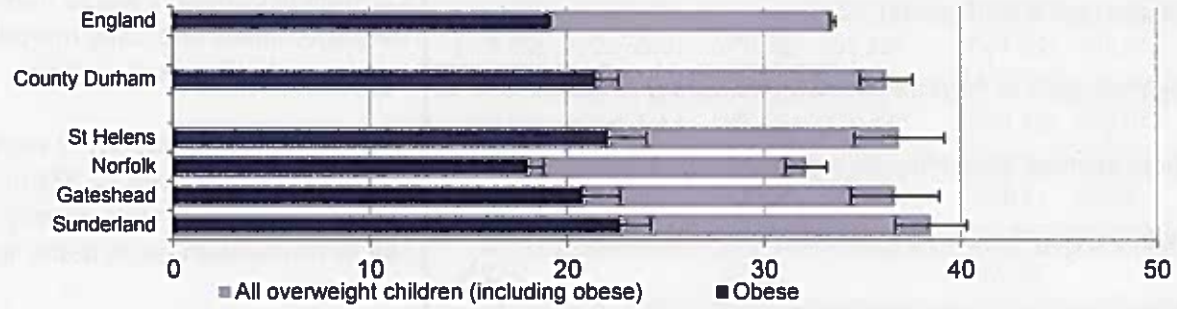
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a worse percentage in Reception and a worse percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2013/14 (percentage)



Children aged 10-11 years classified as obese or overweight, 2013/14 (percentage)

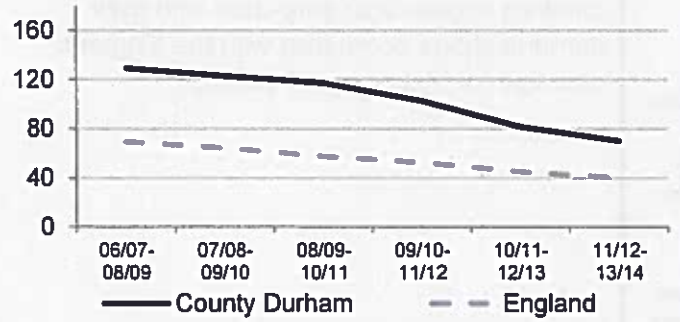


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2006/07-2008/09 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is higher than the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

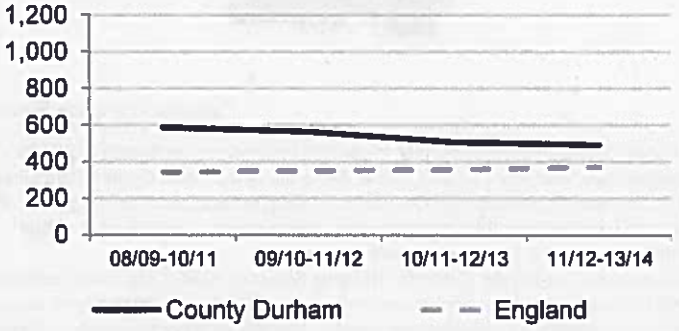


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2008/09-2010/11 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is lower in the 2011/12-2013/14 period. The admission rate in the 2011/12-2013/14 period is higher than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

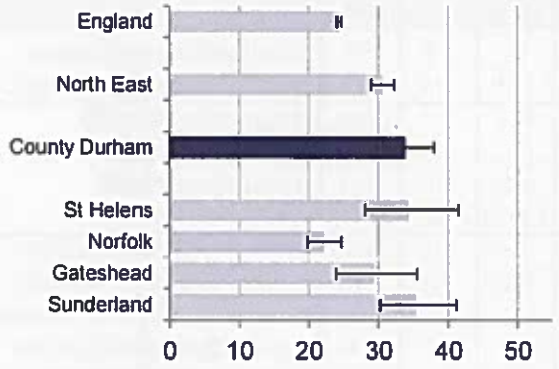


*Information about admissions in the single year 2013/14 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare County Durham with its statistical neighbours, the England and regional average and, where available, the European average.

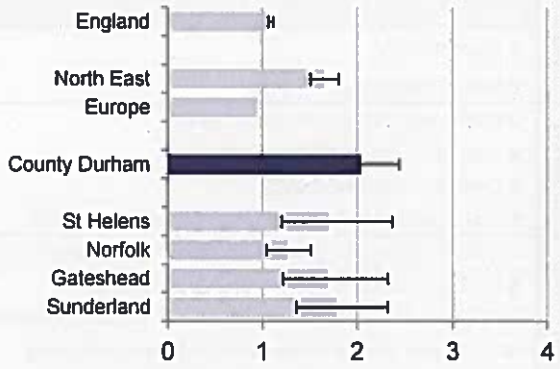
Teenage conceptions in girls aged under 18 years, 2013 (rate per 1,000 female population aged 15-17 years)



In 2013, approximately 34 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is similar to the regional average. The area has a higher teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2013/14 (percentage of all deliveries)

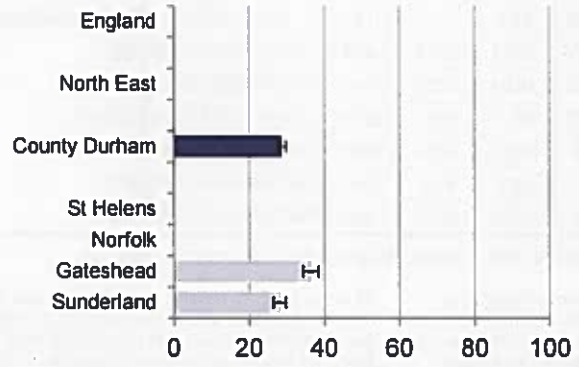


In 2013/14, 2.0% of women giving birth in this area were aged under 18 years. This is higher than the regional average. This area has a higher percentage of births to teenage girls compared with the England average and a higher percentage compared with the European average of 0.9%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2013. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2013/14 (percentage of infants due 6 to 8 week checks)

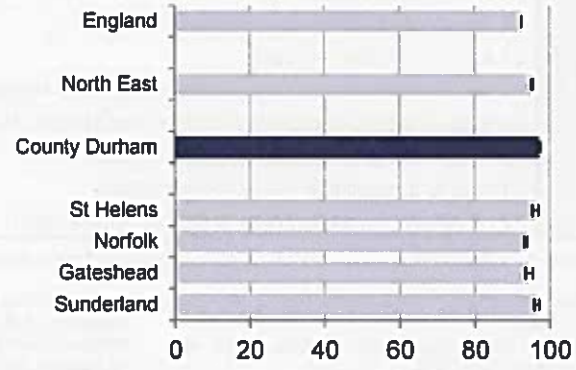


In this area, 28.5% of mothers are still breastfeeding at 6 to 8 weeks. 57.4% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2013/14 (percentage of children age 2 years)



Compared with the England average, a higher percentage of children (97.2%) have received their first dose of immunisation by the age of two in this area. By the age of five, 94.6% of children have received their second dose of MMR immunisation. This is higher than the England average. In the North East, there were 311 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

County Durham Child Health Profile — June 2015

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average
- Significance not tested

	Indicator	Local no.	Local value	Eng. ave.	Eng. Worst	Eng. Best
Premature mortality	1 Infant mortality	19	3.3	4.1	7.5	1.7
	2 Child mortality rate (1-17 years)	10	10.4	11.9	22.8	3.0
Health protection	3 MMR vaccination for one dose (2 years)	5,746	97.2	92.7	78.3	98.3
	4 Dtap / IPV / Hib vaccination (2 years)	5,835	98.7	96.1	81.6	99.1
	5 Children in care immunisations	410	100.0	87.1	27.3	100.0
	6 New sexually transmitted infections (including chlamydia)	2,177	3,193.5	3,432.7	8,098.4	1,899.8
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	3,090	56.7	60.4	41.2	75.3
	8 GCSEs achieved (5 A*-C inc. English and maths)	3,028	57.6	56.8	35.4	73.8
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	12.0	8.0	42.9
	10 16-18 year olds not in education, employment or training	1,250	7.1	5.3	9.8	1.8
	11 First time entrants to the youth justice system	211	473.5	440.9	846.5	171.0
	12 Children in poverty (under 16 years)	20,075	22.7	19.2	37.9	6.6
	13 Family homelessness	121	0.5	1.7	10.8	0.1
	14 Children in care	605	60	60	153	20
	15 Children killed or seriously injured in road traffic accidents	22	25.3	19.1	48.3	8.2
Health improvement	16 Low birthweight of all babies	396	7.3	7.4	10.4	4.6
	17 Obese children (4-5 years)	583	10.7	9.5	14.2	5.5
	18 Obese children (10-11 years)	1,058	21.4	19.1	26.8	10.5
	19 Children with one or more decayed, missing or filled teeth	-	27.2	27.9	53.2	12.5
	20 Under 18 conceptions	293	33.8	24.3	43.9	9.2
	21 Teenage mothers	113	2.0	1.1	2.5	0.2
	22 Hospital admissions due to alcohol specific conditions	70	69.9	40.1	100.0	13.7
	23 Hospital admissions due to substance misuse (15-24 years)	65	94.7	81.3	264.1	22.8
Prevention of ill health	24 Smoking status at time of delivery	1,049	19.9	12.0	27.5	1.9
	25 Breastfeeding initiation	3,006	57.4	73.9	36.6	93.0
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,546	28.5	-	19.4	77.4
	27 A&E attendances (0-4 years)	10,605	368.1	525.6	1,684.5	252.7
	28 Hospital admissions caused by injuries in children (0-14 years)	1,389	168.4	112.2	214.1	64.4
	29 Hospital admissions caused by injuries in young people (15-24 years)	1,387	201.7	136.7	291.8	69.6
	30 Hospital admissions for asthma (under 19 years)	213	200.3	197.1	509.1	54.6
	31 Hospital admissions for mental health conditions	89	88.8	87.2	391.6	25.6
	32 Hospital admissions as a result of self-harm (10-24 years)	508	523.5	412.1	1,246.6	119.1

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2011-2013
2 Directly standardised rate per 100,000 children age 1-17 years, 2011-2013
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2013/14
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2013/14
5 % children in care with up-to-date immunisations, 2014
6 New STI diagnoses per 100,000 population aged 15-24 years, 2013
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2013/14
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2013/14
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2014 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2013
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2013
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2012
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2013/14
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2014
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2011-2013
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2013
17 % school children in Reception year classified as obese, 2013/14
18 % school children in Year 6 classified as obese, 2013/14
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2013
21 % of delivery episodes where the mother is aged less than 18 years, 2013/14
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2011/12-2013/14
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2011/12-2013/14
24 % of mothers smoking at time of delivery, 2013/14
25 % of mothers initiating breastfeeding, 2013/14
26 % of mothers breastfeeding at 6-8 weeks, 2013/14
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2013/14
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2013/14
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2013/14
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2013/14
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2013/14
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2013/14

Health and Wellbeing Board

21 January 2016

County Durham Drug Strategy Action Plan 2014-2017

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

Purpose of the Report

1 The purpose of this report is to inform Health & Wellbeing Board of the progress to date of the County Durham Drug Strategy Action Plan 2014-2017.

Background

2 The Government's Drug Strategy *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life* was published in 2010. It focusses on three themes:

- *Reducing Demand* – creating an environment where the vast majority of people who have never taken drugs continue to resist any pressures to do so;
- *Restricting Supply* – making the UK an unattractive destination for drug traffickers by attacking their profits and driving up their risks; and
- *Building Recovery in Communities* – build on the investment that has been made into treatment to ensure more people are tackling their dependency and recovering fully.

3 A multi-agency Drug Strategy Group was established to drive forward the objectives of the national strategy in County Durham. Following a stakeholder event in January 2014 with professionals, council members, service users and carers, the strategy was agreed for 2014-2017.

4 The aim of the Strategy is *to prevent harm, restrict supply and sustain a future for individuals to live a drug free and healthy life, whilst minimising the impact on communities and families.*

5 The County Durham Strategy has 6 objectives under the three themes of the national Strategy:

Preventing Harm

6 Increase awareness and understanding of drugs in order to reduce drug misuse across the population.

7 Have fewer people taking up drug use and to break the inter-generational path to drug misuse and dependency.

Restricting Supply

8 Reduce the supply of drugs and number of drug related incidents impacting upon families and communities.

Building Recovery

9 Ensure recovery is understood and visible in the community.

10 Support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug use.

11 Involve and support families and carers living with drug related issues.

Performance and Outcomes

12 The Drug Strategy is underpinned by an action plan (Appendix 2) and performance framework. The headline performance issues for Quarter 1 are discussed in table 1:

Table 1: Percentage of successful completions of those in substance misuse treatment – Opiates

Previous Performance Issue	Quarter 2 Update	Update/new actions agreed at Quarter 2 performance session
Successful completions for opiate use increased to 7.1%, but remain below target of 7.9% and national performance (7.6%).	**The percentage of successful completions of drug treatment for opiates was 6.8% in 2014. This is below the 2014 target (8.4%) and below the national average for the same period (7.4%). Performance is slightly better than the regional average of 5.8%** **NB:** Latest data is 6.5% (94/1451) (Apr14 - Mar15 representing up to end-Sep15). This has not achieved the 2014/15 target of 7.9% and is below national performance for the same period of 7.2%.	Lifeline took over the drug and alcohol recovery service for County Durham from 1st April 2015. The data reported therefore relates to the former drug and alcohol treatment providers. Experience from other regions is that it will take 6 months for the Lifeline service to become embedded. The first official Lifeline data on drug treatment will be available in early 2016. There are a number of major implementation issues that have been managed by Lifeline: • The transition of clients who pre-date Lifeline i.e. the clients who completed treatment in the latest quarter commenced their treatment plan with the previous provider. • The transition of Lifeline staff to a new data management system. • The time to recruit and TUPE new staff to the Lifeline service and the provision of relevant training to embed the new recovery model. • The time needed to setup some of the new services such as the Recovery Academies in Durham and Newton Aycliffe. The houses in Durham are currently being furnished and housing is currently being sourced in Newton Aycliffe. Both are currently providing day care. Once complete the RAD will offer a further 36 beds for treatment.

13 The Drug Strategy action plan has a total of 44 actions. Twenty six of these actions are RAG rated green and a further 17 actions are amber that will be completed early in 2016. There is one action rated as red. This is related to strengthening the pathway between Children and Family Services and specialist drug and alcohol services – a multiagency meeting has been organised in January 2016 to progress this.

14 Consultation on the refresh of the strategy and action will commence October 2016.

15 The Drug Strategy Group meet quarterly and review the performance report and monitor progress against the action plan. Any key issues are escalated to the Safe Durham Partnership, Health and Wellbeing Board and/or Children and Families Partnership as appropriate.

Recommendations

16 The Health & Wellbeing Board is recommended to:

- Note the Drugs Strategy Action Plan (2014-2017) for information.
- Note current performance as detailed in paragraph 13.

Contact: **Lynn Wilson, Consultant in Public Health**
Tel: **03000 268680**

Appendix 1: Implications

Finance
No additional financial implications as a result of the implementation of the strategy.

Staffing
Existing staffing already members of the strategy group to be involved with the implementation of the strategy.

Risk
No risk identified in implementing the strategy.

Equality and Diversity / Public Sector Equality Duty
People with drug issues and their families are often identified as priory groups for support.

Accommodation
No implications.

Crime and Disorder
A key strand of the strategy is to tackle the supply of drugs, this is already led by Durham Constabulary.

Human Rights
None identified.

Consultation
The strategy was developed by a range of stakeholders.

Procurement
No additional procurement issues as a result of the strategy.

Disability Issues
Some people with drug issues also have co-morbidities with mental health (referred as dual diagnosis). These are identified as a priority group in the strategy.

Legal Implications
There are no legal implications.

Altogether safer

Safe Durham Partnership

Altogether better for children and young people

County Durham Children and Families Partnership

Altogether healthier

County Durham Health and Wellbeing Board

Drug Strategy Action Plan

2014 - 2017

APPENDIX 2

Objective 1: To increase awareness and understanding of drugs in order to reduce drug misuse across the population

Task no.	Action	Measure	Baseline 2014/15	Performance 2015/16	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
1	Develop a social marketing plan to raise awareness about the harms of drugs	Social marketing plan developed	N/A	N/A	Dec 2015	Kim Michelle			G	Plan developed. Logo developed to be used on all resources.
2	Develop a communications plan for promoting the CDS and recovery community in County Durham	Plan developed	N/A	N/A	Feb 2016	Jane Sunter		A		Comms plan in development in line with overarching Alcohol Harm reduction Strategy and elements of wider system
3	Work with schools and families to promote awareness of the risks associated with drug misuse	No. of schools and families engaged with substance misuse trainer	YP 382 Adults 25 Schools 8	Young People 1145 Adults 105 Schools 21	Annual	Sarah Norman			G	
4	Gain a better understanding of the needs around New Psychoactive Substances (NPS)	Develop knowledge of group and wider partners	N/A	Provide regular updates	Ongoing	Colin Dobson			G	Presentation delivered to Drug Strategy Group. 6.12.15. JS to become part of the PH England Strategy Group for NPS – this will include to delivery of an event in Q4

APPENDIX 2

Objective 1: To increase awareness and understanding of drugs in order to reduce drug misuse across the population								
Task no.	**Action**	**Measure**	**Baseline 2014/15**	**Performance 2015/16**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
5	Work with partners to enhance the knowledge and evidence on NPS.	Deliver NPS strategy group	N/A	N/A	Ongoing	Sarah Norman	**G**	Group already in existence
6	Highlight potential risks and harms of using NPS to enable people to take personal responsibility for their decisions	Lifeline to incorporate into training.	N/A	Complete	Ongoing	Kim Michelle	**G**	NPS is incorporated into the general training.
7	Develop a Key Messages document in relation to drugs and ensure partners sign up to this.	Document developed and shared	N/A		March 2016	Jane Sunter	**A**	To be taken on board as part of the Comms strategy.
8	Support schools and colleges in the delivery of drug education and support the development and implementation of drug policies.	Number of schools engaged with the resilience programme, supported by Specialist training team.	88+ 16 schools Jan - March			Sarah Norman/Lifeline	**A**	Currently 16 school This should tie in with the resilience work being carried out by Gill O'Neill, in public health.

APPENDIX 2

Objective 1: To increase awareness and understanding of drugs in order to reduce drug misuse across the population

Task no.	Action	Measure	Baseline 2014/15	Performance 2015/16	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
9	Include drugs, caffeine and NPS's in the Good Practice Guidance for schools, colleges and youth settings	Good practice doc complete	N/A	Complete	Jan 2015	Sarah Norman			**G**	
10	Map and improve existing drug forums	6 forums	6	Complete	Sept 2015	PH Portfolio Lead/Lifeline Jenny Bryson			**G**	
11	Gain a better understanding of the misuse of over the counter medicines	Report April 15 Further work with Lifeline to support community pharmacy	N/A	Report complete Apr 2015 Work with Lifeline to support community pharmacy	Dec 2015 Dec 2016	Claire Jones			**G** **G**	 CJ providing training and awareness to community pharmacies
12	Provide specialised substance misuse training to raise awareness and promote services with professionals	Number of individuals trained	1070		Annual report	Kim Michelle		**A**		Services identified, training underway

APPENDIX 2

Objective 2: To have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
1	Ensure the delivery of Prevention and Recovery Champions in prisons .	Number of Trained Ambassadors	N/A		May 2016	Kim Michelle		A		People are being trained in Prison. KM to speak to DK about Ambassadors in prison. Challenge is on vetting. Endorsed by Governor HMP Durham Directly Nov 15. KM meeting Lifeline Director re Training course in April 2016.
2	Identify and refer young people, families and carers (including young carers) living with drug related issues, to drug and alcohol services, in order to break the cycle of drug misuse	Number of families referred to D&A service by the stronger families team.	Alcohol Misuse – by Child = 13 Alcohol Misuse – by other person in family/household = 9 Alcohol Misuse –	tbc		Karen Davison		**A**		A Pathways meeting is scheduled for January 2016 and map out processes interlinking with the Lifeline YP and Families teams. Agree indicators. The expansion of the programme to include substance misuse as a headline issue

Objective 2: To have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
			by parent/carer = 189 Drug Misuse – by child = 21 Drug Misuse – by other person in family/household = 13 Drug misuse – by parent/carer = 127							
3	Strengthen the pathway between Children and Family Services and specialist drug	Increase the number of referrals into the Stronger Families	N/A		Ongoing	Karen Davidson Kim Michelle		**R**		To agree at Jan 2016 meeting as above

Objective 2: To have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG	Update report
							R A G	
	services to ensure vulnerable families and children are supported with their	programme from the Lifeline Drug and Alcohol Service						
4	Local Safeguarding Children's Board to undertake themed audits of cases linked to parental drug use and present findings to the LSCB performance management sub group	Number of Children subject to a CP plan where parental substance misuse is a contributing factor. Identify where there is good practice in terms of information sharing between services, identify areas for improvement Nature of service provision, particularly early	N/A	Audit	December 2015	Sean Barry LSCB	A	Cases submitted to Safeguarding Audit - November 2015. Results pending Jan 2016

Objective 2: To have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
		intervention. Identification of any gaps in services to families or need for further training for practitioners Identifying what can be done by partners to reduce incidence of CP plans relating to substance misuse.								
5	LSCB to embed Hidden Harm (inc parental alcohol and substance misuse) into key strategy documents and LSCB training programme to raise awareness of	Refresh neglect training Hidden harm included in annual report and strategy	N/A	To complete	Jan 2016	Sean Barry LSCB		**A**		LSCB neglect training refreshed to include Hidden Harm information and referral routes to services including alcohol and drugs. Hidden Harm included in LSCB

Objective 2: To have fewer people taking up drug use and break the inter-generational path to drug misuse and dependency								
Task No.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG**	**Update report**
							R A G	
	drug and alcohol services, promote treatment and recovery.	0-19 refresh referral routes Practice guidance						Annual Report published Nov 2015. Hidden Harm included in draft LSCB Early Help and Neglect Strategy (to be completed by Jan 2016). Draft refresh of 0-19 Levels of Need include referral routes to drug and alcohol services (to be completed by Jan 2016). Draft Early Help and Neglect Practice Guidance to include Hidden Harm. (to be completed by Jan 2016).

Objective 3: To reduce the supply of drugs and number of drug related incidents impacting upon communities and families

Task no.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
1	Improve the quality of data collection to understand the full impact of drugs on health, crime, offending and reoffending	Health Impact Assessment or Needs Assessment	N/A	N/A	March 2016	Jane Sunter		A		New IT database going out to tender in January 2016.
2	Create a forum to debate the decriminalisation of drug users with the intention of influencing future UK drug policy	The Future of Drug Policy Symposium to be held	27.11.14	Complete		Ron Hogg			G	
3	Tackle supply chain within HMP prison system by ensuring supply and demand strategy is fully implemented	SM strategy documents revised and signed off	N/A	Complete	March 2015	Lifeline			G	
4	Work with the Police and Crime Commissioner to	Co-commissioning with PCC	N/A	Complete	April 2015	Lynn Wilson			G	Review March 2016

Objective 3: To reduce the supply of drugs and number of drug related incidents impacting upon communities and families								
Task no.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
	ensure that funding is allocated to reduce drug related crime and anti-social behaviour							
5	Make full use of the legislative framework and strengthen the enforcement response to NPS	No. of seizures and prosecutions initiated by police, trading standards and food safety, where NPS feature.	No prosecutions to date. There have been two separate seizures of NPS from shops in CLS, and one in Bishop Auckland.	N/A	Ongoing	Colin Dobson	**G**	Legislation will change. Currently in House of Commons. Legislation should be in place by early 2016.
6	To support the development of Checkpoint	Contract award for navigators.	N/A		Quarterly	Steph Killili	**G**	JS attended checkpoint Strategy group. Group pleased with progress. 100 clients going through the scheme. Checkpoint to be standing item on future agendas.

Objective 4: To ensure recovery is understood and visible in the community

Task no.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG	Update report
1	Further support a recovery community in County Durham, including HMPS which celebrates and promotes recovery	Delivery recovery forum		Complete		Dave King	**G**	County Durham Recovery Forum is a combined forum for alcohol and other drugs. They have developed their constitution and meet quarterly.
2	Further develop the work on recovery including recruiting, training and supporting Ambassadors	30 ambassadors	N/A	20	Quarterly	Jackie Hilditch	A	Currently 20 Ambassadors within the programme and a further 9 on 2nd cohort of training.
3	Review the referral pathways into and from GP practices, primary mental health, acute hospital trusts and CRC & NPS	Pathway review			January 2016	PH Portfolio Lead/Lifeline	A	Pathways process meeting for hospital identified as a key priority for new year Agreed with Lifeline. Meeting held with CDDFT and pathway agreed. 29/9/2015 Focus on GP practises. Practise managers are meeting.

Objective 3: To reduce the supply of drugs and number of drug related incidents impacting upon communities and families								
Task no.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
4	Build peer support into the induction process within HMPs	Peer support in 100% establishments	N/A	100%	June 2015	Lifeline/Dave King	G	25/9/2015 Lifeline now run the mentoring and befriending foundation approved provider standard within the prison estate, including Frankland. This is an ongoing service development and will be become a core element of the treatment system.
5	Increase numbers of clients supported in accessing mutual aid groups in the community and in HMPs	Mutual Aid groups in 100% establishments	N/A	100%	Ongoing	Jackie Hilditch (community) Dave King (HMP)	**G**	**HMP** 16.3.15 All establishments have active mutual aid groups up and running LD
		No. of clients facilitated into mutual aid attendees	N/A	Annual increase 100% 2014/15	Ongoing		***G***	**Figures** SMART figures have increased by 100%on 2013/14. .

Objective 3: To reduce the supply of drugs and number of drug related incidents impacting upon communities and families

Task no.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
		No. of community venues	N/A		Ongoing			***A***		**Community** A SMART group is now running at Clayport Library Durham and plans are in place for a SMART Group to begin in the community at Chester le street in the next few weeks. JH to update.
6	Ensure all service users have access to an Ambassador within their own Recovery Centre and in prisons	100% access to ambassador by clients	N/A	100%	Annual	Jackie Hilditch			**G**	All clients have access to an Ambassador. 29/9/2015 – Q1 – 260 clients assessed., July 72 and August221
7	Deliver an annual event celebrating recovery within County Durham	Annual event	Annual event	Completed	June 2016 & ongoing	PH Portfolio Lead			**G**	19.5.15 - A celebration event was delivered in 2015. Prisons also have recovery events.

Objective 5: To support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse								
Task No.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
1	Undertake a review of community based and prisons drug and alcohol specialist recovery service	Review complete		Complete	March 2015	PH Portfolio Lead	**G**	Complete
2	Ensure services are attractive and accessible to underrepresented groups, e.g. pregnant women, veterans and victims of domestic abuse.	Health Equity Audit	N/A		March 2016	PH Portfolio Lead	**A**	
3	Commission and deliver effective treatment and recovery services in both community and criminal justice settings in line with national guidance.	Number of adults using opiates and/or crack cocaine (PDU's) effectively engaged in treatment for 12 weeks or more, or if leaving treatment	Criminal Justice Community		DK need to change indicator Jan 16	PH Portfolio Lead Dave King	**A**	29/9/2015 David King has requested that if numbers in treatment within the criminal justice setting are required we will need to change the wording as we don't have the 12 week measure reported in prisons currently. Lifeline are targeted to achieve 60% of prisoners

Objective 5: To support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
		before 12 weeks, did so free of dependency Number of adults (all drugs) effectively engaged in treatment (see above indicator)								leaving to engage with treatment within 21 days of release. He requested that potentially this data could be used.
4	Explore joint commissioning opportunities between drug, alcohol and mental health services.	Dual diagnosis strategy completion by May 2015. Catherine Richardson to attend Joint Commissioning Group and feedback.	N/A	Complete	May 2015	Lynn Wilson			**G**	Strategy complete. Action plan under development. Catherine Richardson attends Joint Commissioning Meetings. 29/9/2015 Dave King reported that the 1 April 2015 all prisons have the ability to link into addiction psychiatry.

Objective 5: To support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse								
Task No.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
5	Ensure effective pathway with Housing Solutions Services to support people to move on from the Recovery Academy.	Pay for storage and provide bond when discharged from RAD – Ashley Marsden.	N/A	Complete	March 2015	Lorraine Walkden	**G**	Referral route in place with Housing Solutions Service with access to a range of support to ensure access to appropriate accommodation.
6	Supporting Women's Making Every Adult Matter (MEAM) service in Durham to develop accommodation and support needs of those clients excluded from services.	Number of women supported Number of Women with substance misuse issues referred to specialist services	N/A		Andrew to check reporting. DASH substance misuse reporting – **See Appendix 1**	Lorraine Walkden	**G**	Service operational and fully occupied. Steering group established to monitor and provide guidance. Additional funding secured from PCC to provide research / training and support to sex workers across the County
7	Improve Private Rented Sector management standards through inclusion with Durham Key Options – choice based lettings.	Implementation Key Options	N/A	Complete	May 2015	Lorraine Walkden	**G**	IT specification developed. Project plan developed for commencement in May 15. Agreement for pilot with access to support from service provider. Service offer to private

Objective 5: To support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG			Update report
							R	A	G	
										landlords in developments including accreditation required to access service.
8	Develop pathway for integrated model across the life course and identify specific issues effecting successful transition	Commission new service	N/A	Complete	March 2015	PH Portfolio Lead			**G**	
9	Review and monitor the substance misuse related deaths in County Durham	Audit substance misuse related deaths Set up early alert system Actions and improvements identified and implemented	N/A N/A N/A	Annually N/A N/A	November 2016 November 2015 Ongoing	Lynn Wilson Lynn Wilson Lynn Wilson			**G**	Oversight group in place. Audit process agreed Early alert system set up. Action log & risk register monitored Quarterly
10	Raise awareness of referral protocols into and out of police custody	Implement pathways from Diversion and liaison team	N/A		Jan 2016	Kevin Weir, Kim Michelle, Jane Sunter		**A**		JS to facilitate new pathways from the Diversion and Liaison Team. Agreed December 2015.

Objective 5: To support people to successfully recover from their dependency, addressing both their health and social needs arising from their drug misuse								
Task No.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG** R / A / G	**Update report**
11	Ensure that there are effective harm minimization and engagement interventions, which increase numbers accessing treatment for those using drugs who are treatment naive	Interventions	N/A	Quarterly	Ongoing	Dave King	**G**	13.3.15 All HMPS Establishments have robust mechanisms for increasing treatment access and all NE establishments have high take up rate of engagement in treatment. 29/9/2015 A new NPS strategy for prisoners of the North East And Cumbria. Jane to request copy from Dave King

Objective 6: To involve and support families and carers living with drug related issues

Task No.	Action	Measure	Baseline 2014/2015	Performance 2015/2016	Completion Date	Lead officer	Performance RAG	Update report
							R / A / G	
1	Commission specialist family support services and ensure carers needs are met.	Service commissioned			April 2015	Lynn Wilson	G	Commissioned via Lifeline.
2	Ensure families needs are assessed and understood and they receive a collaborative multi-agency whole family response from Team around the Family	Not available	% of eligible families supported by team around family			Karen Davison/ Lifeline	A	Pathways meeting is scheduled for January 2016 to bring all partners around the table together and map out processes interlinking with the Lifeline YP and Families teams. Lifeline developing family work. Will be recruiting ore family workers and ensuring they link in with carers and YP services so that the whole family support is co-ordinated and integrated. 29/9/2015 Jane to chase with Karen Davison.

APPENDIX 2

Objective 6: To involve and support families and carers living with drug related issues								
Task No.	**Action**	**Measure**	**Baseline 2014/2015**	**Performance 2015/2016**	**Completion Date**	**Lead officer**	**Performance RAG**	**Update report**
							R A G	
3	Listen to the views of carers, including young carers and service users to continually improve the quality of services	Not available	Annual report		April 2016	Kim Michelle	A	Report due April 2016

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Health and Wellbeing Board

21 January 2016

Durham Local Safeguarding Children Board Annual Report 2014-15

Report of Jane Geraghty Independent Chair, Durham Local Safeguarding Children Board

Purpose of the Report

1 The purpose of this report is to present the Health and Wellbeing Board with the Durham Local Safeguarding Children Board Annual Report 2014-15 (attached at Appendix 2).

Background

2 Durham Local Safeguarding Children Board (LSCB) is a statutory body established under the Children Act 2004. It is independently chaired (as required by statute) and consists of senior representatives of all the principal stakeholders working together to safeguard children and young people in Durham.

3 Its statutory objectives are to:

- Coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- Ensure the effectiveness of what is done by each such person or body for those purposes

4 The LSCB's primary responsibility is to provide a way for local organisations who have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children and young people in County Durham and to ensure that they do so effectively.

5 Working Together (2015) requires each Local Safeguarding Children Board to produce and publish an Annual Report evaluating the effectiveness of safeguarding in the local area.

6 During 2014/15 the LSCB has seen a year of restructure and development for the Board. This includes the appointment of a new independent chair, a review of LSCB sub-groups and the alignment of the partnership structure of the LSCB Business Unit from Children's Services to Planning and Service Strategy in Children and Adults Services.

7 The Independent Chair has a crucial role in making certain that the Board operates independently and secures an independent voice for the LSCB. Jane Geraghty became the new Independent Chair of the LSCB Board in October 2014. The LSCB has also recruited two lay members to the LSCB Board to provide further independent scrutiny.

8 Throughout August and September 2015 the draft LSCB Annual Report 2014/15 has been presented to the LSCB Board, partner agencies and stakeholders for consultation and comment. The feedback received has been incorporated into the final document.

Annual Report

9 The Durham LSCB Annual Report 2014/15 sets out the work of multi-agency partners to ensure effective arrangements are in place to safeguard and protect vulnerable children and young people from abuse and neglect.

10 The report describes the work undertaken against the 2014-15 priorities and sets out the future priorities for 2015-16. It describes the local governance arrangements and structure of Durham LSCB, the linkages to other strategic partnerships across County Durham and work with other LSCBs.

11 The report provides an overview of the performance monitoring framework and quality assurance plan as well as providing a brief summary of safeguarding privately fostered children, the use of restraint in secure centres, Serious Case Reviews, Child Death Reviews and the single and multi-agency training provision.

12 The LSCB has reviewed its vision, which has been agreed as: 'Every child and young person in County Durham feels safe and grows up safe from harm'.

13 Some achievements and progress highlighted in the Annual Report are as follows:

- Development of the Early Help Strategy
- The introduction of a County Durham Multi-Agency Safeguarding Hub (MASH)
- Development and implemented the 'Collaborative working and information sharing between professionals to protect vulnerable adults and children' information sharing protocol
- Developed a Safeguarding Framework to improve links with Health & Wellbeing Board, Children & Families Partnership and Safe Durham Partnership
- Development of a Child Sexual Exploitation Strategy and delivery plan
- Developing and implementing a Child Sexual Exploitation audit and sharing the information through other council and partnership structures
- Supported 'Never Do Nothing' training (a safeguarding standard for voluntary and 3rd sector organisations)
- Set up a Young People's Reference Group for the LSCB
- Developing a new LSCB website, with input from young people

Challenge and Impact

14 The LSCB has a role in relation to challenging partners on the impact they are making to safeguard children and young people in order to provide assurance to the LSCB. The Annual Report provides examples of challenges raised by the LSCB, the resulting progress and the impact this has had on the delivery of services and improvements in safeguarding.

15 For example, challenging partners to improve the voice of the child has resulted in collaborative work with 'Investing in Children' and the development of the Young People's Reference Group for the LSCB. These young people have met with members of the LSCB Board on a number of occasions and their views have been taken into account in the LSCB work plan and the Board's priority setting arrangements. An example of a direct impact of listening to these young people is the inclusion of the self-harm priority for the LSCB for 2015-16.

16 Other examples within the report include a challenge to partners to:

- Improve Early Help responses leading to the development of a Multi-agency Safeguarding Hub
- Improve links with wider strategic partnerships structures leading to aligning work on cross-cutting Strategies such as the Alcohol Harm Reduction Strategy, Domestic Abuse and Sexual Abuse Strategies
- Improve work on Child Sexual Exploitation (CSE) leading to a CSE audit identifying risk factors and a subsequent action plan
- Improve joint training and alignment of training programmes leading to joint delivery of Domestic Abuse training and Child Sexual Exploitation training and the delivery of e-learning training for Counter Terrorism and Female Genital Mutilation (FGM)

LSCB Priorities for 2015-18

17 Durham LSCB held a development day in March 2015 to review progress on the priorities from 2014-15, consider key challenges, improve the use of its resources and to set its future priorities. In setting the priorities for 2015-16 the Board consulted with children and young people. The Durham Local Safeguarding Children Board has agreed the following priorities:

- Reducing Child Sexual Exploitation
- Improving Early Help
- Reducing Neglect (contributory factors are domestic abuse; alcohol misuse; substance misuse; parental mental health)
- Reducing self-harm and improving young people's self-esteem
- Increase the voice of the Child
- Ensuring that each agency is accountable for delivery of its own safeguarding responsibilities

18 Alongside the identified priorities above the LSCB has highlighted priority areas of work for 2015/16, which include:

- Supporting and challenging the new Children's Services Transformation arrangements for the delivery of children's services
- Improving the performance and quality assurance information to support and improve performance on the Board's priorities
- Strengthening our engagement with children and young people especially those from vulnerable communities such as Lesbian, Gay, Bi-Sexual and Transgender, young carers, Gypsy Roma Travellers, young people who offend and children and young people with additional needs
- Building on the Female Genital Mutilation (FGM) training offered to health professional and develop an Female Genital Mutilation Practice Guidance
- Work with the County Durham Domestic Abuse and Sexual Violence Executive Group (DASVEG) to promote the need for domestic abuse services to support children, young people and their families
- A continued focus on information sharing supporting and promoting good practice across multi-agency teams
- Continue a programme of self-improvement

19 There is the opportunity for the LSCB to develop closer working arrangements with wider partnership on shared or similar priorities. Examples include:

- **The Health and Wellbeing Board** – through greater integration of self-harm and suicide prevention agenda and contributing to the development
- **The Safe Durham Partnership** – contributing to the development of actions covering Hidden Harm in respect of domestic abuse; alcohol misuse, substance misuse. Aligning and improving work within sexual violence, child sexual exploitation and female genital mutilation
- **The Children and Families Partnership** – working together to increasing the voice of the child and Early Help provision

20 The LSCB priorities above and priority areas of work are supported by a detailed LSCB Business Plan outlining the actions to be undertaken in 2015/16.

21 The Durham LSCB Annual Report 2014/15 was agreed at the LSCB Board Meeting on the 15th October 2015.

22 The report is available on the Durham LSCB Website http://www.durham-lscb.org.uk/ and will be disseminated through partners own organisational governance structures.

Recommendations

23 The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Accept the LSCB Annual Report for information as an overview of the work undertaken in 2014/15 and priorities for action in 2015/16.
- Continue to work with the LSCB in the areas outline in paragraph 19.
- Consider and provide feedback to the LSCB on issues where the Health and Wellbeing Board can demonstrate influence and challenge in relation to the safeguarding of children and young people.

Contact: Jacqui Doherty, LSCB Business Unit Manager
Tel 03000 263989

Appendix 1: Implications

Finance
Yearly financial contributions to Durham LSCB are received from partner agencies and are detailed in the LSCB Annual Report.

Staffing
The priorities identified in the LSCB Annual Report will be delivered using existing resources. Durham County Council will contribute to the delivery of the priorities in partnership with other responsible authorities.

Risk
No adverse implications.

Equality and Diversity/ Public Sector Equality Duty
The LSCB Annual Report identifies the actions to safeguard the needs of vulnerable children and young people.

Accommodation
No adverse implications.

Crime and disorder
The LSCB Annual Report reflects priorities and action that impact positively on crime and disorder in County Durham. The report shows effective partnership working with the Safe Durham Partnership.

Human rights
No adverse implications.

Consultation
Consultation with partner agencies and stakeholders has been undertaken as part of the development of the LSCB Annual Report.

Procurement
No adverse implications.

Disability Issues
No adverse implications.

Legal Implications
Durham Local Safeguarding Children Board (LSCB) is a statutory body established under the Children Act 2004. Working Together to Safeguard Children (Statutory Guidance) requires each Local Safeguarding Children Board to produce and publish an Annual Report evaluating the effectiveness of safeguarding in the local area.

APPENDIX 2

Durham
Local Safeguarding Children Board

Annual Report
2014 / 2015

Safeguarding Children in County Durham

Safeguarding is everyone's responsibility

Contents

Section 1: Foreword by Independent Chair

Welcome to my first Annual Report as independent chair of Durham Local Safeguarding Children Board (LSCB). The role of the chair is to bring independent scrutiny and challenge to the work of the LSCB Board. Since being appointed in September 2014 I have immersed myself in scrutinising the work and development of the LSCB and I am encouraged by what I have seen. I am looking forward to my first full year in 2015 and eager to progress the good work of partners in County Durham.

Over the last year we have reviewed and updated our vision to **'Every child and young person in County Durham feels safe and grows up safe from harm'**. Our children and young people are at the heart of all we do and I have already challenged the Board to increase the 'voice of the child' in our plans and actions in the coming years and to understanding more fully the experience of the child or young person receiving help and support.

This Annual Report is intended to give local people an account of the Board's work over the past year to improve the safety and wellbeing of children and young people across County Durham. The report reflects the activity of the LSCB and its sub-groups against its priorities for 2014/15. It covers the major changes and improvements of our partners' service delivery, where they link with the Board's overall strategies and the impact we have had. It will also report on the Serious Case Reviews and Child Death Reviews undertaken and identify the priorities we will take forward into 2015/16.

In 2014/15 we have improved performance in some key areas and responded to continued reforms and changes to public services. Where possible we have used these reforms and changes as an opportunity to learn more about each other's priorities and challenges and to strengthen our partnership working.

2014/15 has also been a year of restructure and development for the Board and my thanks go to LSCB Business Unit for their hard work and dedication during a time of huge demand and tight deadlines. I would also like to thank the many partner agencies whose commitment and motivation helps deliver our shared priorities, develop new innovative initiatives and for the ongoing work to safeguard children in many different settings. It is through your hard working and effective teams that, at times, complex safeguarding issues are addressed and supported. I will continue to act as your critical friend, to scrutinise, challenge and seek continued improvement in services.

Lastly I would like to welcome our two new Lay Members, Helene Petch and Peter Harrison who give their valuable time and expertise to the work of the LSCB in County Durham.

Jane Geraghty
Independent Chair

Section 2: Introduction

The Durham Local Safeguarding Children Board has a statutory duty to prepare and publish an Annual Report which describes how our partners safeguard vulnerable children and young people in County Durham. Our primary responsibility is to provide a way for the local organisations that have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children in County Durham and to ensure that they do so effectively.

Section 3 of the report highlights some statistical information about County Durham and provides a local context for our work. This section gives information on national policy that shapes the work of the LSCB such as the increased national focus on Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM). It provides information on our local challenges that drive local work and innovation. The section also provides information in relation to those young people who have been involved in Children's Social Care and Youth Justice Service.

In Section 4 we describe the local governance arrangements and structure of Durham Local Safeguarding Children Board, the linkages to other strategic partnerships across County Durham and working with other LSCBs. In Section 5 we highlight some of the achievements and the progress that has been made in the last year as well as reporting on the work undertaken against the 2014/15 priorities including Early Help; Information Sharing; parental issues of Domestic Abuse, Alcohol and Drug Misuse and Mental Health; tackling Child Sexual Exploitation; strengthening our engagement with children and young people; supporting the new arrangements for the delivery of children's services and the development and self-improvement of the LSCB Board.

Section 6 covers our Performance Monitoring Framework and Quality Assurance Plan as well as providing a brief overview of safeguarding privately fostered children, the use of restraint in secure centres, Serious Case Reviews and Child Death Reviews. Section 7 discusses our single and multi-agency training provision. The LSCB training programme has seen an increased collaboration with a range of organisations; Durham County Council; County Durham & Darlington NHS Foundation Trust; Tees Esk and Wear Valleys NHS Foundation Trust, Durham Constabulary and Barnardos; in the planning, design and delivery of training. This has strengthened and enhanced the quality of training while avoiding duplication and promoting the importance of inter-agency working. Lastly, Section 8 provides the priorities we will take forward into 2015/16.

The information in this Annual Report is drawn from a wide range of sources from across the Children and Families Partnership, Health and Wellbeing Board and Safe Durham Partnership. Together these Partnerships, (along with Environmental and Economic themes), work under the County Durham Partnership towards the overarching vision of an 'Altogether Better Durham'. The report demonstrates the extent to which the functions of the Durham Local Safeguarding Children Board, as set out in the national statutory guidance 'Working Together to Safeguard Children' (March 2015) are being effectively discharged.

Section 3: The Local Context

3.1 Our Community

In 2014, there were an estimated 517,773 people living in about 228,000 households in County Durham, with 12 major centres of population including Durham City, Chester-le-Street, Newton Aycliffe, Consett and Peterlee. The county stretches from the remote rural North Pennine Area of Outstanding Natural Beauty in the West to the Heritage Coastline in the East and is the home to a range of treasures including Durham Cathedral and Castle, a UNESCO World Heritage Site.

Commonly regarded as a predominantly rural area, the county varies in character from remote and sparsely populated areas in the west to former coalfield communities in the centre and east, where villages tend to accommodate thousands rather than hundreds of people.

The number of children aged 0-15 in 2014 is 88,500 an increase of 200 (0.3%) since 2013. Despite recent increases in birth rates since 2001, this age group has declined by 6.1%, 5,700 fewer children. This is in contrast to national trends the number on children has increased by 3.5% over the same period.

By 2030, the number of children and young people aged 0-17 is projected to increase by 6.5%, reversing some of the declining trends seen prior to 2011.

Between 2001 and 2013, due to the increase in birth rate, the 0-4 age group in County Durham increased by 10.7%. As a result of an increase in the birth rate, it is expected that there will be in the region of 1,220 more primary aged pupils by 2023/24 than there were in 2013/14.

Growing up in poverty has a significant impact on children and young people both during their childhood and beyond. Almost a quarter of children in County Durham (23%) are living in poverty compared to an England average of one fifth (20.6%).

3.2 Key National Policy Drivers

Revisions to Working Together to Safeguard Children March 2015

Following consultation the government has updated and replaced the statutory guidance Working Together to Safeguard Children published in 2013. The revisions include changes to:

- the referral of allegations against those who work with children
- notifiable incidents involving the care of a child
- the definition of serious harm for the purposes of serious case reviews

Tackling Child Sexual Exploitation

The focus on Child Sexual Exploitation continues to grow following the Jay Report into Child Sexual Exploitation in Rotherham and the Casey Inspection Report of Rotherham Metropolitan Borough Council, both of which were damning in their assessment of local services and governance.

In March 2015, HM Government released 'Tackling Child Sexual Exploitation'. The report sets out a range of measures aimed at preventing Child Sexual Exploitation through improved joint working and information sharing, better protection of vulnerable children, stopping offenders and supporting victims and survivors. In recognition of the harm caused to victims, Child Sexual Exploitation was elevated to a national threat with a requirement to adopt the PURSUE approach to combat it.

Female Genital Mutilation

Tackling Female Genital Mutilation (FGM) has risen in prominence in recent years and in 2014 clearer direction from central government about the safeguarding responsibilities of local agencies was issued. The government is clear that political or cultural sensitivities must not get in the way of uncovering and stopping this abuse. FGM should never be ignored, FGM is child abuse.

FGM is a hidden crime and identifying girls at risk of FGM is not straight forward because; it may be the only incident of child abuse, usually from what is otherwise a loving family; there are rarely reasons for routine examinations, so they are not routinely seen by people outside of the family and girls are unlikely to disclose FGM for fear of consequences to and from family members and the wider community.

A factor to be considered in County Durham due to its rural nature is the possible family isolation within the local community – Government research suggests that communities / families less integrated into British society are more likely to carry out FGM because they may be unaware it is harmful or illegal, are isolated and there are no support networks to tell them otherwise.

Troubled Families

In June 2014, the Government announced plans to expand the Troubled Families Programme (known as Stronger Families in County Durham) for a further five years from 2015/16 and to reach an additional 400,000 families across England.

For Durham this means an additional 4,330 families will be targeted. The expanded programme will continue to focus on families with multiple high cost problems and continue to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment. Offender management teams have embedded a 'Think Family' approach into their work and strong links now exist to promote and support the needs of families and children of offenders. This ensure a joined up approach to meeting families' needs and recognising and understanding the impact of adults' problems on a child's life. However, it will also reach out to families with a broad range of problems, including those affected by domestic abuse, substance misuse and those with a range of physical and mental health problems. We know these are indicators of neglect and Durham LSCB is embedded in the work of Stronger Families and Think Family Programmes.

Counter Terrorism and Security Act

The Prevent Strategy is a cross-Government policy that forms one of the four strands of CONTEST: the United Kingdom's Strategy for Counter Terrorism. It includes the anti-radicalisation of vulnerable adults and children. Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism.

There is no obvious profile of anyone likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame. However, we do know young people are vulnerable to grooming and radicalisation. PREVENT includes work to identify and support those susceptible to violent extremism into appropriate interventions. These interventions are aimed to stop the vulnerable being radicalised. Those services working with children and young people (such as schools and Children's Services) continue to work with the Safe Durham Partnership, who oversees this priority.

Transforming Rehabilitation (Probation Reforms)

The Transforming Rehabilitation Programme sets out the Government's plans to transform the way in which offenders are managed in the community, in order to bring down re-offending rates. The key aspects of the reforms are:

- The creation of a new public sector National Probation Service to manage high risk offenders, (which took place in June 2014).
- The creation of 21 regional private sector Community Rehabilitation Companies (CRCs) managing all other offenders (which took place in February 2015).
- Every offender released from custody will receive statutory supervision and rehabilitation in the community.
- A nationwide 'through the prison gate' resettlement service will be put in place, meaning most offenders are given continuous support by one provider from custody into the community. Offenders are held in a prison designated to their area for at least three months before release.
- New payment by results incentives for CRCs to focus on reforming offenders.

Adult offenders managed by the new National Probation Service include all those who pose the highest risk of serious harm to the public – this group will include those subject to Multi-Agency Public Protection Arrangements. The new National Probation Service will continue to carry out assessments of the risk of serious harm posed by each offender and advise the courts and Parole Board accordingly. All other adult offenders will be managed and supervised by Community Rehabilitation Companies.

3.3 Our Local Drivers

Alcohol

Parental alcohol misuse – Parental alcohol misuse has a considerable negative effect on children, young people and the family. Children and young people experience poor outcomes due to parental alcohol misuse including foetal alcohol syndrome, school attainment, inferior health and wellbeing, neglect, greater likelihood of exposure to crime and alcohol-related domestic violence. In 2014/15 18.6% of initial child protection conferences in County Durham were as a result of parental alcohol misuse. Balance (the North East Alcohol Office) estimate that the number of children living with a parent(s) who drink at high risk levels in County Durham is 49,353.

Child Sexual Exploitation – Alcohol is a common vulnerability factor in incidence of child sexual exploitation and grooming. Alcohol increases risk taking behaviour, it can impair decision making processes and can reduce the ability to sense dangerous situations or people. This can also involve child victims and perpetrators exchanging sexual favours for alcohol. Young people often consume alcohol in private homes or

on or off the street, such as wooded areas and parks. Often this alcohol is purchased through 'proxy' sales, i.e. someone else purchasing the alcohol for them.

Alcohol consumption by young people – The amount of young people drinking in the UK is reducing (Health & Social Care Information Centre, 2014) and this is no different in County Durham. However, those young people who do drink alcohol are drinking more in volume and more frequently. Young people are more likely to experience poor outcomes due to their own alcohol consumption than any other age group. Alcohol related youth offending continues to be a focus for our Youth Offending Services and although we have seen reductions in this area we will continue to support interventions to reduce alcohol related offending by young people further.

Under-18 alcohol specific admissions – rates are significantly higher in County Durham than England. The rates are the 18th worst in the Country (LAPE, 2014).

Sexual health and teenage pregnancy – Evidence suggests that alcohol can contribute to misjudgements about sexual behaviour and alcohol consumption in young people is associated with an increased likelihood of having sex and at a younger age, of contracting sexually transmitted infections and teenage pregnancy. Teenage conception rates have reduced from 43.2 per 1,000 population of 15-17 year olds in 2012 to 33.7 in 2014, but remain higher than the national average of 27.7. (Joint Strategic Needs Assessment 2014).

<u>Domestic Abuse</u>

The main parental risk factor leading to a child being made subject to a child protection plan is domestic abuse. In County Durham the levels of domestic abuse related incidents reported to the police have seen a continuous but small increase since 2009/10. Domestic abuse continues to be under-reported. Plans to build on the Central Referral Unit were developed as part of the Early Help Strategy and resulted in the implementation of a Multi-Agency Safeguarding Hub (MASH) launched in March 2015.

In September 2013 Durham County Council commissioned Harbour to deliver a countywide domestic abuse service and a domestic abuse referral pathway was agreed and launched in December 2014 as part of the multi-agency 'Sorry's Not Enough' campaign. From April 2015 the countywide domestic abuse service was widened to provide a holistic service focussed on early intervention. The LSCB has links to the County Durham Domestic Abuse and Sexual Violence Executive Group (DASVEG) and we will continue to promote the need for domestic abuse services to support children, young people and their families.

Our annual training programme in relation to domestic abuse focuses on improving the understanding of risk factors; equipping practitioners with knowledge and skills to undertake effective risk assessment and ensuring practitioners and managers are clear about referral pathways and key points of contact. Over the last year the LSCB were challenged to improve the links and with other Strategic Partnerships. This has had a positive impact on Domestic Abuse training. Both the LSCB training and the Safe Durham Domestic Abuse training has been aligned and brought together with a multi-agency set of trainers now delivering the training.

Information Sharing

This remains an important issue highlighted in learning from Serious Case Reviews both nationally and locally here in County Durham. We will continue to keep a focus on information sharing supporting and promoting good practice across multi-agency teams.

3.4 Our Children

Our approach is to ensure strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting early help and support. In planning, resourcing, designing and managing our work there are some key facts that are of importance to us.

Looked After Children

When children become Looked After there are significant challenges in providing them with placement stability and improved outcomes and in equipping them for life beyond the care system. We know that by understanding the reasons for children become Looked After enables agencies to target their early help and family support services. Reduction in the number of children Looked After is a good indicator of the impact of our early help strategy.

The percentage of Children in Need referrals that occurred within 12 months of the previous referral has reduced from 27.4% in 2013/14 to a provisional figure of 22.8% in 2014/15, which is better than the 2013/14 national rate of 23.4%.

Child Protection Plan

Provisional data at 31 March 2015 indicates that 377 children were subject to a Child Protection Plan, a rate of 37.6 per 10,000 population. This is a reduction from 45.1 in March 2014 and is better than the March 2014 England average (42.1).

The percentage of Child Protection Plans that lasted two years or more is provisionally 0.9%, which is an improvement from the

previous year (2.1%) and is better than the 2013/14 national average (2.6%).

The most frequent reason for children being placed on a child protection plan in 2014/15 was **Neglect** (68.8%) with **Physical Abuse** (16.7%) being the second most significant reason.

The LSCB continues to respond to the issues of neglect and its impact on children and young people's wellbeing and outcomes. We have implemented the provision of specialist training for multi-agency practitioners supporting children identified as at risk or subject to neglect by their parent/carers. We have used improved national guidance and lessons learned from Serious Case Reviews to develop this training further and cover early help, child development and the long term impact of neglect on children.

As a Board we recognise the need to better understand the links between the impact of our training and professional practice on children's outcomes.

Parental Risk Factors

Domestic abuse continues to be the main parental risk factor leading to children becoming subject of a Child Protection Plan, accounting for **36% of child protection conferences** recorded for 2014/15. Parental alcohol misuse, substance misuse and mental health, are the next most common.

Opposite - Number of conferences with specified parental factor (percentage of all conferences, initial and review with specific risk factor recorded) during 2014/15.

	Initial conference	Review conference
Parental factors relating to mental health issues	37 (4.32%)	143 (16.71%)
Parental factors relating to domestic abuse	42 (4.91%)	308 (35.98%)
Parental factors relating to alcohol misuse	22 (2.57%)	159 (18.57%)
Parental factors relating to substance misuse	32 (3.74%)	157 (18.34%)
Parental factors relating to risk to children	12 (1.4%)	60 (7.01%)

In 2012, domestic abuse was identified as a priority for the LSCB and is now embedded into the Board's core activities. Specialist training continues to be provided for multi-agency practitioners and includes awareness raising sessions as well as more in-depth specialist sessions presented by specialist workers.

The Age of Children on a Child Protection Plan

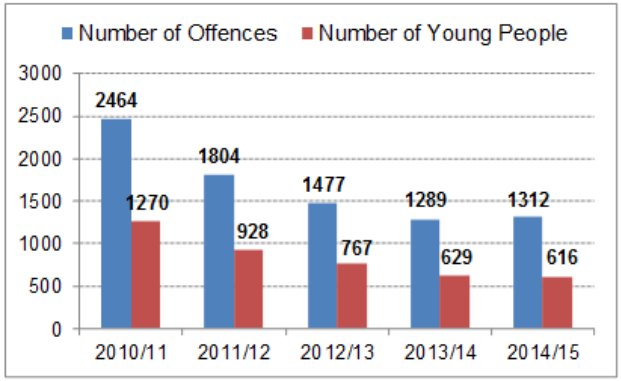
Age	Total	%
Unborn	7	1.9
< 1	42	11.1
1 to 4	115	30.5
5 to 9	132	35.0
10 to 15	76	20.2
16 to 17	<6	1.3
TOTAL	**377**	**100.0**

As shown in the table **43.5% of children** who were made subject of a Child Protection Plan **were under five years old**, (2014-15) indicating how vulnerable this age group is and indicating the importance of the Early Help strategy in engaging with families as early as possible.

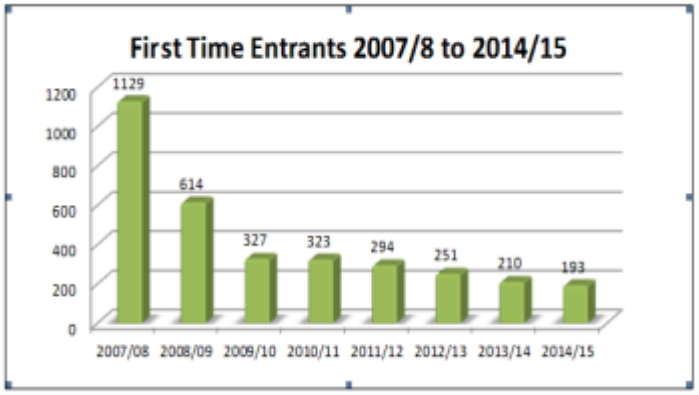
The LSCB continues to support the voluntary and community sector through the provision of targeted safeguarding training to Early Year's providers. This has led to better identification of vulnerable families and children at risk. We have also incorporated lessons learned from Serious Case Reviews into our training in order to support practitioners and managers to improve their understanding and assessment skills.

Youth Justice

Since 2010-11 there has been a **46.8% decrease** in the number of offences committed (2,464 to 1,312) and a **51.5% reduction** over the same period in the number of young people offending (1,270 to 616).



2014-15 saw a fourth successive year reduction in the number of young people offending, however a slight increase in the number offences committed, when compared to the previous year. The graph to the right shows the year on year reduction in young people offending and the reduction, since 2010-11, in the number of offences.



As a result of our integrated pre court/out of court system which provides assessment and intervention at a young person's first point of contact with the youth justice system (first offence), we have reduced first time entrants (FTEs) and re-offending.

Between 2007/08 and 2014/15 we have achieved **82.9% reduction** in first time entrants, from 1129 in 2007/08 to 193 in 2014/15.

Locally County Durham Youth Offending Service has been a key member of the local probation reforms transitional arrangements.

Section 4: Local Safeguarding Children Board Governance and Structure

4.1 Local Safeguarding Children Board

Each local area is required by Law to have an LSCB. The LSCB is a statutory body established in legislation (Section 13 of the Children Act 2004) and works according to national guidance, the most significant being the latest version of 'Working Together to Safeguard Children 2015'.

Our primary responsibility is to provide a way for the local organisations that have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children in the locality, and to ensure that they will do so effectively.

The functions of the LSCB are:

To develop policies and procedures for safeguarding and promoting the welfare of children in the area.

These could include:

- the action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention
- training of persons who work with children or in services affecting the safety and welfare of children
- the recruitment and supervision of persons who work with children
- the safety and welfare of children who are privately fostered
- having a clear strategy in place for tackling Child Sexual Exploitation
- co-operating with neighbouring children services and their Board partners

To raise awareness of both the need to safeguard and promote the welfare of children and action to so do

To monitor and evaluate the effectiveness of what is done by the local authority and their Board partners individually and collectively to safeguard and promote the welfare of children **and advise them on ways to improve**

To participate in the planning of services for children in the area of the authority

To undertake reviews of serious cases and advising the authority and their Board partners on lessons to be learned

The LSCB does not commission or deliver direct frontline services and does not have the power to direct other organisations, which retain their own existing lines of accountability for safeguarding. However, the LSCB does have a role in quality assurance making it clear where improvement is needed and where appropriate reviewing and challenging existing procedures.

To fulfil this role, the LSCB uses data to:

- Assess the effectiveness of the help being provided to children and families, including early help
- Quality assure practice, including through joint audits of case files involving practitioners and identifying lessons to be learned
- Monitor and evaluate the effectiveness of training, including multi-agency training

4.2 Linkages across other partnerships and services

The County Durham Partnership (CDP) is the overarching partnership for County Durham and is supported by five thematic partnerships, each of which has a specific focus:

- ***The Economic Partnership -*** Aims to make County Durham a place where people want to live, work, invest and visit whilst enabling our residents and businesses to achieve their potential

- ***The Children and Families Partnership -*** Works to ensure effective services are delivered in the most efficient way to improve the lives of children, young people and families in County Durham

- ***The Health and Wellbeing Board -*** Promotes integrated working between commissioners of health services, public health and social care services, for the purposes of improving the health and wellbeing of the people in the area

- ***The Safe Durham Partnership -*** Tackles crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and seeks to reduce re-offending

- ***The Environment Partnership -*** Aims to transform and sustain the environment within County Durham, maximising partnership arrangements to support the economy and the wellbeing of local communities.

4.3 LSCB Membership and Governance

The LCSB is a statutory partnership made up of local agencies. In County Durham there is a longstanding and high commitment amongst partner agencies to develop and improve arrangements to protect and safeguard children from harm and to share responsibility and accountability for those services. A membership list is attached at Appendix 1.

Durham LSCB has a Governance and Memorandum of Understanding in place and forms the formal agreement between the Board and all partner agencies. It outlines the accountability arrangements; key purposes; functions and tasks of the LSCB; membership; and agreed standards and expectations of LSCB services. The document also sets out the wider links with other key strategic partnership groups such as the Children & Families Partnership; the Health & Wellbeing Board and the Safe Durham Partnership.

In line with national requirements, the Board continues to be chaired by an independent person, an arrangement that has been in place since 2011. The Chair has a crucial role in making certain that the Board operates independently and secures an independent voice for the LSCB. Jane Geraghty became the new Independent Chair of the board in October 2014, and a new vice chair Gill Findley (Director of Nursing Durham Dales, Easington and Sedgefield CCG and North Durham CCG) took up post in May 2015.

The LSCB Business Unit has been realigned to Planning and Service Strategy within the Local Authority to develop the links with other partnership structures and strengthen the joint working on a range of strategies such as the County Durham Domestic Abuse Strategy, the Alcohol Harm Reduction Strategy and the Early Help Strategy.

4.4 LSCB Board Meetings

The Durham Local Safeguarding Children Board meets bi-monthly and attendance is monitored and reported annually as part of the Board's governance and effectiveness arrangements. Throughout 2014/15 the Board has been well supported by partner agencies. The membership of the Board is made up of the senior strategic leaders and managers of the partner agencies.

Action plans against priorities and performance are reported, monitored and challenged. Progress on Child Death Reviews and Serious Case Reviews are updated and completed Serious Case Reviews are published on the LSCB website for a period of 12 months. The findings and recommendations are disseminated to partners and any action plan coming out of a review is also monitored by the Board.

4.5 Learning and Improvement

Durham LSCB continually monitors the quality, timeliness and effectiveness of multi-agency practice through the LSCB Performance Management Framework. Where gaps are identified, implications for the LSCB are considered and progressed through business planning and the work of sub-groups.

We will continue to:

- Monitor partner compliance with the statutory requirement to have effective safeguarding arrangements in place (section 11)
- Apply the national Children Safeguarding Information Performance Framework, based on an 'Outcomes Based Accountability' approach asking three questions:
  - How much did we do?
  - How well did we do it?
  - Did it make a difference?
- Develop a series of scorecards for priority areas, e.g. CSE
- Develop a multi-agency Audit and Quality Assurance forward plan designed to provide much more information about the quality of work being undertaken and its impact on outcomes for individual children and young people.

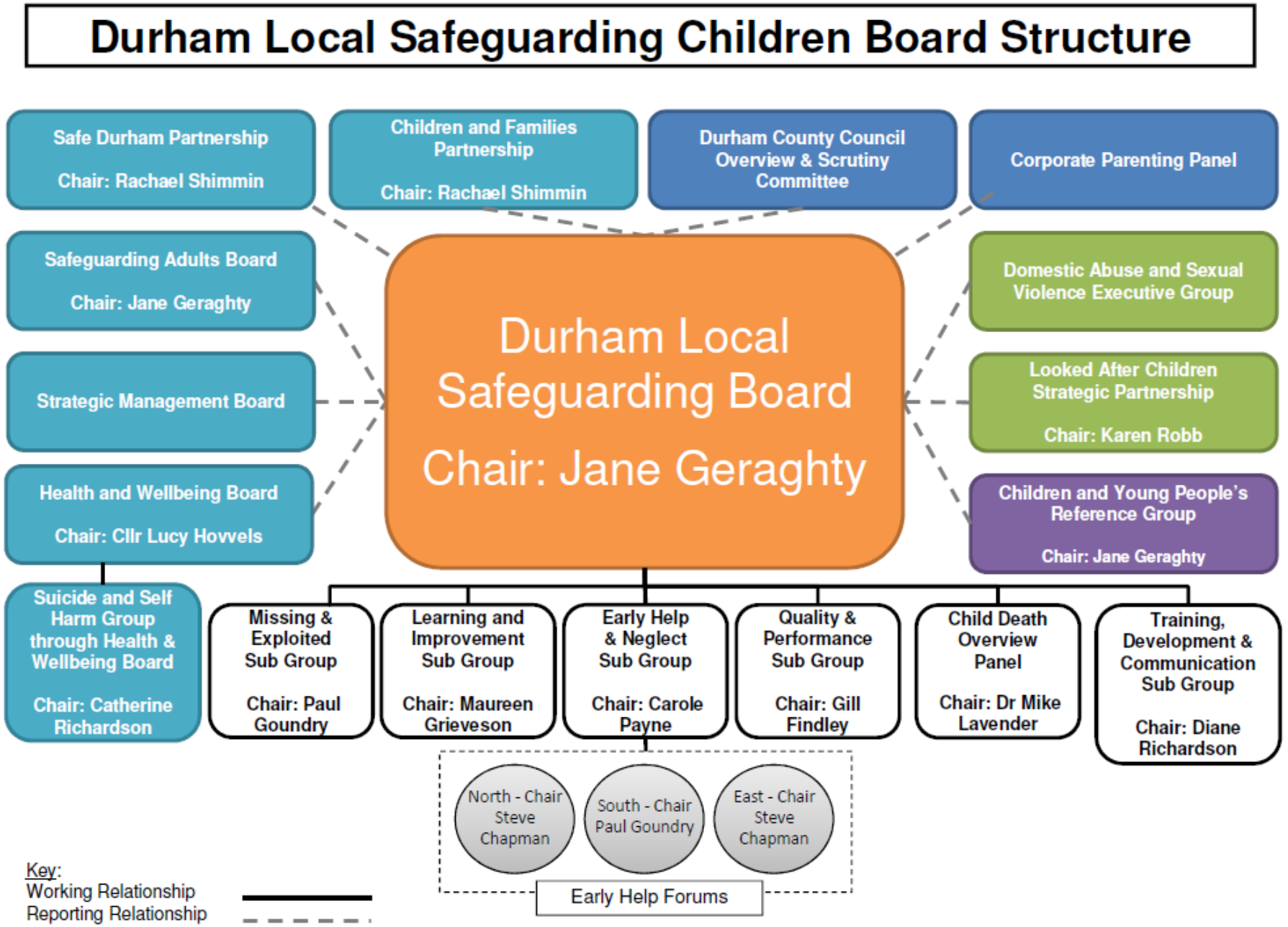
Outcomes and findings feed into our learning and improvement structures to promote a culture of continuous improvement across the LSCB.

In 2014 we have undertaken a range of steps to develop our practice to improve our effectiveness, building on and addressing the outcomes of our LSCB self-assessment and the feedback arising from the Local Government Association review of October 2014.

We continue to implement the recommendations from Serious Case Reviews and host learning events where key messages and the lessons learnt from the Serious Case Reviews we have published are shared with practitioners and agencies.

Child Death Overview Panel for Durham LSCB and Darlington LSCB Boards share key learning from child deaths. Action plans implemented and reviewed by the Child Death Overview Panel at each meeting.

4.6 LSCB Structure & Links to other Strategic Groups



4.7 Sub Groups

The LSCB has in place a number of sub-groups, taking forward the priorities of the Board.

Missing and Exploited Sub-Group (MEG) – This group focusses on monitoring activity and improving services and responses to reported missing and absent children and Child Sexual Exploitation.

Learning and Improvement Sub-group – This group considers serious incidents, commissions serious case reviews, oversees and monitors progress on agreed actions for specific local cases.

Quality and Performance Sub-group – This group oversees the quality and standards of safeguarding practice across the partnership to ensure that the LSCB fulfils its statutory function. Performance is monitored and analysis of the effectiveness of procedures is undertaken. The group also plans and monitors the LSCB audit programme.

Early Help and Neglect Sub-group – This group reviews and improves the referral pathways and access to help and support for families at an earlier stage of need and thereby reduce the number of families entering the system in crisis. This group supports three Early Help Locality Forums for a range of multi-agency practitioners.

Child Death Overview Panel (CDOP) – This is a joint group of both Durham and Darlington LSCBs. It has responsibility for reviewing the available information on all child deaths.

Training, Development and Communications Sub-group – This group reviews, plans and develops delivery of multi-agency training programmes using information from Learning Lessons Reviews, Serious Case Reviews and complaints as well as national and regional guidance. Lastly, this group has responsibility for the development and delivery of a LSCB Communication Strategy.

In addition are the following groups with links to the LSCB Board.

Children and Young People's Reference Group – This group has been set up to actively engage with children and young people and seek their views on a range of safeguarding issues.

Suicide and Self Harm Group – This group is a sub-group of the Health and Wellbeing Board with a relationship to the LSCB and tackles the causal factors for suicide, attempted suicide and self-harm, which incorporates children and young people.

Looked After Children Strategic Partnership – This group has a reporting relationship to the LSCB; it aims to improve educational achievements; to improve post 16 services and to improve the health and emotional well-being of looked after children and young people.

4.8 Equality and Diversity

The LSCB strives to promote equal access to safeguarding services, particularly for those children who are unable to communicate, due to their age, disability or first language, with those people or services that are able to protect them.

Policies and procedures of the LSCB are subject to an equality impact assessment to ensure that new policies and procedures do not discriminate on any basis.

Equality and diversity, challenging discrimination and values underpins the delivery of all LSCB training. LSCB training considers a broad range of issues such as parental mental illness, parental learning disability, substance misuse, child neglect, CSE and children who are deaf or disabled. It also recognises the impact of social disadvantage such as poverty, poor housing and worklessness. Durham LSCB also strives to ensure that its courses are open and accessible to all and create an environment where participants feel able to challenge and be challenged in a safe and constructive way.

The LSCB has a complaints review system in place for child protection conferences to ensure that where there is concern raised by parents and carers and young people, they will be treated with respect, are listened to and their views taken into account.

4.9 Working with other LSCBs

Durham LSCB works collaboratively with other Local Safeguarding Children Boards to share learning and agree safeguarding policies and procedures which impact on children and families and cross our Local Authority boundaries. This includes Cross Boundary Procedure for North East England LSCBs (children who move from one authority area to another), Child Deaths, Serious Case Reviews and lessons learned.

There is invaluable work across the region promoting good practice in areas such as training, policies and procedures and lessons learned. We are an active member of the LSCB Regional Business Managers Group. Our regional priorities will focus on key issues of child sexual exploitation and neglect.

Section 5: Achievements and progress against 2014/15 Priorities

5.1 LSCB Priorities 2014/15

The 2013/14 Annual Plan identified the following priorities:

- Early Help
- Information Sharing
- Parental issues of Domestic Abuse, Alcohol and Drug Misuse and Mental Health
- Tackling Child Sexual Exploitation;
- Strengthening our engagement with children and young people
- Supporting the new arrangements for the delivery of children's services
- Development and self-improvement of the LSCB Board

5.2 Achievements and Progress Highlights

- Development of the Early Help Strategy and sharing with the Children and Families Partnership
- The introduction of a County Durham Multi-Agency Safeguarding Hub (MASH)
- Development and implemented the 'Collaborative working and information sharing between professionals to protect vulnerable adults and children' information sharing protocol
- Developed a Safeguarding Framework to improve links with Health & Wellbeing Board, Children & Families Partnership and Safe Durham Partnership and to align Domestic Abuse, Alcohol and Drug Misuse and Mental Health work
- Development of a CSE Strategy and delivery plan
- Developing and implementing a CSE audit and sharing the information through other council and partnership structures
- Supported 'Never Do Nothing' training (a safeguarding standard for voluntary and 3rd sector organisations)
- Set up a Young People's Reference Group for the LSCB

- The LSCB and the Safe Durham Domestic Abuse training has been aligned and brought together with a multi-agency set of trainers now delivering the training
- LSCB support to Childrens Services innovations funding bid, training programmes, single assessment and Think Family
- Reviewed the leadership of the LSCB and appointed new Chair, Vice-Chair and Business Manager
- Appointed two new Lay Members to act as an independent voice
- Review of the governance of LSCB sub-groups, each of which is now chaired by a LSCB partner member
- Developing a new LSCB website, with input from young people

5.3 Challenge and Impact

Here we provide examples of challenges raised by the LSCB, the resulting progress and the impact this has had on delivery of services and improvements in safeguarding.

In the development of the Early Help Strategy we challenged partners to improve the early help responses within the Central Referral Unit. The impact of this challenge was the development of a successful police innovation funding bid resulting in the implementation of a County Durham Multi-Agency Safeguarding Hub (MASH) launched in March 2015.

A recommendation of the Local Government Association (LGA) peer review challenged the LSCB to improve the links with wider strategic partnership structures. Over the last year we have clarified and improved the LSCB Board's relationship to other strategic partnerships across County Durham. This has already resulted in closer working arrangement such as the Domestic abuse worker now based in the MASH; the development of a Domestic Abuse Referral Pathway and alignment of Training Programmes, the LSCB training and the Safe Durham Domestic Abuse training has been aligned and brought together with a multi-agency set of trainers now delivering the training.

We have contributed into the draft County Durham Alcohol Harm Reduction Strategy and the draft Safe Durham Domestic Abuse and Sexual Violence Strategy. In addition we have been able to utilise wider partnership resources and structures to improve an LSCB response, for example; we have linked the LSCB Self-Harm priority to the work of the Health and Wellbeing Board (HWB) sub-group who are already addressing this issue. This has had the added impact of improving the visibility and influence of the LSCB Board.

A challenge from the Chair of the LSCB was to improve the voice of the child. This has resulted in collaborative work with 'Investing in Children' and the development of the Young People's Reference Group for the LSCB. These young people have met with members of the

LSCB on a number of occasions and their views have been taken into account in the LSCB work plan and our priority setting arrangements. An example of a direct impact of listening to these young people is the inclusion of the self-harm priority for the LSCB 2015-16.

Partners were also challenged in relation to work on Child Sexual Exploitation (CSE) which resulted in a CSE audit taking place to identify numbers and risk factors.

Responding to Working Together guidance's stating volunteer staff need to be aware of their responsibilities for safeguarding and promoting the welfare of children the LSCB have proactively supported the 'Never Do Nothing' training across County Durham. Never do nothing is a safeguarding standard for voluntary and 3rd sector organisations to promote good practice in the safeguarding of children and young people. It provides guidance for individuals; staff, volunteers, carers, etc as well as providing a framework for delivery of safeguarding within any organisation, within any sector – so that no-one is left in any doubt as to what action to take when they have a concern about the welfare of a child or young person in County Durham.

Challenge also takes place at a very senior level through a Chief Officers Safeguarding Group which includes the County Council's Chief Executive, Independent Chair of the LSCB, Corporate Director of Children and Adults Services, Chief Officers of the Clinical Commissioning Groups, the local NHS Foundation Trust and Police Constable as well as other senior managers. This forum allows the opportunity to challenge and share information to ensure line of sight on safeguarding issues including:

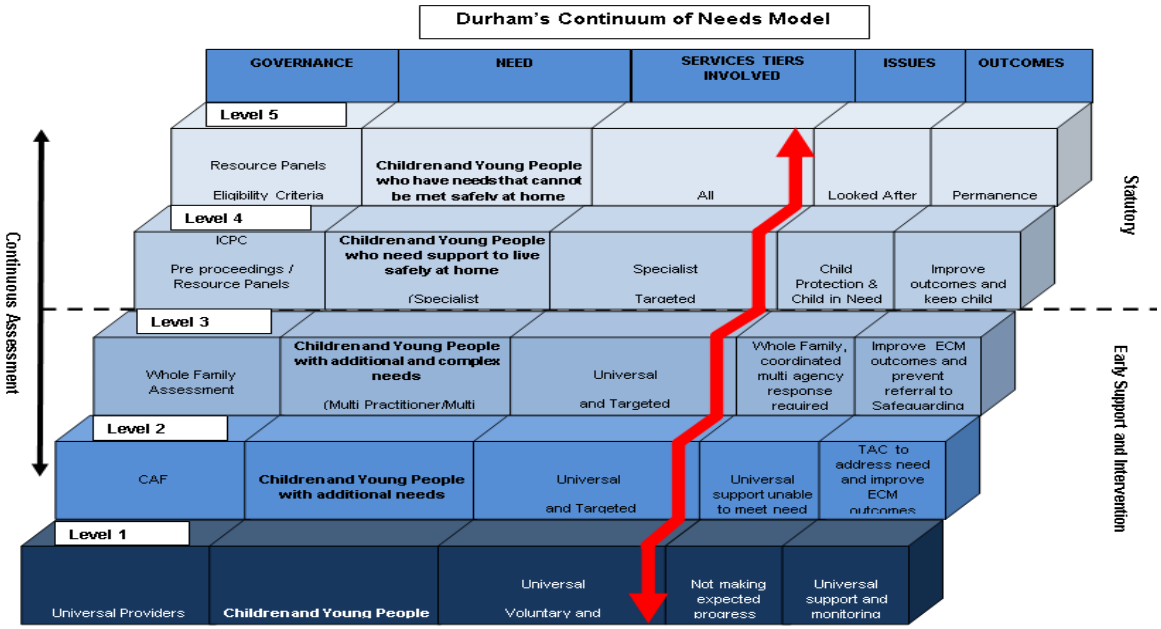
- Child Sexual Exploitation and the commitment to provide additional resources from the Police
- Ensure training programmes are joined up with the LSCBs
- Ensure quality of front-line practice
- Share outcomes of multi-agency audits and action plans

5.4 Progress on LSCB priorities 2014/15

Early Help

The LSCB recognises early help as a key priority area for making significant impact on outcomes for children. 'Working Together 2015' identifies this as an area where LSCBs need to bring more challenge to partners to demonstrate that families are receiving help at an earlier stage and before matters escalate. Partners have responded to the challenge to develop strategies that shape and deliver services in a number of new ways. These include: The Early Help Strategy; a strong continuum of needs framework and the local authority re-design of children's services.

We have worked alongside the Children and Families Partnership to help develop an Early Help Strategy and Action Plan. Our role will continue to be one of challenging partners as to what changes they are making to the way they deliver services to children and families to make them more child centred, more responsive and available at a much earlier point to prevent problems escalating.



The Durham Continuum of Needs Model is designed to reflect the fact that children and young people's needs and those of their families exist along a continuum. The model recognises that needs may change over time and is based on the principle that children and young people's welfare and safety is a shared responsibility and should be a seamless positive journey. Regardless of which 'step' children, young people and families are identified on they will be supported at the earliest opportunity and continue to be supported by the relevant services as they move up and down the staircase.

Through the Stronger Families' programme we have engaged with our offender management structures. Durham Constabulary, Durham Tees Valley Community Rehabilitation Company, Youth Offending Services and Anti-social Behaviour Teams are all fully involved in this work. The second phase of the 'Troubled Families' programme will identify and support families over a wider range of need, one being 'Parents and Children Involved in crime or anti-social behaviour'. This will enable teams to reach not only families where there is a young person involved in crime or anti-social behaviour, but to include adult offenders who have parenting responsibilities.

In terms of safeguarding arrangements outcomes for children and families it is expected that more families will receive help at an earlier point and be empowered to take control of their own lives, avoiding the need for statutory intervention. We look to see a reduction in the number of Children In Need, Look after Children and children subject to a Child Protection Plan.

Impact of the Early Help Strategy can be seen through a range of activity; the development of the Multi-Agency Safeguarding Hub (MASH); Early Help Forums are now up and running across the County. The forums will be used as a line of communication between the LSCB and front line practitioners; 'Never Do Nothing' training (a safeguarding standard for voluntary and 3rd sector organisations); the new single

assessment practice guidance underpins the work across children's services and is now in use alongside a range of practice tools. Multi agency audits continue to be driven by the LSCB and a new audit process within children's services was introduced in June 2014.

Early Help has started to be recognised in everyday practice as crucial to achieving positive outcomes for children and their families. Early Help is now written into many policies, plans and strategies across the Durham partnership.

Information Sharing

This remains an important issue highlighted in learning from Serious Case Reviews both nationally and locally here in County Durham. In 2014 the LSCB developed and implemented an information sharing protocol called 'Collaborative working and information sharing between professionals to protect vulnerable adults and children.' This protocol has also been shared with wider safeguarding arrangements and has been approved by both the LSCB and the Safeguarding Adults Board and endorsed through single agency governance arrangements.

The protocol captures the existing guidance on information sharing and signposts professionals that their safeguarding responsibilities carry with it an expectation that information sharing is the norm. The main emphasis is to ensure information is shared to enable children to be better safeguarded and families offered early help. The protocol is supported by a guidance document for professionals, which is made available as part of LSCB training. In 2015 we will review and revise the protocol to ensure compliance with the latest version of 'Working Together' published in March 2015 and the Care Act 2015.

Parental issues of Domestic Abuse, Alcohol and Drug Misuse and Mental Health

Domestic abuse continues to be the main parental risk factor leading to children becoming subject of a Child Protection Plan. Parental alcohol misuse, substance misuse and mental health, are the next most common. These parental risk factors are discussed in greater depth in section 3.3 'Our Local Drivers'.

Probation reforms have led to a greater focus on rehabilitation and tackling the critical pathways of offending. It is no surprise these align directly with the parental risk factors above. The National Probation Service and Durham Tees Valley Community Rehabilitation Company continue to become more involved in this area of work as they adapt delivery of services to improve the management of offenders in areas such as 'Through the Gate' provision (rehabilitation and resettlement in the community); exit strategies after statutory supervision and pathways into mainstream services and transitional arrangements for young people who offend. Other project such as the 'Checkpoint' (offender diversion scheme) contribute to tackling parental issues of Domestic Abuse, Alcohol and Drug Misuse and Mental Health and as a result impact positively on the outcomes for children.

Child Sexual Exploitation (CSE)

Child Sexual Exploitation can have a serious long-term impact on every aspect on children's lives, health and education. It damages the lives of families and carers, which can lead to family break-ups.

There are strong links between sexual exploitation and those young people who are reported missing from home. Recent analysis conducted by Tasking and Coordinating (Missing From Home Summary Report – Early Findings February 2015) highlighted a range of risks associated with missing including sexual exploitation, mental health, alcohol or drugs issues with motivation for missing including family conflict or relationship issues. The offender profile is one of 'street grooming' and use of social media to exploit children.

We have developed a CSE Strategy and Action Plan to detect, prevent and disrupt all forms of Child Sexual Exploitation including online child abuse as well as contact offences. The Missing from Home (MFH) and Child Sexual Exploitation (CSE) procedures focus on early identification and prevention meaning we identify children at risk and work to reduce this risk, rather than waiting for harm to occur before we act.

Durham was successful in a bid to the Governments Children's Social Care Innovation Fund 2014/15 for a therapeutic support programme at Aycliffe Secure Centre for children who have been sexually exploited. This will offer targeted support in helping young people deal with trauma and in making the transition from the secure setting into more independent living.

We have also developed a CSE Disruption Toolkit allowing practitioners to highlight to the police risk factor behaviour around potential perpetrators. The use of this toolkit continues to be promoted in presentations and awareness raising events.

Durham Constabulary has become the first Force in the UK to adopt a new training package aimed at protecting children from abuse. 'Intervene to Protect a Child' (IPC) is a new and proactive training tactic which has had significant success in the United States. Early successes in Durham indicate the potential this training can have on protecting children from abuse. The Transforming Rehabilitation agenda (probations reforms) have enabled offender managers greater collaboration with Multi-Agency Safeguarding Hubs and Missing and Exploited Group. Hundreds of police officers and other agency staff such as teachers, neighbourhood wardens and probation officers have been trained in this innovative technique. In 2014/15 we have also:

- Carried out LSCB audits for both CSE and missing children incidents to assess child protection practice and improve outcomes for children who go missing
- Undertaken an audit of responses for named suspects

- Developed a CSE marketing strategy
- Created the 'ERASE' brand (Educate and Raise Awareness of Sexual Exploitation) to tackle child sexual exploitation (ERASE offers parents and carers advice on how to communicate with their children about who they speak to on-line and off-line)

Agencies continue to work together to tackle CSE and planned actions for 2015/16 include:

- A dedicated ERASE team will be piloted and launched in August 2015 and will include a Detective Sergeant, two PCSOs and an Admin Support Officer. This team will focus on early identification of young people at risk and suspected offenders and use problem solving tactics to address CSE
- Widen our training and awareness to those services not traditionally associated with safeguarding e.g. taxi drivers
- Development and launch of an 'ERASE' website
- Develop transitional arrangement with Safeguarding Adults Board for those young people reaching their 18th birthday, who remain vulnerable to sexual exploitation
- Develop stronger relationships with communities through Area Action Partnerships (AAP), raising awareness of CSE and how to report concerns or intelligence of CSE
- Actively engage young people within identified vulnerable groups at risk of CSE (for example, lesbian, gay, bisexual or transsexual, and special needs) that face additional barriers around reporting and support

<u>Strengthening our engagement with children and young people</u>

The LSCB actively engages and seeks the views of children and young people on wider safeguarding issues.

We have continued to improve the way we involve young people, throughout 2014/15 we have worked collaboratively with 'Investing in Children' to set up a Young People's Reference Group for the LSCB. These young people have met with members of the LSCB on a number of occasions and their views have been taken into account in the LSCB work plan and our priority setting arrangements.

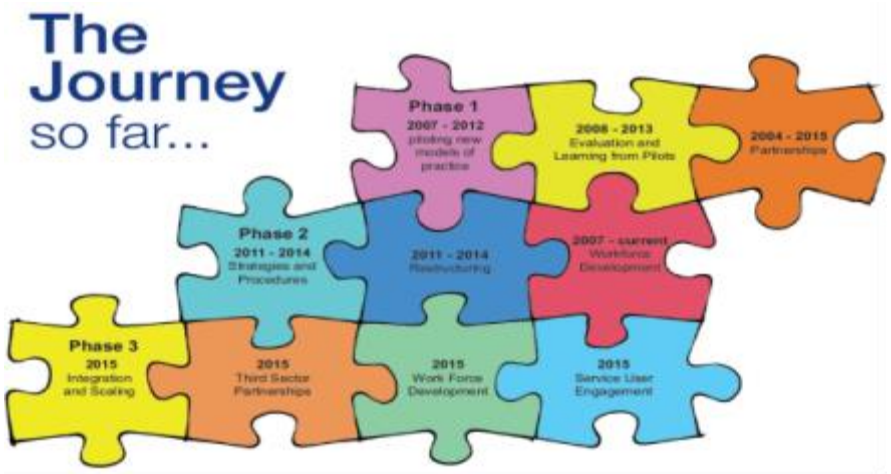
Staff from the LSCB have conducted community visits alongside these young people to see first-hand their concerns. A direct impact of listening to these young people has been the inclusion of the self-harm priority for the LSCB 2015-16.

Working with young people and local communities is a key area for the LSCB to take forward into 2015/16. This direct link to young people in their own communities and understanding the 'voice of the child' has brought a positive and different perspective into the LSCB Board, listening to what young people tell us and acting upon it. We will continue and widen our engagement with young people and will work towards achieving Investors in Children status in 2015.

We will also create a more cohesive link with Area Action Partnerships to encourage communities to be more 'safeguarding of children and young people' focused and promoting safeguarding is everyone's responsibility.

<u>Supporting the new arrangements for the delivery of children's services</u>

Durham County Council Children's Services is on a journey of major transformation and has completed two phases of that work. The vision is being delivered through a transformational change programme.



The programme consists of three main phases:

1. Piloting of new service forms – reflection and learning 2009/12
2. Service transformation, policy and procedure development – 2013/14
3. Service reform based on learning from phases 1 and 2 – 2015/16

Phase 1 and Phase 2 have already been delivered.

Durham was successful in a bid to the Government's Children's Social Care Innovation Fund 2014/15. The funding will allow Children's Services to build on the progress they have already made to date and accelerate developments more quickly than we would otherwise have been able to do without this significant additional investment. The Project is underpinned by a significant programme of workforce development designed to create a new culture by developing new skills and attitudes, through training, mentoring, clinical consultation and challenge.

The main innovative elements of Durham's Project are:

- Creation of 10 integrated teams (Families First) across the County, focussed on early help and significantly increasing the range, access, quality and effectiveness of services for the whole family across the continuum of need
- Creation and development of third sector alliances to build community capacity and sustainable change for families
- An intensive workforce development programme to support the new teams and the whole workforce

- Significantly enhanced service user engagement to change the relationship between professional and service user

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

Three child protection teams will continue working with children subject to Child Protection Plans and children in care proceedings and a Looked After Children's Team will work with children with permanence plans. We hope to see:

- A reduction in the number of Look after Children
- A reduction in the number of children subject to a Child Protection Plan
- More Children and families receiving Early Help
- Improved social work practice

An independent evaluation will commence in March 2016.

Development and self-improvement of the LSCB Board

The LSCB Board recognises the importance of self-improvement, to be effective it needs to continuously learn from its own experiences and that of others. Building on and addressing the outcomes of our LSCB self-assessment and feedback arising from the LGA review of October 2014 we have:

- Revised our performance indicators and implemented a new dataset to better reflect priorities
- Appointed two lay members
- Strengthened the scrutiny / challenge role and developing a framework for evidencing impact and difference
- Strengthened the engagement and participation of children and young people in the work of the Board
- Clarified the Board's relationship with other partnership forums
- Improved the visibility and influence of the Board
- Strengthened the engagement and participation of frontline staff including involvement in audit work

We have undertaken a range of steps to develop our practice and values to improve our effectiveness - keeping the child's journey at the forefront of what we do. In addition, we have clarified our business objectives and aligned our LSCB operations against our objectives.

Section 6: Performance Monitoring and Quality Assurance

6.1 Performance Monitoring and Quality Assurance

Durham LSCB's primary responsibility is to provide a way for local organisations that have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children in the locality, and to ensure that they will do so effectively. Our Performance Monitoring Framework and quality assurance plan monitor and developed these arrangements.

In the last year we have continued to monitor and develop Section 11* auditing covering the following organisations:

- Durham Constabulary
- North Tees and Hartlepool Hospitals NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- County Durham Youth Offending Service
- Durham County Council Children's Services
- Durham Dales Easington and Sedgefield Clinical Commissioning Group
- North Durham Clinical Commissioning Group
- Hassockfield Secure Training Centre (up to Oct 2014)
- National Probation Service (Durham)
- Durham Tees Valley Community Rehabilitation Company
- Children and Families Court Advisory Support Services
- County Durham and Darlington Foundation Trust

We have also carried out LSCB audits for both CSE and missing children incidents to assess child protection practice and improve outcomes for children who go missing and undertook an audit of responses for named suspects.

*Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions – and any services that they contract out to others – are discharged having regard to the need to safeguard and promote the welfare of children. The LSCB provides a statutory function of auditing the Board's partner organisations to ensure their compliance to this statute.

6.2 Quality Assurance Forward Plan

In 2015/16 we will:

- Develop an on-line version of Section 11 audits
- Review governance arrangements
- Review Memorandum of Understanding
- Develop consistent use of auditing tools and processes
- Identify and develop areas for auditing
- Develop reporting formats to include case studies and make the voice of the child more visible
- Develop additional 'Quality' reporting to include areas such as complaints, serious case reviews and child death overview monitoring

6.3 Safeguarding Privately Fostered Children

The LSCB Board monitors the local arrangements for safeguarding children who are privately fostered. The Board includes specific data in its 'Top Ten' performance indicator list and on an annual basis is provided with a full report setting out the Local Authority's strategy and specific arrangements to raise awareness in the community, monitor and support children and young people who are in such placements.

6.4 The Use of Restraint – Safeguarding Young People in Secure Settings

County Durham is among a small number of Councils who have secure services within its boundaries. In 2014/15 the Youth Justice Board (YJB) took the decision to close Hassockfield Secure Training Centre, this means only partial data for this centre can be provided. The LSCB also monitors the use of restraint at Aycliffe Secure Services Centre. Many of the children are placed by Local Authorities outside the area

and by the criminal courts. Since 2011 and in line with Working Together guidance we have reported on the use of restraint in the two secure settings within County Durham.

Hassockfield Secure Training Centre

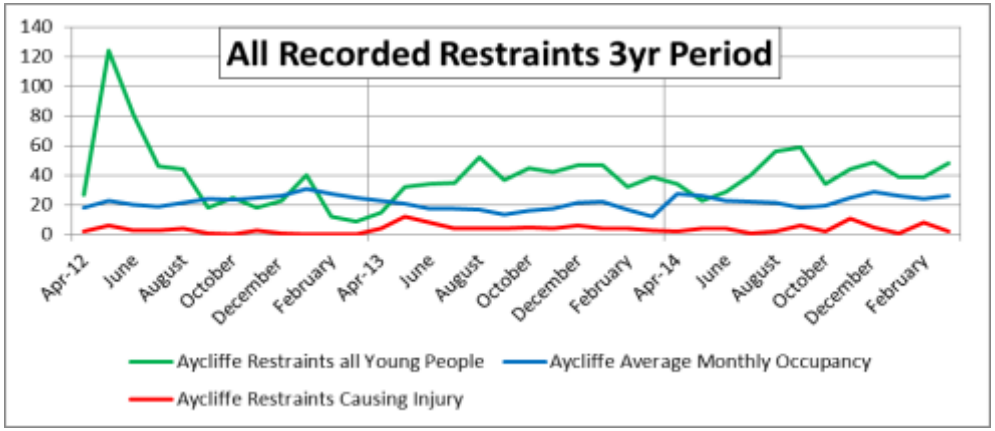
Month	Hassockfield Restraints all Young People		Hassockfield Restraints Causing Injury		Hassockfield Average Occupancy	Hassockfield Occupancy at 1st of Month
	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
April	89	61	17	6	45	55
May	65	19	9	1	42	43
June	75	32	11	4	42	37
July	43	47	6	3	42	38
August	45	28	3	5	45	41
September	45	36	5	3	42	32
October	58	18	3	0	50	32
November						
December						
January						
February						
March						
TOTAL	**420**	**241**	**54**	**22**		
Average per month	**60**	**34.4**	**7.7**	**3.1**	**44**	**39.7**

Table 1: Total Incidence of Restraints and Restraints causing Injury: ***(April 2014 – Nov 2015 & the previous period for comparison.)***

This centre was closed in November 2014. Hassockfield catered for up to 58 young people, male and female. Young people lived in four separate house blocks with three of the 'house' blocks having two residential living units.

During the last reporting period, up to the point of closure, the gender occupancy ratio was consistently a little over 2:1 (annual totals - male 232:109 female). However, incidents of restraint by gender were closer to 4:1 (annual totals - male 19:50 female).

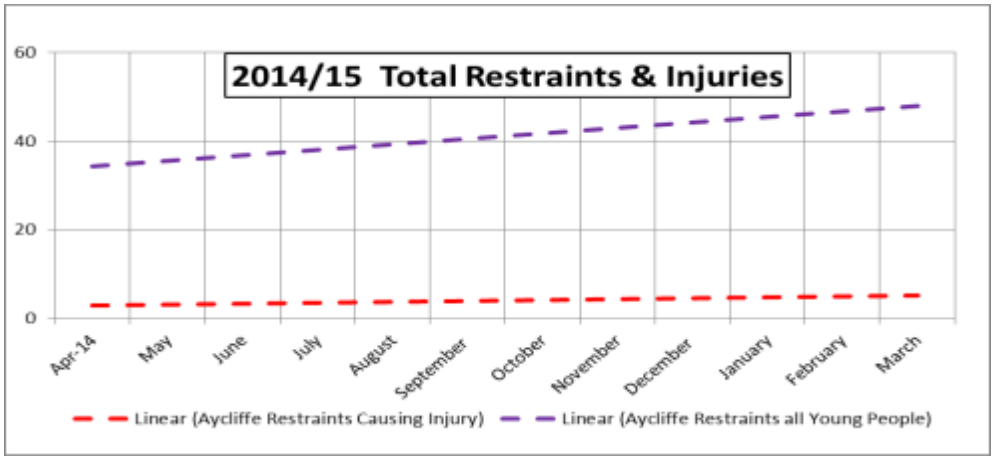
Aycliffe Secure Services Centre



Aycliffe Secure Services Centre is licensed by Ofsted for up to 42 places. The centre has five secure children's homes and a step-down facility with 24 beds commissioned by the Youth Justice Board. Local Authorities can also commission places for young people on welfare grounds if the courts decide that young people meet the legislative criteria required to place them in a secure setting.

The trend of restraint incidents has stayed consistent with a very slight downward direction of travel during the three year period shown in graph above. Peaks most often occuring around late Summer and the Christmas holiday periods.

The trend of restraint incidents leading to injury has also maintained a consistent level but with a slight upward trend in the 2014/15 reporting period.



The trend over the course of the reporting period (2014/15) defies the longer term trend with an upward direction, however, during this period there have been 107 Restrictive Phyisical Intervention (RPI) incidents relating to a single individual. As a statistical outlier, incidents relating to this young person represent 22% of all the incidents at the centre during the reporting period. This rate of incidence is high, even amongst other high incidence individuals.

Overall, there was a total of 111 different young people at Aycliffe between April 2014 and March 2015. 74 young people (66.7%) were required to be restrained in this period. Nine young people were responsible for 50% of the RPI's with 12 young people being restrained ten or more times during their stay at Aycliffe.

6.5 Serious Case Review Function

We have commenced five Serious Case Reviews in 2014/15. There are a number of recurrent themes running through these reviews:

- Parental misuse of substances or alcohol
- The role of males within a family setting / household who have contact with children and young people
- Multi-agency engagement with safeguarding processes
- Information sharing

These themes are reflected in national findings for Serious Case Reviews published in 2014/15.

We continue to implement the recommendations from Serious Case Reviews both multi-agency and single agency recommendations. Action plans are reviewed by the Learning and Improvement Group bi-monthly.

In 2015 we will host a range of learning events where key messages and the lessons learnt from the Serious Case Reviews we have published will be shared with practitioners and agencies. We will also present progress against Serious Case Reviews action plans.

The LSCB will continue to challenge agencies to demonstrate that they have implemented the learned lessons.

6.6 Child Death Review Function

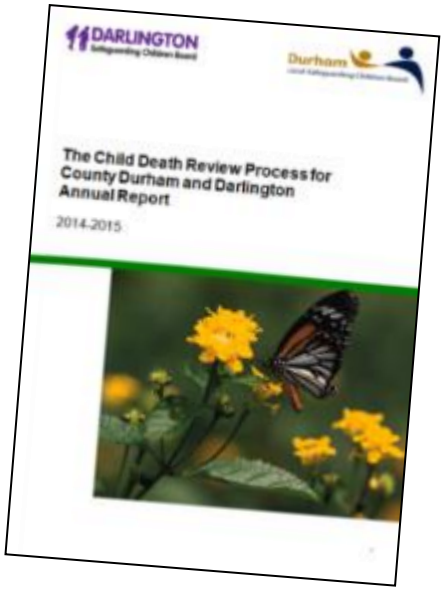
There are two interrelated processes for reviewing child deaths:

1. Rapid Response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death; *and*
2. An overview of all deaths up to the age of 18 years (excluding both those babies that are stillborn and planned terminations of pregnancy carried out within the law) in Durham and Darlington areas, undertaken by a panel

Child Death Review Notifications

There were 31 child death reviews in County Durham between 1 April 2014 and 31 March 2015. Of the 31 child deaths there were:

- 25 Rapid Responses (this is a process for gathering key professionals to enquire into and evaluate circumstances of an unexpected death)
- 20 deaths that have been or will be considered at a Local Case Discussion meeting (for most unexpected deaths a local case discussion takes place when all the information has been gathered and all agencies involved with the child and family before and at the time of their death are invited to the meeting.)
- 17 deaths reviewed at Panels during 2014/15 (the Child Death Overview Panel's purpose is to conduct an overview of all child deaths)
- 21 child deaths are ongoing reviews and will be brought forward to 2015/16



Child Death Overview Panel (CDOP)

Between April 2014 and March 2015 there were six Child Death Overview Panels in which 44 cases were reviewed. At each Child Death Overview Panel, the Designated Doctor for Child Deaths presents the circumstances of each death to the multi-agency panel. The case is reviewed in detail and recommendations/actions logged for monitoring purposes.

The CDOP were of the view that there were 15 deaths in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of locally or nationally achievable interventions, could be modified to reduce the risk of future child deaths.

Out of the 44 Child Death Reviews completed, nine Local Case Discussions were presented at the Child Death Overview Panel.

Timescale for Child Death Review Completion

Out of the 44 completed reviews, 20% were completed in less than six months. This is an increase from 9% in 2013-14. A large majority of reviews that were 'carried forward' from an earlier period were completed during 2014/15. We will continue to work together to complete reviews in a more timely way.

Key learning from child deaths

A thematic review was undertaken during the 2014/15 operating period of all child deaths and the findings presented at the Child Death Overview Panel and Durham LSCB and Darlington SCB Boards. As a result an action plan was formulated and is reviewed by the Child Death Overview Panel at each meeting to ensure that all actions have been completed.

The following themes were identified:

- Perinatal and infant deaths
  - CTG training (electronic foetal monitoring during labour)
  - Consultant presence on obstetric wards
  - Awareness of risk factors to prevent Sudden Infant Death (SIDs)
- Other child deaths
  - Mandatory training in paediatric resuscitation
  - Consultant assessment in children with complex health problems
  - Emergency care plans for children with complex health problems

6.7 Policy and Procedures

Durham LSCB proactively reviews policies and procedures as systems change and are developed. These form part of the work undertaken with Early Help, Children Services Transformation and Child Sexual Exploitation to name a few.

Others include:

- Updated Single Assessment Framework and thresholds document to support new ways of working and focussing on early help
- Re-alignment of LSCB sub-groups to match priorities
- Safeguarding Framework - Improved links with Health & Wellbeing Board, Children & Families Partnership and Safe Durham Partnership
- Taking forward recommendations of LGA peer review
- Strengthening the influence of the board in key areas, particularly schools
- Clarification of the role and contribution of students attending child protection conferences

Building on the outcomes of our LSCB self-assessment and feedback arising from the LGA review we have aligned our LSCB operations against our objectives and re-alignment the LSCB sub-groups to match priorities. The Policy and Procedures group was disbanded in January 2015 as part of this re-alignment and the policy and procedures function has passed to the LSCB Business Unit.

As the new arrangements for the delivery of Children Services continue to be implemented in County Durham we will review and update our procedures accordingly. These will include Child Protection Procedures; Single Assessment Procedures; Missing Children Procedures and Families First Procedures.

Section 7: Training

7.1 Single and Multi-Agency Training Provision

All agencies working with children either directly or indirectly are required to provide training in order to carry out their own roles and responsibilities. This includes being able to recognise and raise concerns about children's safety and welfare. The current LSCB training group work plan includes a requirement to monitor single-agency training, undertake a training needs analysis and evaluate the impact of both single-agency and multi-agency training.

We have reviewed the Domestic Abuse training programmes of the LSCB training and the Safe Durham with the result that Domestic Abuse training has been aligned and brought together with a multi-agency set of trainers now delivering the training.

In March 2014 the LSCB Board agreed that it had a significant role in supporting the Local Authority in the delivery of training relating to the transformation of Children Services. During the year the LSCB training programme has seen an increased collaboration with a range of organisations; most notably the County Council's Learning and Development Team; County Durham & Darlington NHS Foundation Trust; Tees Esk and Wear Valleys NHS Foundation Trust, Durham Constabulary and Barnardos; in the planning, design and delivery of training. This has strengthened and enhanced the quality of training while avoiding duplication and promoting the importance of inter-agency working.

7.2 Training Programme

The purpose of the LSCB multi-agency training is to support staff and volunteers to achieve better outcomes for children and young people by fostering:

- a shared understanding of the tasks, processes, principles, roles and responsibilities outlined in national guidance and local arrangements for safeguarding children and promoting their welfare
- more effective and integrated services at both the strategic and individual case level
- improved communication and information sharing between professionals, including a common understanding of key terms, definitions and thresholds for action
- effective working relationships, including an ability to work in multi-disciplinary groups or teams

- sound child focused assessments and decision-making
- learning from Serious Case Reviews (SCRs) and reviews of child deaths

All new and existing courses were updated in line with Durham's Single Assessment procedures.

7.3 Courses delivered in 2014/15

A total of **84 courses** were held throughout the year and were attended by **1,580 staff and volunteers**. The courses with the highest total attendance over the year were:

- Safeguarding Processes
- Assessment and Intervention
- Engaging with Families
- Child Sexual Exploitation
- Neglect

Overall, 75.2% of the 84 courses delivered were filled to capacity; of those participants offered a place 16.4% cancelled and 11.1% did not attend without notice. Of those applicants attending a LSCB training course, 72.8% were offered a place on the course they applied for, however 19.9% of these applicants still cancelled their places indicating that access to preferred courses is not the cause of cancellations.

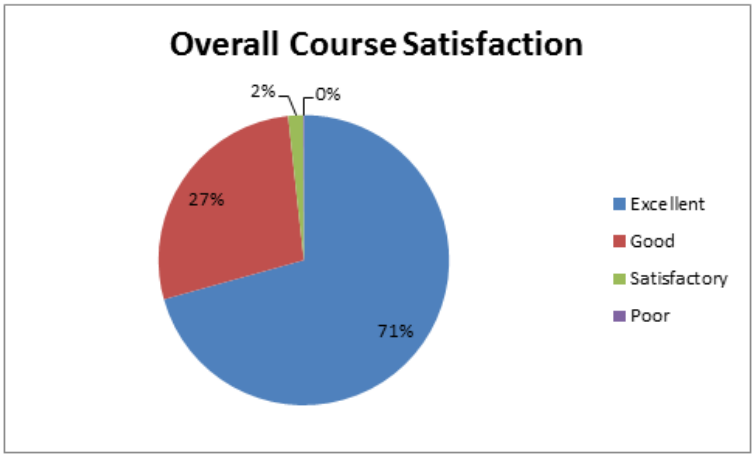
Courses were well attended by services such as One Point, Durham County Council Children Services, County Durham and Darlington NHS Foundation Trust and the Voluntary Sector. Attendance from Police, School staff and Adult Services (who all have key objectives in protecting children) has been low and this low attendance will be addressed in 2015/16.

7.4 E-learning

Currently three e-learning courses are available on the Durham LSCB website; Awareness of Child Abuse and Neglect (ACAN), Safeguarding Children from Abuse by Child Sexual Exploitation (CSE) and PREVENT – Counter Terrorism awareness. Over the last year **1,707 people** have accessed and passed the ACAN course and **2,090 people** have accessed and passed the CSE e-learning.

7.5 Training Evaluation

Evaluation sheets for all training delivered by Durham LSCB are completed at the end of each training session. The training courses received very positive feedback with 71% of attendees marking the training they received as excellent. The chart opposite illustrates overall satisfaction levels of the courses delivered throughout 2014/15.



Follow up evaluations are carried with staff in the three months after attending a training session to assets the longer term benefits of training. 100% of those surveyed stated that the training had fulfilled their personal objectives set within the training and 81% of those surveyed agreeing that the learning from their training had improved outcomes for their clients.

'The course gave a clear picture of the process and actions needed by other professionals prior to the case being allocated to a social worker.'

'I feel able to explain the purpose of my assessment to the family which promotes their confidence to share their circumstances with me.'

'I am now more able to support the child / young person as I am now more aware of the long term effects Neglect has on them.'

'Greater understanding and knowledge of parental mental health, able to offer better advice when speaking to affected parents on the phone, understand what they are going through and their stresses and concerns better.'

'This course is applied on a daily basis, every hour of every day to change the lives of clients.'

'More comfortable when involved in core groups.'

'Gave me new ideas of activities to carry out with parents around children's needs.'

'I am wiser on how to get the child's views on the process.'

Comments from evaluation surveys 2014-15

7.6 Future Training

In 2015/16 several new courses will be offered. These are:

- LADO – Local Authority Designated Officer training. This two hour briefing is designed for Senior Nominated Officers within organisations that have responsibility for safeguarding issues including managing allegations against staff and volunteers
- Forced Marriage, Honour Based Violence and Female Genital Mutilation – This one day course will be delivered in collaboration with County Durham and Darlington NHS Foundation Trust and HALO (honour based violence and forced marriage project)
- Child Sexual Exploitation and Online Grooming – This full day aims to increase awareness of child sexual exploitation of internet abuse, online grooming and abusive images of children and provides staff with a greater understanding of the issues and processes so that children and young people can be safeguarded
- Child Sexual Exploitation training sessions will be developed specifically for taxi drivers operating in the Durham area
- Aligned Domestic Abuse training (amalgamated LSCB / Safe Durham training)
- Hidden Sentence – Funded by Think Family, this covers the impact of prison on children and families

Section 8: Future Priorities

The LSCB will continue to tackle child protection and safeguarding issues and support partners providing child safeguarding.

8.1 LSCB Priorities 2015/16

The Durham Local Safeguarding Children Board has agreed the following priorities for 2015/16:

- Reducing Child Sexual Exploitation
- Improving Early Help
- Reducing Neglect (contributory factors are Domestic Abuse; Alcohol misuse; Substance misuse; parental mental health)
- Reducing self-harm and improving young people's self-esteem
- Increase the voice of the Child
- Ensuring that each agency is accountable for delivery of its own safeguarding responsibilities

8.2 Priority areas of work

Alongside the identified priorities above the LSCB has highlighted priority areas of work for 2015/16, these are:

- Supporting and challenging the new Children's Services Transformation arrangements for the delivery of children's services
- Improving the performance and quality assurance information to support and improve performance on the Board's priorities
- Strengthening our engagement with children and young people especially those from vulnerable communities such as Lesbian, Gay, Bi-Sexual and Transgender, young carers, Gypsy Roma Travellers, young people who offend and special needs children and young people
- Building on the Female Genital Mutilation (FGM) training offered to health professional and develop an Female Genital Mutilation Strategy / Practice Guidance
- Work with the County Durham Domestic Abuse and Sexual Violence Executive Group (DASVEG) to promote the need for domestic abuse services to support children, young people and their families
- We will continue to keep a focus on information sharing supporting and promoting good practice across multi-agency teams
- Continue a programme of self-improvement

8.3 Plan on Page

Our 'Plan on a Page' (within our Business Plan 2015-18) identifies actions for our 2015-16 strategic priorities.

Outcome and Business Priorities	Objectives for 2015-18	Actions in 2015-16
Reducing Child Sexual Exploitation	Ensure services are targeted, responsive and effective Embed the prevent, protect and pursue agenda into practice and service	1) Deliver taxi driver awareness sessions to taxi drivers in County Durham 2) Promote the Erase website 3) Increase soft intelligence of perpetrators
Improving Early Help	Ensure services support families at an earlier stage to prevent child protection intervention Reduce the number of young people subject to child protection plans	4) Embed the Early Help Strategy into practice 5) Review the understanding of the early help agenda across services 6) Refresh the governance and focus of the Early Help Forums
Reducing Neglect (contributory factors are Domestic Abuse; Alcohol misuse; Substance misuse; parental mental health)	Ensure that services are targeted, responsive and efficient for children suffering from neglect Reduce the impact of neglect contributory factors on the outcomes of children and young people suffering from neglect	7) Refresh Early Help Strategy to include Neglect and Hidden Harm 8) Engage thematic partnerships (Safe Durham / Health and Wellbeing / Children and Families) and align joint actions on Neglect
Reducing self-harm and improving young people's self-esteem	Ensure services are targeted, responsive and effective	9) Review the services for children and young people who self-harm 10) Review the services for children and young people who experience poor self esteem
Increase the Voice of the Child	Views of children and young people are used to inform services and best practice	11) Embed the learning from the young people's reference group into service provision and practice
Ensuring that each agency is accountable for delivery of its own safeguarding responsibilities	Continued development of Leadership, Challenge and Learning (as below)	
Leadership	Ensure collective leadership across all agencies Increase access of data and analysis and improve understanding Expand collective learning and improvement Develop effective policies and procedures across all agencies	12) Deliver new LSCB business plan 13) Embed Performance Management Framework 14) Conduct SCR Lessons Learned events 15) Update the Child Protection Procedures and ensure document control process is in place
Challenge	Develop effective systems, processes and polices through audits Use evidence of impact to challenge Ensure audits of practice	16) Partners to implement recommendations from audits to ensure they are fulfilling their statutory obligations 17) Challenge agencies to demonstrate lessons learnt following a Serious Case Review
Learning	Ensure that the skills and knowledge of practitioners is effective, using learning from Serious Case Reviews	18) Publish SCR reports 19) Continue to analyse impact of training 20) Progress the thematic tool for SCRs

These actions will be assigned to the appropriate sub groups and be monitored and reviewed quarterly by the LSCB Board.

Appendix 1 – LSCB Membership

Durham LSCB Membership

- The Board is chaired by an independent person commissioned by the Durham County Council Chief Executive
- National Probation Services – represented by the Head of Durham
- Durham Tees Valley Community Rehabilitation Company – represented by Head of Services County Durham and Darlington
- North Durham, Dales, Easington & Sedgefield Clinical Commissioning Groups – represented by:
    - Director of Nursing (Vice-Chair of Durham LSCB)
    - Designated Nurse Safeguarding Children and Looked After Children
- NHS England – represented by the Deputy Director of Nursing
- Tees, Esk & Wear Valleys NHS Foundation Trust – represented by the Associate Director of Nursing (Safeguarding)
- County Durham & Darlington NHS Foundation Trust – represented by:
    - Associate Director of Patient Experience & Safeguarding
    - Designated Paediatrician
    - Head of Children and Families
- North Tees & Hartlepool Hospitals NHS Foundation Trust – represented by the Deputy Director of Nursing
- Cafcass (County Durham) – represented the Service Manager
- County Durham Council represented by:
    - Corporate Director, Children & Adults Services
    - Head of Children's Services
    - Head of Adults Care
    - Head of Education
    - Strategic Manager - Youth Offending Service
    - Director of Public Health County Durham
    - Housing Solutions Manager
- National Offender Management Service – represented by Public Protection Manager

- Durham Constabulary – represented by the Force Lead for Safeguarding (Superintendent Level)
- The Voluntary & Community Sector – represented by the Voluntary Sector x2 Representative
- Schools represented by:
  - Durham Association of Secondary Heads
  - Durham Association of Primary Heads
  - Durham Association of Specialist Schools
- Further Education – Head of Student Services, Bishop Auckland College
- Lay Members – represented by two members of the community whose role is to support stronger public engagement in local child safety issues and to challenge the LSCB on the accessibility by the public and children and young people of its plans and procedures
- Lead Member – represented by the Portfolio Holder for Children and Young People Services
- Faith Communities – represented by the Safeguarding Lead for Durham Diocese

LSCB Advisors

The Board is advised by:

- A member of Durham County Council Corporate & Legal Services nominated as the Board's legal advisor
- Durham LSCB Business Manager
- Head of Planning and Service Strategy, Children and Adult Services, Durham County Council
- Strategic Manager Policy Planning and Partnerships, Children and Adult Services, Durham County Council

Appendix 2 – LSCB Staffing and Budget 2014/16

Staffing:

The LSCB is supported by the following officers:

- LSCB Business Manager
- LSCB Quality & Performance Co-ordinator (deputises for Business Manager)
- LSCB Strategy and Development Officer
- LSCB Training Co-ordinator
- LSCB Admin Co-ordinator
- LSCB Administrator

LSCB Budget

The financial year runs from 1 April to 31 March in each year. Budget management is the responsibility of the Durham LSCB Business Manager and financial reports will be presented to the Board at six monthly intervals.

The majority of the budget relates to staffing costs, this includes costs associated with the independent chair. Other major costs relate to training and Serious Case Reviews.

The financial contributions from partner agencies in 2014/15 were as follows:

Partner	Contribution
Durham County Council	£171,604
Clinical Commissioning Groups	£95,097
Tees, Esk & Wear Valleys NHS Foundation Trust	£2,680
County Durham & Darlington NHS Foundation Trust	£2,680
North Tees & Hartlepool NHS Foundation Trust	£2,680
Durham Constabulary	£29,285
Durham Tees Valley Probation Trust	£2,680
Hassockfield Training Centre	£2,680
Further Education Colleges	£1,400
NHS England	£2,000
Cafcass	£550
Total	**£313,336**

The financial contributions from partner agencies in 2015/16 are as follows:

Partner	Contribution
Durham County Council	£171,604
Clinical Commissioning Groups	£95,097
Tees, Esk & Wear Valleys NHS Foundation Trust	£2,680
County Durham & Darlington NHS Foundation Trust	£2,680
North Tees & Hartlepool NHS Foundation Trust	£2,680
Durham Constabulary	£29,285
Durham Tees Valley Community Rehabilitation Company	£1,340
National Probation Service	£1,340
Further Education Colleges	£2,100
Cafcass	£550
Total	**£309,356**

Appendix 3 – Partner updates in the wider partnership

Stronger Families

In April 2012, the Government launched the Troubled Families Programme, known locally as the Stronger Families Programme, to incentivise local authorities and their partners to turn around the lives of over 120,000 families by May 2015. Durham Local Safeguarding Children Board, the Children and Families Partnership and Safe Durham Partnership work jointly on this agenda.

Phase 1 of this programme aimed to work with families where children are not attending school, young people are committing crime, families are involved in anti-social behaviour and adults are out of work. The County Durham Stronger Families Programme met the target in March 2015 to turn around its targeted number of 1,320 families by May 2015. Families have received help and support delivered with a 'Think Family' multi-agency approach coordinated by a Lead Professional and a Team Around the Family utilising a single multi-agency care plan in order to reduce duplication and maximise impact.

Clinical Commissioning Groups (CCGs)

The two Clinical Commissioning Groups (CCGs) that cover Durham are:

- NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES)
- NHS North Durham Clinical Commissioning Group (covering Derwentside, Chester-le-Street and Durham)

Both CCGs' Directors of Nursing and the Designated Professionals are active Board members and also support the LSCB chairing a LSCB sub-group. In addition, CCGs are active members of the Safe Durham Partnership Board and multi-agency strategic groups for Domestic Abuse, Multi-Agency Public Protection Arrangements (MAPPA) and the strategic group for Looked After Children.

The CCGs have mandatory safeguarding children training well established for their staff. In addition, annual education sessions are offered to the CCG governing bodies regarding their corporate safeguarding responsibilities.

The CCGs have continued to support primary care in their safeguarding responsibilities by ensuring that training is delivered through Protected Learning Time (PLT) events. The CCGs audited the impact of the safeguarding training in the 2014 to 2015 academic year which has indicated

that 47% of attendees who had previously attended safeguarding children training had used the knowledge gained over the last year. 28% of the total attendees stated that their practice had changed procedures as a result of the training.

CCGs have also continued to support GP Practice safeguarding leads through the programme of quarterly development sessions. These are led by the Designated Professionals, are well attended and are generally evaluated positively.

North Durham CCG led the development of the ChildSafe Trigger Tool which provides a systematic way of ensuring all correspondence regarding trauma in children is looked at by GP Practices from a safeguarding perspective. The information then forms part of the whole picture of the child's life and experience.

The ChildSafe Trigger Tool was audited in April and May 2014 and showed it was generally embedded within primary care practice in North Durham. The ChildSafe Trigger Tool has been included as good practice in the updated national Royal College of GPs Safeguarding Children Toolkit.

The CCGs have strengthened the quality requirements within the NHS contract, requesting NHS provider Trusts to provide evidence of their training, policy and safeguarding activities and assurance that actions and any learning has been taken forward. The information is considered through clinical quality review groups, where CCGs and designated professionals are positioned to question and acknowledge practice.

The CCGs both evidence their commitment to the safeguarding of children in County Durham through a safeguarding declaration on their website and a safeguarding children strategic delivery plan. Both CCGs have a link on the front page of their websites to the LSCB procedures.

Durham Constabulary

Durham Constabulary continued to support schools in raising awareness around CSE and online safety to young people, including offering training at conferences and events. Durham Police also organised young people's conferences, which included learning from a range of agencies around CSE, internet safety and healthy relationships and respect. Safeguarding and Neighbourhoods have merged Commands ensuring the accurate education of children and their parents/carers around safeguarding issues is included in the Mini Police, Junior Neighbourhood Watch, Jet and Ben lessons, School Carousels and by Neighbourhood Teams who engage with young people.

The Police continue, in partnership with the LSCB, to monitor and improve practice when tackling CSE. In summer 2015 we will see the implementation of a dedicated multi-agency team (ERASE Team) which will focus on early identification, problem solving and offender disruption to reduce the number of children who are frequently reported Missing From Home and reduce the risk of Child Sexual Exploitation.

Durham Police are the first Force nationally to pilot pioneering training and techniques to spot warning signs around those who may pose a risk to children by providing an understanding of how sex offenders operate. The training and tools will continue to be developed and multiagency training offered in 2015 and 2016.

The Durham Police and Crime Commissioner (PCC) and Durham Constabulary continue to work closely with a range of other agencies to improve outcomes for young people. In December 2014 the PCC held a 'One Year On' Regional Violence Against Women and Girls Strategy. Since its launch work there has been a number of achievements including employing a worker from Harbour to work within the MASH who engages victims at critical times to offer support and help. The strategy will also focus more closely on child sexual exploitation.

In January 2015 the Force launched its 'through the eyes of a child' campaign to focus officers attending domestic abuse incidents to consider what life is like for the children in that family. In support of this initiative officers are required at every domestic abuse incident to wear body worn cameras, speak with any children in the home and view their living conditions including bedrooms and to capture their voice and act upon any concerns. At the same time the Safe Durham Partnership has increased the numbers of its Independent Domestic Abuse Advocates to improve the support we give to victims. A New Domestic Abuse Team will launch in September 2015, focusing on those standard and medium risk victims to make sure they and their families are supported and to ensure perpetrators are disrupted using tools such as domestic violence protection orders and notices and perpetrator programmes.

County Durham & Darlington NHS Foundation Trust

This update provides an overview of the activity and developments which has been undertaken within the County Durham and Darlington NHS Foundation Trust (CDDFT) around safeguarding children during the 12 month period April 2014 to March 2015.

Safeguarding Children Training **–** During 2014/15 the Safeguarding Training Team undertook a review training needs analysis is in line with the Safeguarding Children and Young People: roles and competences for health staff, Intercollegiate Document 2014 and refreshed the Safeguarding Children Training Strategy to reflect the changes identified.

Central Referral Unit (CRU) Durham **–** All domestic abuse cases are reviewed by the Police within the CRU and cases screened as medium and high are circulated to Health Visitors, School Nurses, Family Nurse Partnership and Midwives by the safeguarding teams.

Multi Agency Safeguarding Hub (MASH) Durham **–** A bid has been drafted to increase the health resources within the MASH.

SystemOne **–** This is being developed as an information management system for the safeguarding team. This will increase efficiency within the team allowing enhanced information exchange at an operational level. Systems and policies have been developed and it is planned for implementation by September 2015.

Policies and Procedures **–** A full review of Safeguarding Children Policies and Procedures has been undertaken in line with the publication of Working Together 2015.

Safeguarding audits **–** A supervision audit has been completed which has informed the policy development and provides assurances around quality of supervision. In addition a Key Performance Indicator (KPI) audit was completed which identified the level of compliance with regard to Safeguarding KPI's. The audit also allowed staff to comment and provide feedback on the various safeguarding services. The feedback from staff was generally positive and complimentary towards the staff and services involved.

Safeguarding model - Safeguarding team and Family Nurse Partnership **–** The FNP safeguarding model is now well embedded into practice and follows guidance in the FNP manual.

Acute Senior Nurse Safeguarding role **–** The team currently has 1 WTE Acute Senior Nurse Safeguarding Children (SNSC) who provides safeguarding advice, support, training and supervision to both Durham and Darlington Acute sites and allied health professionals, including the Sexual Health Team. Several audits are on-going as part of this role. Task forces have been established for Emergency Departments on both hospital sites. A safeguarding link group has been implemented and meets bi monthly to promote good communication between Neonatal Unit, Maternity, Paediatrics and Specialist Nurses. Acute SNSC ensures staff awareness/ updates are provided regarding policy and practice by delivering regular briefings. Acute SNSC works very closely with Consultant Paediatricians and is the key link between Acute sites and community.

Female Genital Mutilation – A time limited task and finish group including the Domestic Abuse Co-ordinator, Named Nurses and Specialist Midwife are leading the development of Trust wide protocols and pathways regarding Female Genital Mutilation (FGM).

CP-IS (Child Protection Information Sharing) **–** CP-IS focuses on improving the protection of children who have previously been identified as vulnerable by Children's Services when they visit the following NHS unscheduled care settings:

- Emergency Departments
- Walk-in Centres

- Out of Hours GPs
- Minor Injuries Units
- Paediatric Wards
- Maternity Units
- Ambulance Services

The project will link the IT systems of NHS unscheduled care to those used by child protection teams, to enable minimal information on a restricted set of children to be shared.

- Those with a Child Protection Plan
- Those classed as Looked After (i.e. children with full and interim care orders or voluntary care agreements)
- Any pregnant woman whose unborn child has a pre-birth protection plan.

A project team has been established to take CP-IS forward for the Trust and a project plan is being prepared.

Looked After Children (LAC) **–** There are a number of updates under this subject as follows:

- **Initial Health Assessments:** The number of IHA's being completed within the statutory 20 working day timescale, has increased from 7.6% to 72.2%. Improvements to date have been influenced by multi-agency implementation of the Initial Health Assessment Escalation policy this is on-going
- **Review Health Assessments:** Performance for RHA's 2014-15 has been reported by Local Authority at Durham 92.3% which is much higher than the 86% target
- **Teenage Initial Health Assessments** flow charts have been developed and implemented to ensure all young people are offered an Initial Health Assessments with a Paediatrician and if declined this is followed up
- **On-going LAC audit:** health care plans are audited to ensure standards are maintained following briefing sessions being provided to staff to ensure a high quality of assessments
- **Policy update:** The Adoption Policy has been updated and is awaiting ratification

- **Joint LAC and Safeguarding Supervision Policy** This has been updated to include recommendations from School Nurse and Health Visitor Service Specification awaiting ratification
- **Reorganisation:** Following reorganisation the LAC processes and practices have been standardised across Durham and Darlington to ensure equity of care across the County. The LAC administrators are now to be co-located for Durham and Darlington to ensure continuity and provision is maintained for working week
- **Working Relationships:** Close working relationships have been developed with the Local Authority and CCGs joint working a number of work streams for example gap analysis of the new promoting the health and wellbeing of looked after children (2015)
- **Fostering and Adoption Panels** have representation from the LAC nurses in Durham and Darlington. There is also representation on the Placement Resource Panel.

National Probation Services and Durham Tees Valley Community Rehabilitation Company

The Ministry of Justice 'Transforming Rehabilitation' programme of Probation reforms split probation services into two new organisations during 2014/15. These are:

- A new public sector National Probation Service (NPS) dealing with all those who pose the highest risk of serious harm to the public.
- Twenty one regional private sector Community Rehabilitation Companies (CRCs) managing all other offenders
- Extending statutory supervision and rehabilitation to those offenders sentenced to less than 12 months in custody
- Reorganising the prison estate to provide 'resettlement' prisons and a nationwide 'through the gate' resettlement service

Offenders managed by the new National Probation Service include all those who pose the highest risk of serious harm to the public – this group will include those subject to Multi-Agency Public Protection Arrangements. The new National Probation Service will continue to carry out assessments of the risk of serious harm posed by each offender and advise the courts and Parole Board accordingly.

All other offenders are managed and supervised by Community Rehabilitation Companies.

In response to these reforms partners have been working together to mitigate identified risks and issues including; migration and splitting of local probation services and systems; working arrangements for statutory and non-statutory responsibilities, timely agency access to offenders in resettlement prisons and 'through the gate' provision.

Durham Tees Valley Probation Trust contract with the Ministry of Justice ended 31 May 2014. Probation staff were identified and aligned to either the National Probation Service or the Community Rehabilitation Company with the migration and splitting of probation services and systems taking place 1 June 2014.

The public sector Community Rehabilitation Company provided probation services until the end of January 2015 before a mobilisation phase transferring over to ARRC (Achieving Real Change in Communities). ARRC is a local mutual with members including Durham Tees Valley Probation Trust, Local Authorities, Housing Association and Private Investors. The Contract Packaged Area for our local area covers the existing Durham Tees Valley Probation Trust boundaries (Durham and Cleveland).

Our focus now turns to the implementation of the CRC Service Delivery Model. As this becomes available partners within the County Durham Partnership will continue to updated as we adapt delivery of services to improve the management of offenders

Below is a simple explanation of 'Who does what':

Durham Tees Valley Community Rehabilitation Company Limited (CRC): The CRC delivers contracted offender management rehabilitation services in the community and will be the main point of day to day contact for partners, organisations and service uses.

ARRC (Achieving Real Change in Communities): The ARCC are small group of investors who own shares in Durham Tees Valley CRC. They won the Ministry of Justice contract for offender management rehabilitation services in the Durham Tees Valley area and direct the CRC to deliver the contract.

National Probation Service (NPS): The NPS is a statutory criminal justice service that supervises high-risk offenders released into the community. The local NPS Durham Area is co-terminus with the Durham Constabulary area and will be the main point of contact for partners, organisations and service uses.

National Offender Management Service (NOMS): The NOMS Contract Management Team work on behalf of the Ministry of Justice to monitor / review compliance of the contract. The Ministry of Justice are the commissioners of the contract.

Durham LSCB Annual Report 2014 / 2015 - Safeguarding Children in County Durham

The Durham Local Safeguarding Children Board has a statutory duty to prepare and publish an Annual Report which describes how our partners safeguard vulnerable children and young people in County Durham. Our primary responsibility is to provide a way for the local organisations that have a responsibility in respect of child welfare, to agree how they will work together to safeguard and promote the welfare of children in County Durham and to ensure that they do so effectively.

Over the last year we have reviewed and updated our vision to ***'Every child and young person in County Durham feels safe and grows up safe from harm'***.

This Annual Report gives an account of the Board's work over the past year to improve the safety and wellbeing of children and young people. The report reflects the activity of the LSCB and its sub-groups against its priorities for 2014/15. It covers the major changes and improvements of our partners' service delivery, where they link with the Board's overall strategies and the impact we have had. It also reports on the Serious Case Reviews and Child Death Reviews undertaken and identifies the priorities we will take forward into 2015/16.

Please ask us if you would like this document summarised in another language or format.

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Durham Local Safeguarding Children Board

Safeguarding is everyone's responsibility

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Health and Wellbeing Board

21 January 2016

Safeguarding Adults Board Annual Report 2014/15

Report of Jane Geraghty, Independent Chair, County Durham Safeguarding Adults Board

Purpose of Report

1 The purpose of this report is to present the Annual Safeguarding Adults Report (attached at Appendix 2) to Health and Wellbeing Board and in doing so provide information on the current position of the County Durham Safeguarding Adults Board (SAB) and outline achievements during the year 2014/15.

Background

2 There are a number of specific areas covered by the Annual Report which are as follows:

- Safeguarding in its current context.
- Achievements during the year 2014 /15 from the Board's subgroups.
- The Strategic Plan for 2015/18.
- Perspectives of the partners.
- Key data on safeguarding activity in County Durham.

Safeguarding in its Current Context

3 Much of the work of the Board in 2014/15 has focussed on preparing for the implementation of the Care Act in April 2015. The Act places adult safeguarding on a statutory footing and implements changes to the way in which safeguarding enquiries are managed. If not already in place, the local authority **must** also set up a Safeguarding Adults Board to provide assurance that local safeguarding partnership arrangements act effectively to protect adults in its area.

4 The Care Act requires the SAB to fulfil three core duties;

- It **must** publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.

- It **must** publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy.

- It **must** conduct any Safeguarding Adults Review in accordance with Section 44 of the Act.

5 In addition to these legislative changes, the work described in this year's annual report has continued to take place against a backdrop of austerity. As in the previous year, our public services have continued to rise to the challenge and the SAB partners have continued in their commitment to prioritising safeguarding activity. This is reflected by the achievements outlined in the annual report which remain significant.

6 While not a primary responsibility of SAB, Deprivation of Liberty Safeguards (DoLS) has received much attention over the period of this Annual Report. A ruling by the Supreme Court in March 2014 significantly lowered the threshold to what constitutes a deprivation of someone's liberty. Under DoLS local authorities must assess whether people who lack capacity to consent to their care arrangements are being deprived of their liberty in care homes or hospitals and, if so, whether this is in their best interests and necessary to protect them from harm. The DoLS are designed to provide independent scrutiny, by social workers and health professionals, of these care arrangements. There were a total of 1416 such applications in 2014/15. This represents an 8 fold increase from the previous year, with the figure set to rise to approximately 2500 applications in 2015/16.

Key Achievements from the Annual Report 2014/15

7 All reported safeguarding concerns have risen from 2153 in 2013/14, to 2502 in 2014/15. This continues to demonstrate the effective promotion of safeguarding adult's issues across the health and social care economy resulting in low thresholds for reporting concerns to the local authority.

8 The overall number of multi-agency investigations has reduced from 502 to 375 over the same period. This reflects successful changes to procedures and operating practices. A more thorough risk assessment of reported concerns is undertaken early in the process, resulting in a more proportionate response. Full multi agency investigations are reserved for the high risk cases.

9 The SAB website and all of the associated leaflets, publicity materials, procedures and guidance have been revised to ensure they are Care Act compliant. The website usage has had a 50% increase in page views when compared to the previous year.

10 The appointment of Jane Geraghty, an independent chair to both the Adult and Children Board was complete in October 2014. Jane took over the chair of SAB from Lesley Jeavons, head of Adult Care in January 2015. SAB appointed Susan Harrison, a lay member at the same time. Together, these two roles provide an enhanced level of independent scrutiny of the work of the Board and its partners.

11 In February 2015, the SAB commenced development work with the support of two Local Government Association consultants to transform its business planning and performance management processes. This has resulted in the formation of a 'Plan on a Page' and a new outcome focussed performance framework.

The Strategic Plan 2015-18 (Plan on a Page)

12 This plan is shaped by the following vision:

"We will support adults at risk of harm to prevent abuse happening; when it does occur, we will act swiftly to achieve good outcomes."

13 The plan will shape the strategic priorities of the SAB for at least the next 3 years. The priorities focus on the following seven areas;

- Performance
- Legislative Compliance
- Prevention
- User/Carer Voice
- Awareness
- Partnership Engagement
- Learning Lessons and Improvement

14 Each of these priorities will be aligned to a sub group of the SAB. The sub group will then oversee the development of associated practice and service delivery. To strengthen our governance arrangements a new performance framework has been devised to focus on the same priority areas. The development of these key documents will focus much of the work of SAB in strengthening its multi-agency collaboration from 2015/16 onward. It is envisaged that a self/ peer audit tool will be devised covering the same strategic priorities; again to bring greater cohesion to the development of this vital partnership arrangement.

Perspectives of the Key Partners

15 In addition to the local authority, the annual report features update summaries from Durham Constabulary, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups, Tees, Esk and Wear Valleys NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust. These summaries bare testimony to the ongoing commitment of these key partners in prioritising training and development work to further the development of safeguarding standards across County Durham.

Key Data on Safeguarding Activity in County Durham

16 In addition to the performance information featured earlier in this report under key successes; the Annual Report continues to feature data on trends pertaining to safeguarding adults investigations. It is reassuring to note that the vast majority of this data remains consistent with previous years. This perhaps illustrates a maturity in our reporting processes and provides some scope to predict the nature and prevalence of safeguarding concerns when developing our future plans.

Recommendations

17 The Health and Wellbeing Board is recommended to:

- Note the contents of this report
- Recognise the continued progress of the Safeguarding Adults Board as highlighted in the annual report.

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Appendix 1: Implications

Finance – Ongoing pressure on public service finance will challenge all agencies to consider how best to respond to the safeguarding agenda.

Staffing – The sustaining of adult safeguarding activities requires continued priority to staffing to ensure adequate resources are maintained. The continued contribution to staffing from partner agencies determines the sustainability of dedicated safeguarding adults posts/ functions.

Risk – The risks associated with not appropriately managing responses to safeguarding are extremely high and include risks of ongoing abuse and neglect and the risk of serious organisational damage to statutory and non-statutory agencies in County Durham.

The Safeguarding Adults Board puts considerable effort into training and awareness-raising to ensure that abuse and neglect recognised and reported. All reports of concerns are screened and directed so they receive the most appropriate response.

Equality and Diversity – Adult safeguarding is intrinsically linked and this is covered in the SAB policies and procedures.

Accommodation – N/A

Crime and disorder - Adult safeguarding is intrinsically linked and this is covered in the SAB policies and procedures.

Human rights - Adult safeguarding is intrinsically linked and this is covered in the SAB policies and procedures.

Consultation – Report available for all partner agencies.

Procurement – The adoption of safeguarding principles in the procurement of health and social care services is essential.

Disability issues – Safeguarding Adults procedures apply to ‘adults at risk’ who are adults that are deemed eligibly for social care services.

Legal implications – While there is no legal requirement for an Annual Report at present, however there will be a statuary requirement to produce an annual report from 2015 when the Care Act 2014 comes into force.

County Durham
SAFEGUARDING ADULTS
INTER-AGENCY PARTNERSHIP

Annual Report 2014/2015

Working with The Safe Durham Partnership *Altogether safer*

Contents

Foreword from Jane Geraghty, Chair, County Durham Safeguarding Adults Board

I am delighted to present the County Durham Safeguarding Adults Board Annual Report 2014/15.

I was appointed as Independent Chair of both the Children and Adult Board in October and have begun to develop positive and constructive relationships with all the partners represented on the Board. We all have a shared objective to make County Durham a place where adults at risk are protected from abuse and supported in making decisions about their own safety.

This annual report illustrates how the Safeguarding Adults Board (SAB) has continued to make a significant contribution towards making vulnerable adult's safe and protecting them from harm. This is all the more impressive when viewed in the light of the austerity measures the public sector continue to operate within. The local authority continues to operate within a difficult financial environment with significant reductions to its settlement, the Police have made a significant reduction of some 600 officers in recent times and health partners have had to realign many of the services that they provide.

Much of the work of the Board has involved preparing for the implementation of the Care Act. The publication of the Care Act guidance has provided a statutory framework prescribing how the SAB operates. This includes a focus on three additional areas of abuse, those of Domestic Abuse, Modern Slavery and self-neglect which will all provide challenges in their right.

The main partner organisations of the board have an obligation to co-operate in order to protect the adult from harm. The local authority must now make enquiries or cause others to do so if it believes that there has been abuse and neglect.

The Act provided an opportunity for the Board to take time out to re confirm its priorities and agree its performance framework that ensures all partners can demonstrate their commitment to safeguarding both within their own organisations and working collaboratively with partners.

The Board is concerned to ensure that its work makes a real difference to the most vulnerable. A key priority is to hear and respond to the voice of the user and care.

I would like to put on record my thanks to all Board members and all members of the business unit for their hard work, enthusiasm and commitment to ensure County Durham is a safe place.

Jane Geraghty
Independent Chair
Safeguarding Adults Board

Introduction

The Safeguarding Adults Board (SAB) in County Durham is a well-established multi-agency arrangement that has been developed over a number of years based on the 'No Secrets' guidance and the Association of Director of Adult Social Services (ADASS) National Framework of Standards.

The introduction of the Care Act 2014 places adult safeguarding on a statutory footing. This means if not already in place, the local authority **must** set up a Safeguarding Adults Board and its main objective is to assure itself that local safeguarding arrangements and partners act to help and protect adults in its area

The SAB has three core duties;

- It **must** publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan should be evidence based and make use of all available evidence and intelligence from partners to form and develop its plan.
- It **must** publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy.
- It **must** conduct any Safeguarding Adults Review in accordance with Section 44 of the Act.

Strategically the SAB should be viewed as 'greater than the sum of the operational duties of its core partners' and will have an oversight on safeguarding in the area. It will be seen as an important source of advice and will have a particular interest in preventing abuse and neglect.

The Care Act states that we should not limit our view of what constitutes abuse and it has highlighted three additional categories that should be considered, namely domestic abuse, modern slavery and self-neglect. It has placed an emphasis on identifying exploitation and patterns of serial offending. Much of the work carried out by the SAB over the period of this annual report has been preparatory work to ensure that adult safeguarding will be Care Act compliant.

This annual report highlights some of the initiatives that the SAB has developed during 2014/15 through the Performance & Quality, Policy & Practice and Communications & Training/ Engagement Sub Groups which are the operational mechanism of the SAB. (Learning and Improvement)

Each of the main partner agencies has highlighted some of their organisational contributions to support the development of safeguarding. There is also data contained toward the back of this report that helps to provide an understanding of the extent and nature of safeguarding activity in County Durham.

Strategic Overview of Safeguarding Adults

The Safeguarding Adults Board (SAB) has been through a year of transition in preparation for the introduction of the Care Act 2014.

There have been some new appointments to the Board. Jane Geraghty has been appointed as the new Independent Chair, and Susan Harrison as the first Lay Member. The Police lead is now Chief Inspector Stephen Chapman, who has taken over as Force Lead from Paul Goundry who will focus on child protection.

The new Adult Safeguarding Chair is also the Chair of the Local Safeguarding Children's Board and it is expected that this will further enhance the good working relationship we have between the two Boards.

The SAB Policies and Procedures and much of the SAB literature have undergone a full review in order to ensure that they are Care Act compliant. The SAB website has continued to be used as a key source of information, with a 50% increase in use on the previous year.

The reporting of safeguarding concerns has increased by 349 to a level of 2502 which is the first significant rise in four years whilst repeat referrals have remained on a gradually downward trend.

The Board has continued to build on the success of the previous radio campaigns by leading on the fourth regional awareness campaign which incorporated promotional events in high footfall areas within Durham and other local authority areas. This was followed by a further Durham based, four week campaign, early in 2015 which was supported by a number of articles in local authority publications.

SAB has engaged with the 'Making Safeguarding Personal' initiative which is a national initiative focused on making the victims of abuse and neglect more central to the safeguarding process. The main partners of the SAB have undergone a self-assessment process; the results of which were very positive as they have demonstrated a strong commitment to promoting the safeguarding arrangements and working collaboratively to recognise and address concerns associated with abuse and neglect.

There has been widespread recognition across the partnership to refocus our approach to monitoring performance which has predominantly concentrated on local authority qualitative data taken from safeguarding adults investigations. 2015/16 will see the introduction of a greater emphasis.

The Performance and Quality Sub Group has reviewed its practices and the information that it reviews. There is now a general shift from quantitative data to a more qualitative analysis on qualitative analysis taken from a range of SAB partners.

Regional Perspective

The Safeguarding Adults Board has continued to fully participate in regional safeguarding activities in connection with ADASS.

The current ADASS Safeguarding North East Network work plan encompasses the following areas:-

- Adult engagement and participation
- Care Act 2014 audit of implementation
- Communications strategy
- Quality assurance models
- Good practice presentations and links to strategic safeguarding
- Peer Review Feedback
- Safeguarding Adults Reviews (SAR) models

As mentioned above the Durham SAB has been instrumental in securing funding and leading on the regional awareness campaign. On behalf of the region, it has also commissioned training regarding the Social Care Institute for Excellence (SCIE) 'Learning Together Model' (methodology for safeguarding adult reviews), Legal Literacy and Sexual Exploitation (eLearning).

Durham SAB has also been responsible for re-establishing and chairing the Regional Training group which again shares information and good practice across the 11 local authority areas that cover the North East.

Safeguarding Operations

The total number of safeguarding concerns have risen for the first time in four years; the number of referrals (the portion of reported concerns that require further scrutiny under our safeguarding procedures has remained stable at around 1000). However, this has coincided with a reduction in the number of safeguarding investigations where procedures are invoked. This downward trend is entirely due to lead officers and team managers making informed decisions regarding the most appropriate response since the change in procedures which increased the decision making period from one to up to five days.

It has been a challenging year for the Safeguarding Lead Officer team which has expected higher than average levels of staff turnover and vacancy during the 2014/15 period. This in turn has made it difficult to meet the organisational targets for completing investigations. On a positive note the team is now up to full strength and the staffing levels have been increased to provide more resilience and to cope with the extra demands that will be created by engaging with the 'Making Safeguarding Personal' initiative.

Deprivation of Liberty Safeguards (DoLS)

Following a ruling in March 2014 by the Supreme Court which clarified the definition of a Deprivation of Liberty, there has been a substantial increase in DoLS applications in County Durham. Prior to the Supreme Court judgement there was an

average of 14 applications per month. The applications were assessed by Best Interest Assessors (BIA) who were based in social work teams and worked on a rota basis. However, following the judgement, the number of applications rose considerably. From April 2014 to March 2015 there were a total of 1416 applications. To manage the increased number of applications in the short term, three full time Best Interest Assessors were appointed in addition to those working on a rota basis.

The significant rise in applications which has also been seen within other Local Authorities across the country has continued in 2015, reflecting the increased awareness of care homes and hospitals regarding their responsibilities within DoLS.

Transformational Change and Prevention

The Care Act 2014 was implemented in April 2015. The new legislation identifies the aim of "care and support" as helping people achieve the outcomes that matter to them in their life. It emphasises the principles of well-being and prevention as underpinning the Local Authority's role when carrying out any of their care and support functions and introduced new national minimum eligibility criteria for service users and carers. Carers are given the same rights as those they care for; this includes the right to an assessment, a care and support plan and a Personal Budget.

The new legislation consolidates best practice around personalisation and reinforces the objectives of transformational change. Durham County Council Adult Care Services have made significant progress towards meeting these objectives over the past year. This has been supported by a comprehensive programme of staff training workshops and publication of the monthly bulletin "New Beginnings" to inform staff of the coming changes.

Working with partner agencies, the council successfully bid for funding from the Better Care Fund. This will be used to enhance the local integration of health and social care services. A pooled budget has been established and the fund has been committed to key themes which include:

- Intermediate Care Plus (IC+)
- Equipment and adaptations for independence
- Supporting independent living
- Supporting carers
- Combating social isolation

Community Chest Grants have been used throughout 2014-2015 to support the development of voluntary and community sector resources to support people who have social care needs. During the year the Community Chest supported **77** projects delivered by **73** organisations across County Durham with grants of between £500 and £10,000.

"Locate" www.durhamlocate.org.uk went live in April 2015. This new website provides information about care and support available across all sectors in County Durham. Members of the public, partner agencies and local authority staff are

encouraged to access Locate when considering care and support needs. This will promote the use of community resources rather than formal social care provision.

Reporting and Interface Arrangements

The Board has interface arrangements with a number of organisational management teams across the council and partner agencies. There are also connections to a number of multi-agency partnership groups such as the Local Safeguarding Children Board, the Safe Durham Partnership and the Health and Wellbeing Board.

See Appendix 1 for a diagram of the multi-agency interface arrangements.

In addition to these arrangements a Chief Officer Group has been established which includes the councils Chief Executive alongside Chief Officers from the Police and NHS. The group is concerned with assessing quality and effective interventions across all statutory agencies.

Working with the Local Safeguarding Children Board (LSCB)

Strong links continue to be maintained between SAB and the LSCB. The Independent Chair of the SAB is also the Independent Chair of the LSCB several members from partners including the Corporate Director of Children and Adults Services, also attend both Boards. Training opportunities are well established for both safeguarding boards and training leads have begun exploring areas of joint interest with a view to developing a more co-ordinated approach to training delivery.

Links to Domestic Abuse

A countywide specialist service for domestic abuse is now in place across County Durham. Harbour Support Services provide support to victims and programmes for perpetrators. Harbour are about to commence a programme of training to Adult Care staff in relation to domestic abuse following the introduction of The Care Act 2014 which highlights domestic abuse as a specific safeguarding issue.

The governance for domestic abuse continues to come from the Domestic Abuse and Sexual Violence Executive Group (DASVEG), which is a thematic group of the Safe Durham Partnership Board (SDPB) and provides the linkage to Adult Safeguarding. There is also adult safeguarding representation on a number of domestic abuse operational groups. A single agreed multi-agency referral pathway is also now in place to support frontline practitioners. This pathway will strengthen the links between adult safeguarding and support services.

The Safeguarding Adults Board Membership

The Board is comprised of senior representatives from the following agencies:

- Durham County Council, Children & Adults Services
- Clinical Commissioning Groups (CCG)
- National Health Service England (NHS England)
- Tees, Esk & Wear Valleys NHS Foundation Trust
- County Durham & Darlington NHS Foundation Trust
- Durham Constabulary
- Her Majesty's Prison Service
- National Probation Service
- Care Quality Commission
- Age UK County Durham
- Victim Support
- Lay Membership

Key Objectives for 2014/15

The three Sub Groups of the Safeguarding Adults Board meet four times per year. They carry out much of the development work on behalf of the Board and during the past year have achieved the following key objectives;

- **Policy and Practice –** Ensure compliance following the implementation of the Care Act 2014

- **Performance & Quality –** Closely monitor increase in referral rates for DOLS and associated impact on resources
- **Communication and Training/Engagement** – Develop awareness material for vulnerable adults regarding protecting themselves from sexual abuse.

Key Milestones Achieved: April 2014 – March 2015

The following key milestones have been achieved by the Board's thematic sub groups:

Empowerment

To develop and maintain a structured approach to supporting and involving adults at risk to ensure that decisions are made in their best interests.

January 2015	A witness support, preparation and profiling scheme (WSPP) which gives vulnerable adults better access to the Criminal Justice System has been further developed and the first witness has been supported through the system. The scheme is now ready to be launched and the policy document is ready for sign off.
March 2015	Safeguarding policies and procedures have been updated and are now Care Act compliant. The SAB website information and leaflets have also been reviewed and updated to ensure service users have the most up to date information regarding the safeguarding process.
March 2015	Safeguarding Adults Review / Learning and Improvement subgroup has been established to learn the lessons from Safeguarding Adult Reviews (SAR) and the executive strategy process with a view to improving performance and processes.
	A service user survey is sent on a monthly basis to all service users where safeguarding procedures are invoked. The survey and interview process has been reviewed and revised.

Prevention

To have communities and a workforce that are able to recognise, report signs of abuse and neglect and take action to support the adult at risk.

May 2014	Dedicated training session has been delivered to matrons in County Durham and Darlington Foundation Trust (CDDFT) with additional sessions to follow.
January 2015	Leaflets, information and policies and procedures have been updated to be Care Act compliant and are available on the SAB website.
January 2015	Two radio awareness campaigns were commissioned. Funding of £18,000 was secured for a Durham lead 12 week regional campaign from July – September 2014 and second campaign

March 2015	which was a Durham based project ran in January 2015, incorporating articles in a number of local authority publications.
Ongoing	The percentage of invoked safeguarding referrals that were classified as occurring in the service users own home has increased.
	Page views on website have been monitored and have increased by 50% from the previous year.
	Protection
June 2014	**That all partners have systematic processes in place to recognise, report and manage adults at risk or allegations of abuse**.
January 2015	Local authority reporting processes are compliant with SAB policies and procedures through Social Care Direct and the social services IT system (SSID) updated to give better identification of source of health referrals.
February 2015	Safeguarding Adults policy for Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES) and North Durham Clinical Commissioning Group (NDCCG) practices now in place.
	Annual audit was conducted on 100 safeguarding referrals chaired by the local authority and TEWV Lead Officers. Self-assessments were carried out by the local authority, health and police partners.
Ongoing	Incidents of repeat abuse are reported quarterly and scrutinised by the Performance and Quality Sub Group and team managers. A draft Partnership Agreement is to be presented to the October SAB meeting.
Ongoing	Policies and procedures have been reviewed and are now Care Act compliant and are available on the SAB website.
Ongoing	Strategic Plan has been reviewed and redesigned.
	Proportionality
	To undertake good quality, timely risk assessments that are responsive to the needs of the individual and the least intrusive course of action central to the persons wishes, values and feelings.
February 2015	New IT monitoring systems are now in place for DoLS. Additional staff recruitment has been approved to deal with the increase in demand and the referral levels will continue to be

	monitored.
	The CCG is working with the local coroner around specific guidance for GPs in relation to their role as a result of death of a patient subject to a DoLS.
March 2015	Policies and procedures are being updated in line with the Care Act to ensure that responses to safeguarding concerns are proportionate and appropriate.
March 2015	There will now be a distinction between safeguarding and adult protection, which will be triggered when there is a need for multi-agency investigation.

Partnership

The Board fosters a one team approach to safeguarding adults at risk, which places the health and wellbeing of the individual above organisational boundaries.

January 2015	Safeguarding and local authority marketing staff have updated materials and are now Care Act compliant. This will be reviewed annually.
February 2015	Regional Training Group explored ways in which good practice and resources could be shared across the North East region with three training packages developed. Further developments expected once Training and Development Officer is in post.
February 2015	Funding sourced for SCIE Learning Together training designed to support safeguarding adults reviews with course dates set.
March 2015	Safeguarding Adults Review/Learning and Improvement Subgroup established.

Accountability

The Safeguarding Adults Board has open and transparent governance arrangements, ensuring that roles of all agencies are clear and holds to account partners for safeguarding adults

January 2015	Independent chair and a Lay Member appointed.
March 2015	Partner agencies preparing presentations to the SAB outlining organisational achievements for 2014/15 and their proposed initiatives for 2015/16.

March 2015	A briefing note was issued to staff at the end of March 2015 and a briefing for managers was arranged in April 2015 on the Care Act which includes safeguarding.
March 2015	Further Care Act training is arranged in respect of safeguarding and will begin once Training Officer in post.

Strategic Plan 2015 – 2018

The following provides an overview of the SABs Strategic Plan to support delivery of our key priorities over the next 3 years.

Our Vision

We will support adults at risk of harm to prevent abuse happening; when it does occur, we will act swiftly to achieve good outcomes.

Performance Framework (Performance and Quality Sub Group)

Establish a performance framework that prescribes targets that are then met across the strategic priority areas of this plan and meet national performance requirements.

Care Act/ Legislative Compliance (Policy and Practice Sub Group)

Ensure our adult protection processes comply with legislative requirements and are person centred and outcome focussed.

Prevention (Policy and Practice Sub Group)

Support people to identify and report signs of abuse and suspected criminal offences. This will involve training staff and considering how we make our local community safer in all our work. When abuse occurs, we will provide support aimed at removing or reducing risks or reoccurrence.

User/Carer Voice (Performance and Quality Sub Group)

Ensure the user's voice is heard throughout the adult protection process and user feedback is used to inform future practice. Where an individual lacks capacity, we will act in their best interests.

Awareness (Training and Communication Sub Group)

Establish and maintain a wide range of awareness raising initiatives across partner agencies that provide individuals with the right information about how to recognise abuse and how to keep themselves safe.

Partnership Engagement (Training and Communication Sub Group)

Ensure that partners are fully engaged and fulfilling their resources in achieving the objectives of SAB. In doing so, foster a 'one team' approach that places the welfare of individuals before the 'needs' of the system.

Learning Lessons and Improvement (Learning and Improvement Sub Group)

Ensure learning from serious concerns investigations, including domestic homicide reviews influences practice development across all partner agencies.

Perspectives of Key Partners

The perspective of Durham County Council is reflected throughout this document as the lead agency. The following represents a brief summary of the developments that have taken place within the other key safeguarding adults partnership organisations.

Durham Constabulary

Durham Constabulary continues to meet a growing demand in the safeguarding arena through dedicated Safeguarding Adult Teams staffed by qualified and experienced detectives.

The service is committed to working closely with partners to reduce the demand created by repeat victims/perpetrators. Good practice includes a designated Detective Superintendent to drive forward this partnership working which includes increased focus on mental health. This is already paying dividends with mental health practitioners working out of our custody suites and improved pathways into local health services. The introduction of the Care Act has also given increased focus towards the needs/expectations of vulnerable adults and the Constabulary will continue to work hard to meet these requirements. A designated Detective Chief Inspector now focuses on these issues, recently introducing front line training around the Care Act.

In addition the force is managing Operation 'Seabrook' an historic investigation into physical and sexual abuse by staff on the inmates of former Medomsley Detention Centre from the 1960,s to 1987. The investigation has brought over 1200 victims forward, making it one of the largest enquiries of its kind and it has been praised nationally for its victim care strategy that has resulted in over 300 victims now accessing counselling services. There has also been increased demand on the police adult protection staff as a result Operation Yew Tree which has encouraged many people to report incidents of historic sexual abuse.

Tees, Esk & Wear Valleys NHS Foundation Trust

We continue to prioritise safeguarding as one of the Trust's strategic objectives in order to safeguard and promote the welfare of all adults who come into contact with our services and monitor its effectiveness through the Trust's governance arrangements and we remain fully committed to the safeguarding adult's partnership through the Safeguarding Adult Board and associated subgroups.

The Trust Board remains fully committed to on-going developments to enhance safeguarding arrangements and throughout 14/15 has continued to meets quarterly with our Local Authority colleagues through the Trust's multi agency Safeguarding

Adult steering group and internal operational group to oversee Safeguarding activity within the Trust, share information, monitor action plans in response to serious case reviews, domestic homicide reviews, inspections and audit.

Ensuring clinical staff has the necessary knowledge and skills to manage safeguarding effectively has been a key priority for 14/15 and has seen a significant increase in qualified staff trained at Level 2 with the added resources to support its delivery. As part of our commitment to the safeguarding agenda the level 2 training includes the Department of Health 'Workshop to Raise Awareness about Prevent' (WRAP) 3 session.

County Durham and Darlington NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust is accountable to patients for their safety and wellbeing through delivering high-quality care in a range of settings. This duty is underpinned by the NHS constitution that all providers of the NHS services are legally obliged to take account of. Quality is defined as providing care that is effective and safe which results in a positive patient experience.

Some patients may be unable to uphold their rights and protect themselves from harm or abuse. They may have the greatest dependency and yet be unable to hold the service to account for the quality of care they receive. The NHS has particular responsibilities to ensure that those patients receive high-quality care and that their rights are upheld, including their right to be safe.

County Durham and Darlington NHS Foundation Trust continues to be fully committed to the Safeguarding Adults Board. The Associate Director of Nursing (Patient Experience and Safeguarding) is a member of the SAB and the Safeguarding Adult Lead deputises. The Safeguarding Adults Lead is also an active member of the Board's Sub Group arrangements and is fully committed to ongoing developments to enhance safeguarding arrangements.

During 2014/15 the Trust's internal safeguarding group has continued to meet bi-monthly and is chaired by the Associate Director of Nursing (Patient Experience and Safeguarding); members include representation from all care groups, safeguarding adult lead, safeguarding children lead, looked after children team, training, named and designated professionals. The group oversees safeguarding activity within the Trust, shares information, monitors action plans in response to serious case reviews, domestic homicide reviews, inspections and audits, the group also reviews safeguarding policies, processes and procedures. The terms of reference and minutes of the meetings are received by the Quality and Healthcare Governance Committee which is a sub-committee of the Trust Board.

Since April 2012 all staff receives safeguarding adults awareness training as part of their mandatory training. At 31st March 2015, 92.7% of staff employed by the Trust had received some form of safeguarding adults training. The Trust continues to support the delivery of multi-agency safeguarding adults training and the Trust's dedicated safeguarding adults trainer has facilitated Level 2 safeguarding training sessions and Level 3 safeguarding training sessions were delivered to matrons and

managers with a lead responsibility for safeguarding. Mental Capacity Act 2005 and DoLS awareness has been raised through the essential training programme; this also includes key messages from the governments PREVENT strategy.

North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (ND, DDES CCG)

CCG's are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards adults at risk of abuse or neglect. ND and DDES CCG's continue to be committed to the safeguarding agenda and work closely with provider organisations to ensure that robust systems and processes are in place. The CCG, through the contractual clinical quality review process and commissioner assurance visits, looks for assurance that providers are meeting their contractual requirements. Safeguarding referrals are being received and acted upon and those without capacity are being cared for in their best interest. Failure to comply with such standards is identified and acted upon through the quality requirements of the NHS contract schedule.

Regular monitoring of associated activity takes place on a bi-monthly basis through the clinical quality review groups for key provider organisations.

Both of the CCG's are committed to the Durham Safeguarding Adults Board with CCG board level membership and the Safeguarding Adults Manager in attendance. The Safeguarding Adults Manager attends SAB Sub-Groups and chairs a newly formed Learning and Improvement Sub-Group looking at lessons learned and improvements to practice arising from Safeguarding Adult Reviews and serious incidents.

Key developments for 2014/2015 have included; the placing of lead GPs in all practices, awareness sessions to outline and support the lead GP role were delivered in October and January. A nurses/senior carer clinical forum for staff within care home settings has been set up on a bi-monthly basis to offer peer support/share best practice. It also provides clinical supervision, revision of the MAPPA process, policies for domestic violence and embeds safeguarding adults across primary care. A named GP in both areas continue to contribute to key pieces of work in relation to primary care and offer support and advice to practices as required.

Both CCGs are committed to training with a requirement that all staff undertake mandatory eLearning training in relation to adult safeguarding. Regular performance reports are received regarding compliance with any gaps addressed.

Safeguarding adults Mental Capacity Act (MCA) training events have been delivered through Protected Learning Time events in November for Derwentside, December for DDES and March for Durham and Chester le Street. All events were well attended.

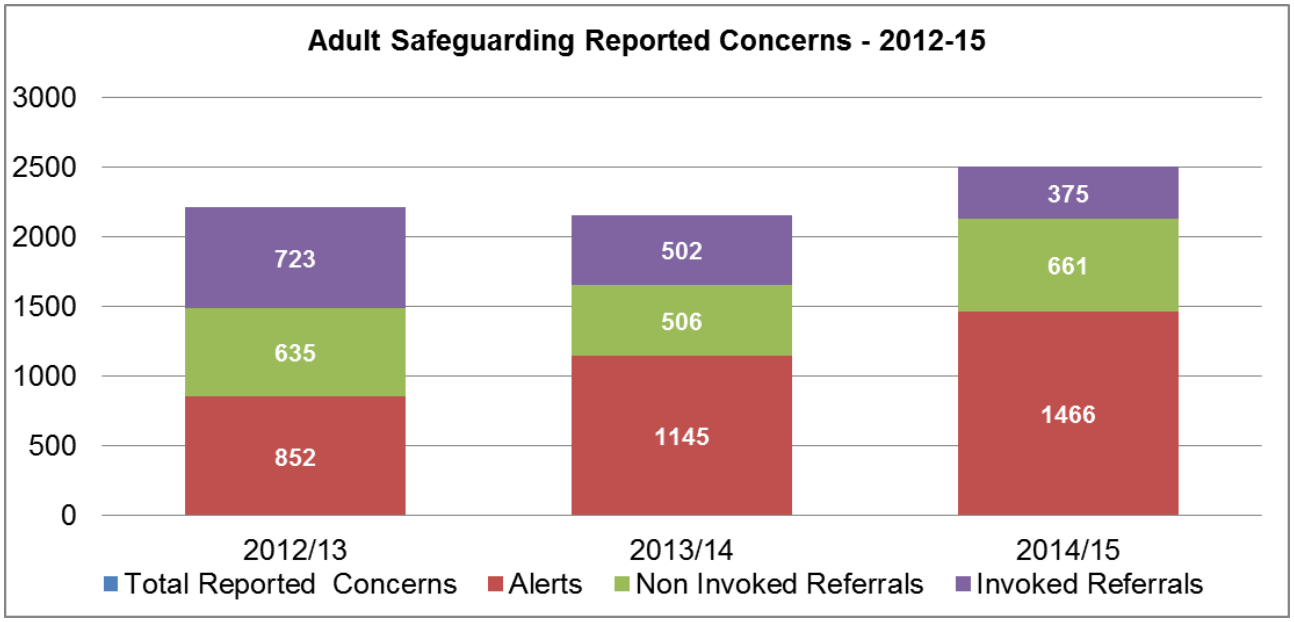
The Safeguarding Adults Manager and Named GPs have met with the Care Quality Commission (CQC) Inspection Manager for Primary Medical Services to further

develop an understanding of the safeguarding requirements for primary care. Initial feedback has been given to safeguarding leads at their initial training sessions.

During the year NHS England allocated monies to CCGs to raise awareness of the MCA/DoLS amongst a wide range of health staff including primary care. The programme of work developed has benefited primary care, secondary care, specialist mental health and learning disabilities, as well as independent sector providers (including care homes). Joint MCA events have been held across all three CCGs served by the safeguarding team with a total of 687 staff receiving awareness/training sessions, thereby offering assurance that a wide range of health staff have received MCA/DoLS awareness.

Safeguarding Activity in Durham

Table 1a and 1b (Reported Concern Rates - All Safeguarding Adults Referrals)



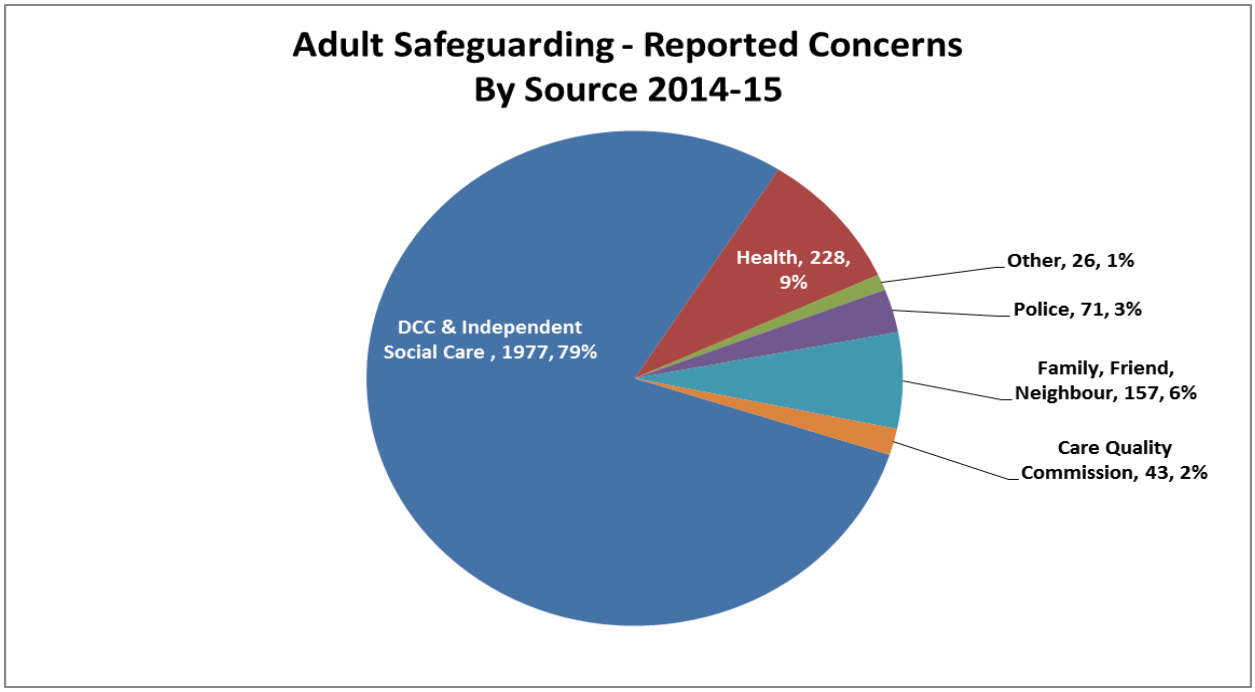
	All Reported Concerns	Referrals	Invoked	% Referred Invoked
2012/13	2210	1358	723	53%
2013/14	2153	1008	502	50%
2014/15	2502	1036	375	36%

For a number of years the Safeguarding Adults Board has invested a significant amount of time and effort providing training and awareness campaigns to help people recognise abuse and neglect and this has coincided with a progressive rise in the rate of reported concerns. Table 1a and 1b demonstrates an increase in 2014/15 of 349 from the previous year's producing a total of 2502 reported concerns.

Each reported concern is assessed around the risks and complexity of the case and is addressed with the most appropriated response. There are many ways that concerns can be addressed such as care management or care coordination, where a social worker may address the problem or issue in hand. Typically, it is the more serious or complex cases that require the safeguarding adults multi-agency procedures to be invoked. Of the 2502 reported concerns in 2014/15 there were 375 cases where safeguarding procedures were invoked and were dealt with using a multi-agency approach.

Table 7a and 7b also show a gradual decline in the number of cases where procedures are invoked. This is largely as a result of chances to procedures and operating practices that collect and advise information and resulting in more informed decision making and risk management.

Tables 2a & 2b Concern Source – (where identified)



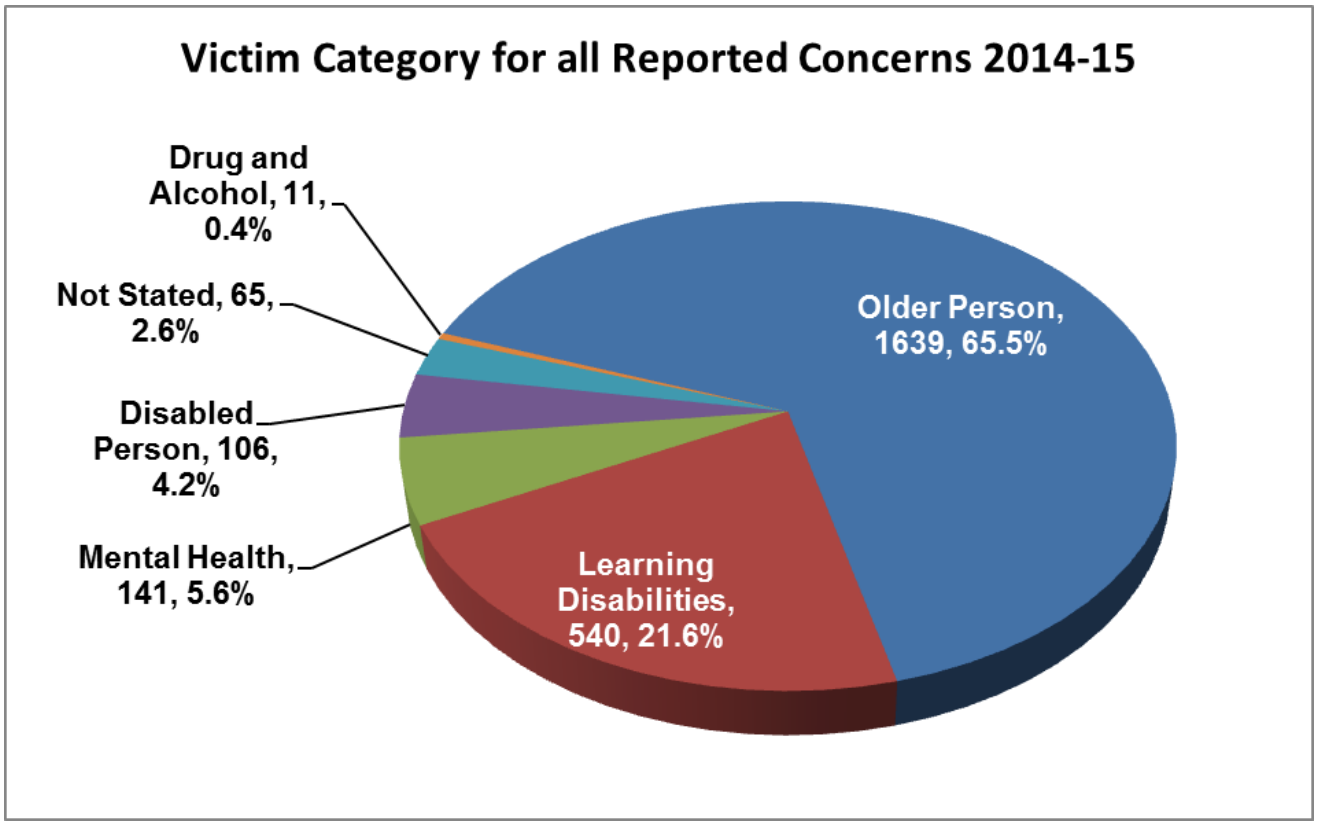
All Reported Concerns			
Source of Referral	**2012-13**	**2013-14**	**2014-15**
DCC & Independent Social Care	72.5%	80.2%	79.0%
Health	10.2%	6.2%	9.1%
Other	1.7%	1.4%	1.0%
Police	5.9%	4.2%	2.8%
Family, Friend, Neighbour	9.7%	8.0%	6.3%
Care Quality Commission	0.0%	0.0%	1.7%

Table 2a and 2b highlight that the largest source of reported concerns is from the local authority and the care provider sector which is consistent with previous years. This sector has had a strong focus on training and awareness in recent years and

staff working in this sector have regular close contact over long periods with service users.

Reported concerns originating from health (NHS) have risen close to the levels of 2012-13. This has coincided with development work carried by SAB and its NHS partners to improved reporting thresholds and mechanisms by NHS staff.

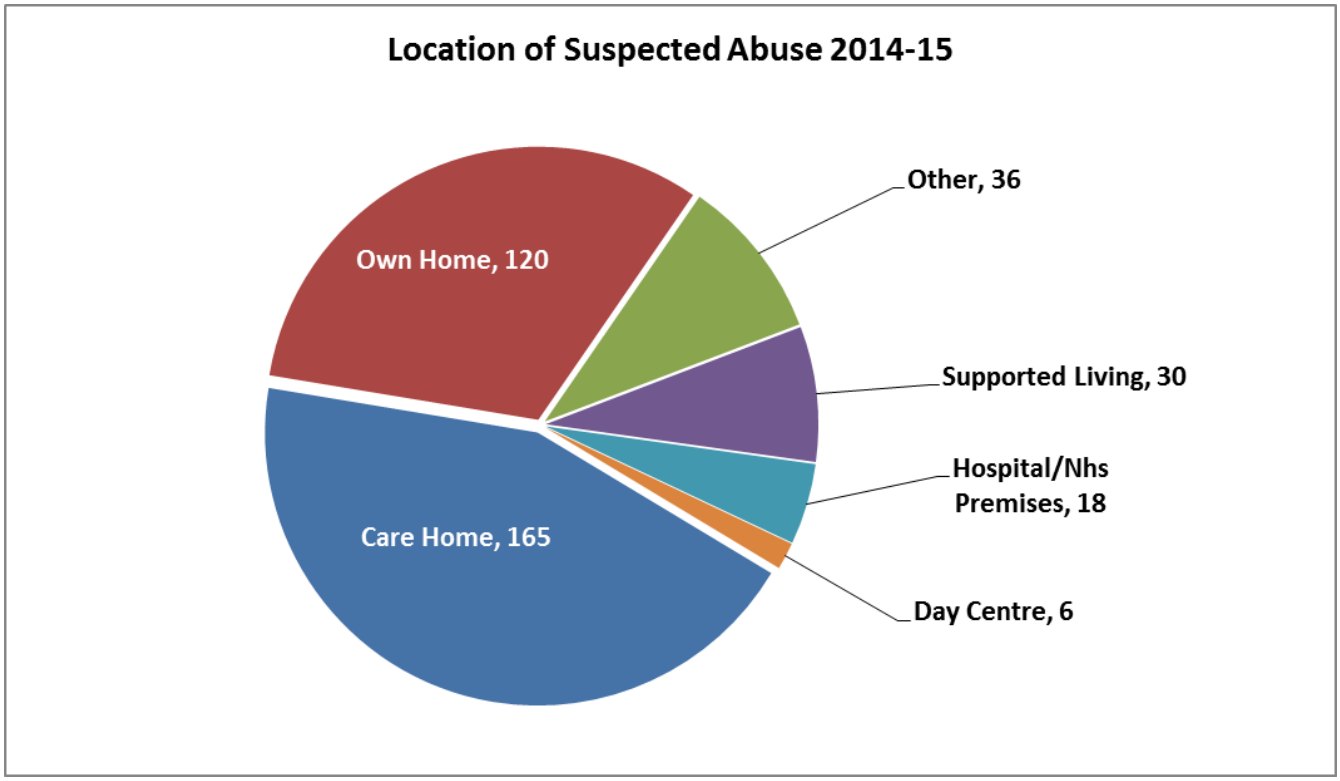
Table 3a & 3b (Victim Category - All Reported Concerns)



	2012-13		2013-14		2014-15	
Party Category	**Total**	**%**	**Total**	**%**	**Total**	**%**
Older Person	1397	63.2%	1345	62.5%	1639	65.5%
Learning Disabilities	458	20.7%	444	20.6%	540	21.6%
Mental Health	154	7.0%	209	9.7%	141	5.6%
Disabled Person	136	6.2%	116	5.4%	106	4.2%
Not Stated (Alerts)	41	1.9%	24	1.1%	65	2.6%
Drug and Alcohol	24	1.1%	8	0.4%	11	0.4%
Grand Total	**2210**		**2153**		**2502**	

There has been no marked percentage change in the types of alleged victims when compared to previous years other than that of mental health, which has seen a 4% drop. The categories of older person and learning disability continue to be the most prevalent. This is broadly in line with the prevalence of individuals in receipt of adult social care from these groups.

Tables 4a & 4b (Location of Abuse – Where Adult Safeguarding procedures were invoked)



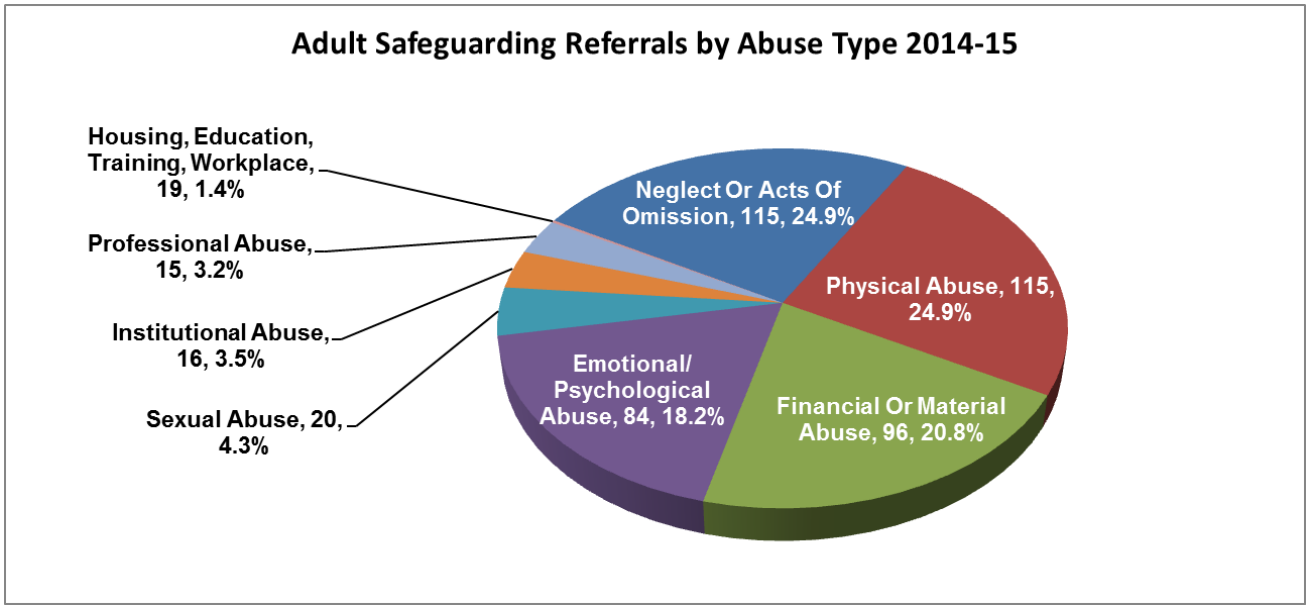
	2012-13		2013-14		2014-15	
Location	**Total**	**%**	**Total**	**%**	**Total**	**%**
Care Home	381	52.70%	250	49.80%	165	44.00%
Own Home	212	29.30%	175	34.90%	120	32.00%
Supported Living	51	7.10%	34	6.80%	30	8.00%
Hospital/NHS Premises	23	3.20%	21	4.20%	18	4.80%
Other	51	7.10%	17	3.40%	36	9.60%
Day Centre	5	0.70%	5	1.00%	6	1.60%
Total	**723**		**502**		**375**	

Table 4a and 4b highlight that the most prevalent location of reported abuse comes from the care home sector followed by own home which is consistent with previous years and the national picture.

The overall number of invoked referrals has reduced but this is in line with the overall drop in those cases where the multi-agency procedures are invoked.

The Safeguarding Adults Board continues to raise awareness and standards linked to reporting safeguarding incidents in both the community and care settings.

Tables 5a & 5b (Type of Abuse - Where Adult Safeguarding procedures were invoked)

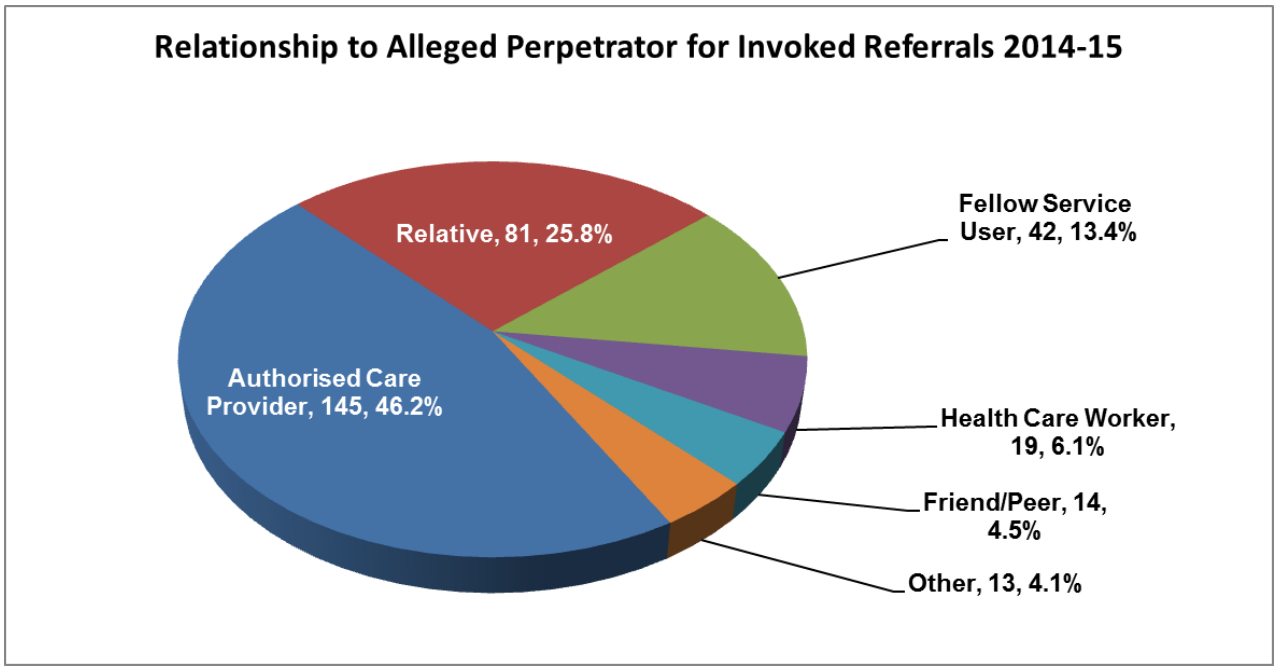


	2012-13		2013-14		2014-15	
Type of Abuse	**Total**	**%**	**Total**	**%**	**Total**	**%**
Discriminatory Abuse	4	0.50%	3	0.50%	1	0.20%
Emotional/ Psychological Abuse	128	14.80%	95	15.10%	84	18.20%
Financial Or Material Abuse	165	19.10%	126	20.00%	96	20.80%
Institutional Abuse	13	1.50%	22	3.50%	16	3.50%
Neglect Or Acts Of Omission	236	27.30%	167	26.60%	115	24.90%
Physical Abuse	262	30.30%	158	25.10%	115	24.90%
Professional Abuse	18	2.10%	9	1.40%	15	3.20%
Sexual Abuse	38	4.40%	49	7.80%	20	4.30%
Grand Total	**864**		**629**		**462**	
N.B. There may be more than one abuse type per referral.						

Neglect or acts of omission and physical abuse represent the most commonly reported forms of abuse. This is closely followed by financial/material abuse and emotional/psychological abuse. Not only does this reflect the pattern of the previous 2 years in Durham, it is broadly consistent with both national and regional figures.

Of the 375 invoked referrals, a total of 462 types of abuse have been referred. This is because an individual can be identified as a victim of more than one form of abuse.

Tables 6a & 6b (Perpetrator Category)

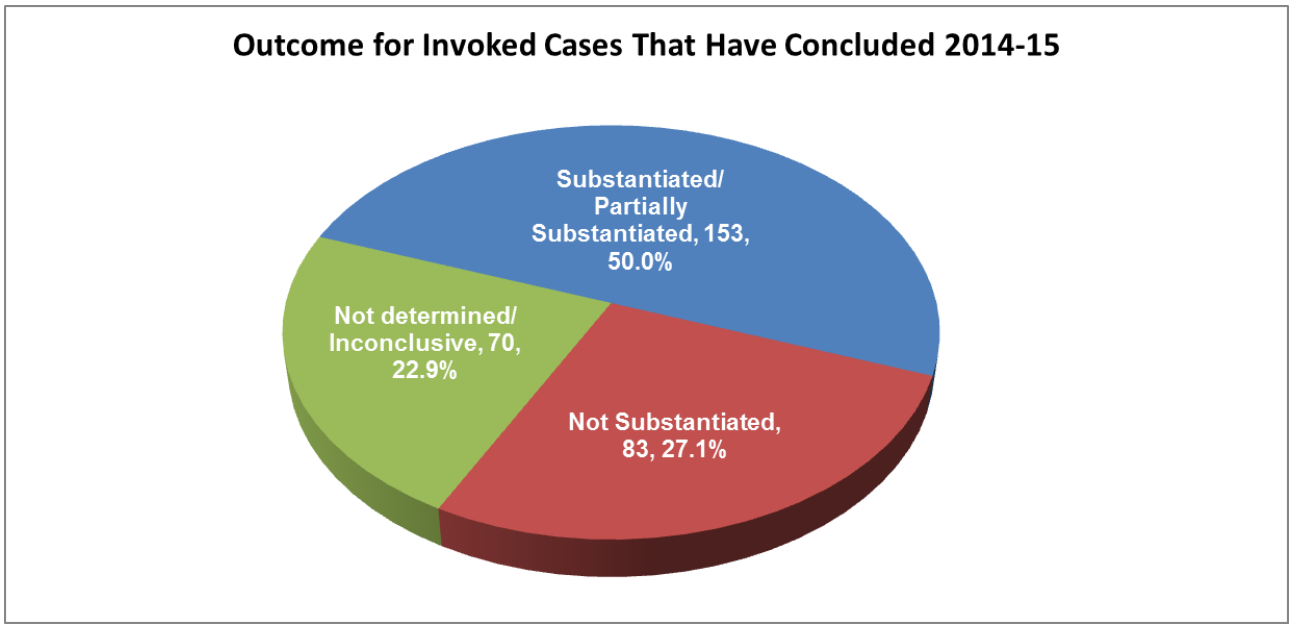


	2012-13		2013-14		2014-15	
Relationship Type	**Total**	**%**	**Total**	**%**	**Total**	**%**
Authorised Care Provider	175	33.2%	204	45.9%	145	46.2%
Relative	139	25.5%	85	19.1%	81	25.8%
Fellow Service User	99	18.3%	63	14.2%	42	13.4%
Health Care Worker	15	3.1%	22	5.0%	19	6.1%
Friend/Peer	11	2.0%	5	1.1%	14	4.5%
Other	97	18%	65	14.6%	13	4.1%
Grand Total	**545**		**444**		**314**	

There is relative year on year consistency in the levels of each perpetrator category type. ‘Health Care Worker’ has seen a gradual percentage increase and fellow service user has seen a general percentage decrease. The category of ‘Other’ has seen a marked decrease signifying better recording practice

The close contact that care providers and relatives have with service users means that they generally attract more allegations than other relationship types.

Tables 7a & 7b (Outcomes of Invoked Referrals)



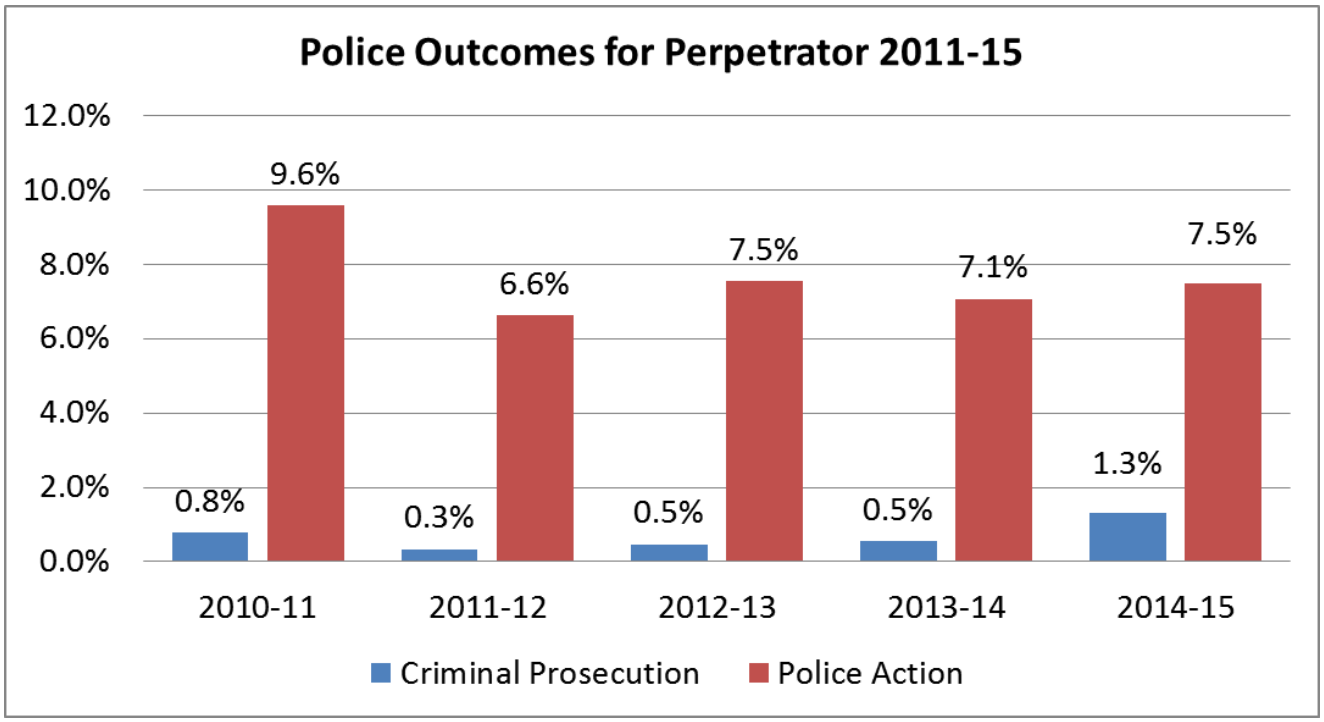
	2012-13		2013-14		2014-15	
Outcome	**Total**	**%**	**Total**	**%**	**Total**	**%**
Substantiated/ Partially Substantiated	361	51.1%	221	49.3%	153	50.0%
Not Substantiated	170	24.1%	123	27.5%	83	27.1%
Not determined/ Inconclusive	175	24.8%	104	23.2%	70	22.9%
Grand Total	**706**		**448**		**306**	

Fifty percent of invoked cases were substantiated or partially substantiated, which represents a slight increase from the previous year. In these cases there are a variety of interventions that can and do take place to protect individuals including ongoing professional support, revisions to care/protection plans, advocacy and counselling interventions.

There are many reasons why the remaining cases (50%) are determined as not substantiated or inconclusive, which include malicious/false allegations and insufficient evidence following completion of an investigation. Where it is required, ongoing support is provided to those people who need it.

In general terms, there remains a high degree of consistency year on year.

Tables 8a & 8b (Police Outcomes for Perpetrator)



	2012-13		2013-14		2014-15	
Outcome for Perpetrator	**Total**	**%**	**Total**	**%**	**Total**	**%**
Criminal Prosecution	4	0.5%	4	0.5%	6	1.3%
Police Action	65	7.5%	52	7.1%	35	7.5%
All Outcomes	**861**		**736**		**468**	

The police action and prosecution rates are consistent with previous years and remain low although there is a small increase in prosecutions on previous years.

There are a number of inherent difficulties mounting prosecutions involving vulnerable victims/witnesses such as communication and mental capacity issues of the victims.

In Durham, we have recently introduced a Vulnerable Victim/Witness Support Service. This service aims to support such individuals in being able to give evidence and participate in the criminal justice process. In future years, it is hoped this will help to support a further increase in the number of criminal prosecutions.

Conclusion from the Safeguarding and Practice Development Manager

2014/15 has been both a challenging and exciting time to work within the field of safeguarding adults. Despite years of austerity significantly reducing public sector funding, efficiencies have continued to be made that protect frontline services that serve the most vulnerable in society. Dedicated safeguarding adults personnel working across the local authority, police and NHS services have been retained and additional resources have been found for an additional Safeguarding Lead Officer role in the local authority to increase capacity and resilience in coordinating investigations. Temporary monies have also been approved by the CCGs that will initially enable the SAB to create a 2 year Business Manager post. This post will be created in 2015/16 to bring a much needed resource to SAB and enable it to strengthen collaboration across the partnership and to fulfil its strategic priorities following the implementation of the Care Act.

Much of our effort this year has focussed on the implementation of the Care Act in April 2014. This provides a statutory platform to SABs and requires the local authority, CCGs and the Police to be represented. In Durham, an implementation plan was produced then was overseen by an inter-agency task and finish group made up of key SAB partners. This has resulted in a coordinated implementation process covering the key requirements of this new legislation.

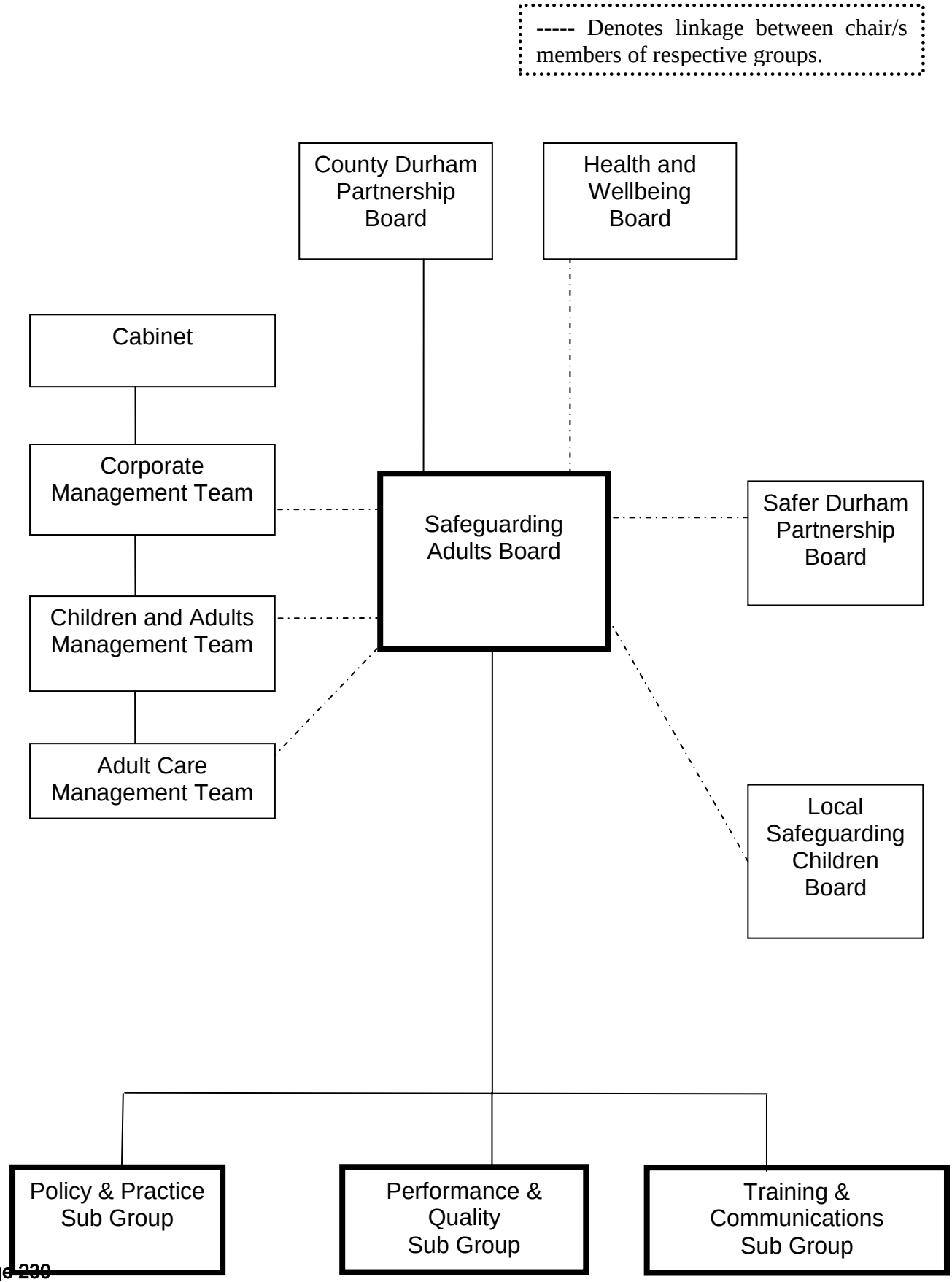
Looking ahead, the introduction of 'Adult Protection' as a new concept following the introduction of the Care Act will perhaps be the most significant change to our inter-agency procedures. In essence, the Care Act guidance recognises the term 'safeguarding adults' to be wide reaching. Self-neglect is introduced as a new category of abuse together with modern slavery and domestic abuse. As with other categories of abuse, each of these new categories typically presents with a different set of issues that may require very different responses depending on the risks and the vulnerability of the victim. The term 'adult protection' will be used to define those cases that require the consideration of a full inter agency investigation. In addition, over the forthcoming year further work will be undertaken to strengthen processes so ensuring that, in cases of Child Sexual Exploitation (CSE), when children transition to adulthood they are captured within adult care services framework.

Finally, the development of new strategic planning and performance monitoring processes will be the focus of much of the SAB's business during 2015/16. Our priorities will include placing greater emphasis on partnership engagement, learning lessons and improvement and improving the user/carer voice.

Lee Alexander
Safeguarding and Practice Development Manager

Appendix 1

Reporting and Interface Arrangements



Appendix 2

Abbreviations / Glossary of Terms

ADASS - Association of Directors of Adult Social Services (formerly ADSS)

BIA - Best Interest Assessor

CCG - Clinical Commissioning Group

SDPB – Safe Durham Partnership Board

CAS – Children and Adults Services

CDDFT - County Durham & Darlington NHS Foundation Trust

CQC - Care Quality Commission

CRU - Central Referral Unit (Police)

DASVEG – Domestic Abuse and Violence Executive Group

DBS – Disclosure & Barring Service

DOH - Department of Health

DoLS - Deprivation of Liberty Safeguards

GP – General Practitioner

HMPS – Her Majesty's Prison Service

IC+ - Intermediate Care Plus

LA - Local Authority

LSCB - Local Safeguarding Children Board

MAPPA - Multi-Agency Public Protection Arrangements

MARAC - Multi-Agency Risk Assessment Conference

MCA - Mental Capacity Act

NHS - National Health Service

NHS CDD - NHS County Durham & Darlington

NHSE – National Health Service England

NPS – National Probation Service

SAB - Safeguarding Adults Board

SAR – Safeguarding Adults Review

SCIE – Social Care Institute of Excellence

SLO - Safeguarding Lead Officer

SSID - Social Services Information Database

TEWV - Tees, Esk and Wear Valleys

Contact Details

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For more information on Safeguarding Adults in Durham:
Go to: www.safeguardingdurhamadults.info

To report a safeguarding alert please contact:
Social Care Direct 03000 267979

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Health & Wellbeing Board

21 January 2016

Children's Services Update

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

Purpose of the Report

1 The purpose of this report is to provide an update to the Health & Wellbeing Board on the national and local developments in relation to Children's Services.

Background

2 A report was presented to the Health & Wellbeing Board on 14 May 2015 providing information on the national and local developments which support early intervention and prevention for effective and rigorous protection of children and young people.

3 The report provided the Health and Wellbeing Board with an overview of the Children's inspection regime, significant areas of focus and an update on the transformation journey that has been undertaken in Children's Services in Durham.

National Context

Single Inspection Framework (SIF)

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

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

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

6 Benchmarking and learning from other Local Authorities who have already been subject to inspection by Ofsted under this framework continues in the service. To date, 74 Local Authorities have been inspected and had reports published. Of these, 17 (23%) have received an overall effectiveness judgement of 'good'. Over three-quarters are rated below Ofsted's benchmark of 'good', with 38 (51%) judged to 'require improvement' and 19 (26%) as 'inadequate'. No local authorities have been judged as 'outstanding' under the SIF.

7 With regard to reviews of the LSCBs in 74 of the local authorities inspected under SIF, 22 have been judged to be 'good' (30%), 39 (53%) as 'requires improvement' and 13 (17%) as 'inadequate'. No LSCBs have been judged to be 'outstanding' under the SIF.

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

9 Ofsted, the Care Quality Commission as well as Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation released a consultation on the framework for joint area inspections on 15 July 2015; the outcome of the consultation is awaited.

Children's Centre inspections

10 The Minister for Childcare and Education announced in July 2015 a consultation on the future of children's centres. This included a discussion of what accountability framework is needed to best demonstrate their effect. In light of this, the Department for Education (DfE) has agreed with Ofsted to pause the children's centre inspection cycle, pending the outcome of the consultation.

11 This means that any children's centre inspections due in the 2015/2016 academic year as prescribed by the Children's Centre (Inspections) Regulations 2010 will not now take place until after the consultation.

12 Children's centres are expected to continue their work as usual during this pause, including collecting and monitoring of data in preparation for inspection. Ofsted will continue inspection of early years provision on the site of children's centres as part of the new common inspection framework implemented from September 2015. Ofsted will also continue to respond swiftly to any complaints or safeguarding concerns in children's centres.

Child Protection Taskforce

13 In June 2015 the Prime Minister announced a new taskforce to drive forward fundamental reforms to transform child protection.

14 Chaired by the Secretary of State for Education the taskforce will focus on transforming social work and children's services, improving inspection and tackling child sexual exploitation. It will join the 10 other implementation taskforces, including the digital taskforce, already established across government to monitor and drive delivery of the government's cross-cutting priorities.

15 The taskforce's terms of reference are to drive improvements in the protection of vulnerable children by extending and accelerating reforms to the quality of children's social work practice and leadership; promoting innovative models of delivery; and overhauling the way that police, social services and other agencies work together locally.

Failing Children's Services in local authorities

16 In December 2015 the Prime Minister announced reforms which will mean poorly performing children's services will be subject to a new service leader if they do not improve.

17 In a formalised academy-style system, sharper triggers will be put in place so an emergency Ofsted inspection can be ordered where there are concerns about an authority's performance. If a local authority's children's service fails to improve within six months of their Ofsted inspection, a new service leader (Commissioner) will be put in place. High-performing local authorities, experts in child protection and charities will be brought in to turn the children's service around.

Youth Justice

18 The Lord Chancellor and Secretary of State for Justice announced the national review of the Youth Justice System, on 11 September 2015. The Youth Justice Board (YJB) has welcomed the review.

19 The review will look at evidence, current practice and governance arrangements in preventing youth crime and rehabilitating young people who offend and explore how the youth justice system can most effectively interact with wider partner services for children and young people. The results of the review will be reported in summer 2016.

20 Following an announcement by the Secretary of State for Justice, the YJB issued a 10.6% in year cut to the Youth Justice grant to Youth Offending Teams (YOTs) was confirmed in November.

Regional Context

Child Sexual Exploitation (CSE)

21 The region continues its commitment to addressing CSE and has established a North East Tackling Exploitation Board which includes senior representatives from local authorities, the three police forces in the region, NHS England and a local academic. The Board seeks to progress actions from a regional workshop held on 4th September 2015 on Lessons Learnt from Operation Sanctuary around tackling the exploitation of children and vulnerable adults.

22 **Training**

23 A regional website is also being developed to bring together all the new workforce initiatives within the region including participation in Frontline, Step Up to Social Work, Think Ahead and to promote our regional masterclass programme.

24 Discussions are underway with all 12 local authorities and the universities in the region (plus York University) about the future of social work training within the region in the context of the Teaching Partnerships paper published by the Department for Education. Durham County Council is heavily involved in the development of new models for accreditation of social workers.

Regional Adoption agencies

25 In June, 2015 the Department of Education set out proposals to move to regional adoption agencies to help speed up matching and markedly improve the life chances of neglected and damaged children; improve adopter recruitment and adoption support; and reduce costs.

26 The Government are providing £4.5m of support to early adopters of regional adoption agencies to accelerate their development and early implementation in 2015-16. The overall aim of this funding is to stimulate initial change in the sector. Therefore, the Government are looking to work with local authorities, voluntary adoption agencies and other organisations who wish to redesign radically their approach to adoption in 2015/16. Decisions on funding for 2016-17 and beyond will be subject to the Spending Review.

27 A Regional Adoption Board chaired by the Stockton Director of Children's Services is leading this work.

Local Context

Child Sexual Exploitation (CSE)

28 The Durham Local Safeguarding Children Board (LSCB) has prioritised work on Child Sexual Exploitation (CSE) since 2011. Child Sexual Exploitation was identified as a strategic policing requirement in March 2015. CSE is also a community safety priority as outlined in Louise Casey's inspection report of Rotherham Metropolitan Borough Council.

29 The LSCB Missing and Exploited Sub-Group (MEG) carried out an analysis of Child Sexual Exploitation in County Durham in 2014 and this has recently been updated to cover the period April 2014 to March 2015. The analysis found that:

- Online CSE continues as the most common model of sexual exploitation. The prevalence of this has increased (from 25% to 37%).
- There were 230 young people identified as at risk of CSE.
- Little community intelligence is being gathered or submitted.
- The online model of CSE continues to be the most common.
- Most victims are female with the most common age being between 13-16 years.
- Most common nationality of perpetrators is British, people from the Middle East make up only 3%.
- Perpetrators of online CSE can reside anywhere in the world and can be difficult to identify and convict. Online vigilantes are an emerging trend identified in the data.

30 Seen in historical operations into CSE, 'Position of Trust' is a newly considered model which was not presented in previous profiles. This involves a perpetrator employed or volunteering in a position where the young person would be expected to trust that person who then goes on to sexually exploit the victim.

31 There are strong links between sexual exploitation and those young people who are reported missing from home. LSCB audits for both CSE and missing children incidents have highlighted a range of risks associated with those young people who go missing including sexual exploitation, mental health, alcohol or drugs. The offender profile is one of 'street grooming' and use of social media to exploit children.

32 The LSCB Child Sexual Exploitation Strategy and action plan 2014-2017 outlines the key actions to be progressed to achieve the strategic aims of:

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

33 Progress against actions since the last report includes:

- Intervene to Protect a Child' (IPC) training - a new and proactive training tactic to identify and disrupt offenders.
- Developing stronger relationships with communities through Area Action Partnerships (AAP), raising awareness of CSE and how to report concerns or intelligence of CSE.
- Working with primary and secondary schools to advise on internet eSafety, utilising Sexual Relationships Education (SRE) to deliver messages on consent and healthy relationships and through the ChildLine Schools Service using workshops and assemblies delivered by specialist trained volunteers, to educate primary school children, aged nine to 11 years old to understand abuse and help them stay safe.
- Widening our CSE training and awareness to those services not traditionally associated with safeguarding.

34 This has led to a programme of voluntary training for taxi drivers with over 600 taxi drivers trained and further sessions planned for later in the year. The sessions have been delivered by police and LSCB trainers with a CSE expert on hand at each session. The sessions have been coordinated by the LSCB Business Unit and Environment Health and Consumer Protection (EHCP). The sessions have also enabled police to gain intelligence from taxi drivers prompted by the training received.

35 The MEG plan to continue the training in 2016 and to widen the invitation to other external services such as Hotels, Take Away outlets, Off-licence trade and internally to staff such as Waste and Recycle Teams, Environmental Services, and Neighbourhood Wardens.

36 The ‘ERASE’ brand (Educate and Raise Awareness of Sexual Exploitation) has been created to tackle child sexual exploitation (ERASE offers parents and carers advice on how to communicate with their children about who they speak to on-line and off-line)

37 A dedicated multi-agency ERASE team was launched in August 2015 focusing on early identification of young people at risk and suspected offenders to prevent further missing / absent episodes and further improve our response to child sexual exploitation.

38 The ERASE website was launched in November 2015. The front page has links for younger children, older children, parents/carers and professionals and also links to the LSCB website.

39 A CSE Disruption Toolkit has also been developed to enable practitioners to highlight to the police risk factor behaviour around potential perpetrators. The use of this toolkit continues to be promoted in presentations and awareness raising events.

Multi Agency Safeguarding Hub (MASH)

40 Launched on 2nd March 2015 the MASH consists of a multi-disciplinary team which works together as part of the First Contact Service to screen, gather, analyse and share information relating to concerns about children in County Durham who may be at risk of harm, or who need support services. The team also has access to information via single point of access (SPOC) across a range of organisations who specialise in mental health (Tees Esk and Wear Valleys NHS Foundation Trust) and drugs and alcohol (through the new provider, Lifeline).

41 The MASH team is made up of a MASH Co-ordinator, Social Workers and School Attendance Enforcement Officer (from Children's Services), a Detective Sergeant and Detective Constable, a Senior Safeguarding Nurse and a Harbour Domestic Abuse Service Co-coordinator.

42 Since their launch the MASH has dealt with 3,623 concerns about children and young people. Further achievements include:

- Information shared at the point of referral has led to quicker and better informed decisions about risk.
- Information is more easily accessible and has resulted in more timely referrals to the right services
- A collective understanding of thresholds has improved consistency of families referred to the appropriate service.

Children's Social Care Innovation Programme

43 Durham was successful in two bids to the Children's Social Care Innovation Fund.

44 The first was for £496,000 for a therapeutic support programme at Aycliffe secure centre for children that have been sexually exploited. This offers targeted support in helping young people deal with trauma and in making the transition from the secure setting into more independent living. The Durham Unit team became operational from 18 May 2015 and the service is being delivered in partnership with Barnardos and Odysseus Mentoring Project.

45 The funding allows for a three pronged approach:

- Therapeutic and mentoring services are being offered within a secure unit for a minimum of 3 months and then up to 3 months as part of resettlement into the community (up to 18 months for the mentoring services). A step down facility is available as part of the transition.
- New training programme for Aycliffe staff in CSE and trauma to prioritise more effective interventions.
- Clinical supervision for staff to embed the training and provide increased awareness and learning so that a therapeutic culture is developed on the unit.

46 The Durham Unit is 6 months into its support programme and is awaiting its midway evaluation report, which will be carried out by Oxford University in November 2015.

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

48 Progress on the main innovative elements of Durham's programme are as follows:

- **Creation of Families First Teams** - all three first stage integrated early help and social work teams achieved 'go-live' week commencing 20th July 2015, with the teams adopting flexible ways of working.
- **Third sector alliances have been strengthened** with positive regional interest in Durham's developments. A memorandum of understanding (MOU) has been finalised, which underpins the voluntary community sector (VCS) Alliance Model, the model provides long-term and sustainable help and support for children, young people and families.
- **An intensive workforce development programme has commenced** - all staff in stage 1 teams received induction training prior to go-live with further staff events held in September and November 2015. The pilot reflective practice model which promotes integrated working has been agreed and commenced in November 2015.
- **Enhanced service user engagement** is a key feature of the Innovations Programme and ongoing staff and partner engagement and briefings held regularly. Stage 1 Go Live area was launched on 29th September 2015 at Shotton Hall Conference Centre. The event was opened by Councillor Tracie Smith, Cabinet Support Member for Children and Young People's Services and was well attended with over 180 participants from across all partnership agencies.

49 The evaluation of the programme is ongoing and an interim report has been produced and submitted to the Department for Education (DfE). A Service User Survey and Staff Survey took place during October to November 2015 and the results are awaited. Dedicated research staff have been appointed and trained to progress future evaluation of the programme

50 Work is on target with phased implementation of the remaining seven Families First teams between January and February 2016.

Stronger Families

51 Durham successfully implemented and delivered Phase 1 and met its full target of 'turning around' 1,320 families by March 2015.

52 Following Durham's invitation in August 2014 to be one of the of the Troubled Families programme's Early Starters Durham will work with 4,330 families and deliver Phase 2 over a 5 year time period.

53 This new phase includes much broader eligibility criteria enabling the majority of families worked with by social care services to be part of the programme and to achieve results payments. There is a very clear need to shift our focus to ensuring families are worked with in such a way that supports significant and sustained change.

54 All programmes are required to develop a local Family Outcome Framework (FOF), describing the programme's identification criteria and outcomes.

55 The key actions for phase 2 include:

- Embedding the use of the FOF and development of outcome-focused care plans.
- Coordination of the workforce development with the Service Transformation and Innovations Programme and LSCB.
- A range of ICT developments to help manage the information requirements of the expanded programme, including Family Progress Data and outcomes evidence collection for payment-by-results.
- Revise the payment-by-result methodology and grant terms of reference with our Internal Audit service.
- Carry out a 'refresh' of the cost saving calculator data once data is available and investigate the cases where there is a particular increase in the costs associated with fostering and residential care.

56 The Stronger Families programme has informed the development of the Children's Services Innovations programme. Stronger Families will cease to be identifiable as a separate programme, and will become the core of new Families First teams. This will make best use of the learning and expertise built during the programme, but also the resources generated through the programme, in order to achieve improved outcomes for all vulnerable families in County Durham.

Youth Offending Service (YOS)

57 A peer review of County Durham (CDYOS) took place in October 2015 following a request by the Senior Leadership Team and approval by the Chair of the Management Board in late 2014.

58 Youth Justice Peer Reviews are part of the sector-led improvement process and are designed to be collaborative an opportunity at no cost for CDYOS and the Management Board to gain a fresh perspective on the service from critical friends.

59 The scope of the peer review and specific key lines of enquiry (KLOE) were agreed at a scoping meeting in August 2015. The focus of the review was to examine how CDYOS, with its partners, is delivering youth justice services. The overarching aim was to review the developments put in place since the Short Quality Screening (SQS) inspection (July 2014) and the effectiveness of the restructure (February 2014). Specific KLOEs included reviewing restorative justice practice and the young person's pathway through the service.

60 The findings of the review are positive and the Management Board will oversee an action plan as part of the Service Improvement Plan.

61 Additionally CDYOS gave evidence to the All Party Parliamentary Group on Speech and Language Difficulties on 19 October 2015. The CDYOS presentation showcased the progress and key learning from the Service's Speech, Language and Communication Needs (SLCN) Strategy, which commenced in March 2014.

Performance

62 Improvement in performance is shown across a range of key indicators. As at the end of September 2015 reductions and favourable benchmarking comparison are shown in the number and rate of children in need (339.8 per 10,000) and the number and rate of children whose needs are met through a Child Protection Plan (33.9 per 10,000).

63 The rate of children in need re-referrals is also reducing, with 21.8% referred again within 12 months of a previous referral, and with 9.7% of children requiring a child protection plan for a second or subsequent time within 2 years of the last one (April – September 2015).

64 As at end of September 2015, a high proportion of our looked after children are in foster care, (82.3%) with only 8.5% in residential care. Provisional data as at 31st March 2015 shows 90.6% of our children are placed within 20 miles of home; 78.6% within the boundaries of County Durham, a much better rate than national levels.

65 There has been improvement in the timescales for the average number of days between a child entering care and moving in with its adoptive family (for those who have been adopted) from 533 days in 2013/14 to 449 days for 2014/15. 100% of children are placed for adoption in 9 months, compared to the national average of 17 months.

66 The work and performance outlined above has been achieved through continued budgetary pressures, the demands of possible inspection and whilst austerity measures continue. Children's Services has embarked on an ambitious programme of transformation whilst ensuring existing services continue to deliver good services to children and their families.

Recommendations

67 The Health & Wellbeing Board is recommended to:

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

Contact: Carole Payne, Head of Children Services
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Appendix 1: Implications

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

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

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

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

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

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

Human Rights
None

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

Procurement
None at this stage

Disability Issues
None at this stage

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

Health and Wellbeing Board

21 January 2016

Update from Healthwatch County Durham

Report of Judith Mashiter, Interim Chief Executive, Healthwatch County Durham

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the strategic direction, structural changes, activities and outcomes of Healthwatch County Durham during the period April to September 2015.

Background

2. On 1 April 2015 Healthwatch County Durham Community Interest Company (CIC) became the body commissioned by Durham County Council to deliver the statutory local Healthwatch service. The contract is due to finish in March 2015 and, at the time of writing, plans are being made for arrangements beyond that time.

3. The board, staff and volunteer team of Healthwatch County Durham continue to evolve and develop in response to experience and better understanding of the stakeholder landscape, changing policies in the health and social sector and an increasing base of evidence from consumers.

4. The three strands of Healthwatch work are:

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

5. Healthwatch County Durham publishes a news bulletin every month and its Annual Report 2014/15 was published in June 2015 and presented to the Health and Wellbeing Board in September 2015.

Strategic direction

6. Healthwatch County Durham published 'Our Plan', setting out its strategic priorities for 2014/15 to 2016/17. Priorities are being reviewed and a refreshed 'Our Plan' will be published in March 2016. For the period covered by this report the Healthwatch priorities align with those of many key organisations within the local health and social care economy. The two priority issues on which Healthwatch County Durham has been gathering people's views are: Integrated health and social care; and 'Making sense of it all' (knowledge, understanding, accessibility and navigation around the systems). The three priority groups of people with whom Healthwatch County Durham has been engaging are: Those seldom heard; Children and young people; and The elderly and those with dementia.

Governance, organisational and staffing changes

7. Healthwatch County Durham CIC was formed with the specific purpose of delivering the local authority's statutory Local Healthwatch service. The organisation is an independent, free-standing social enterprise.

8. In the early part of 2015/16 four Advisory Board members became Corporate Board members and since that time the Corporate Board has been quite stable in membership and oversees both the Healthwatch consumer champion service delivery, and the business, infrastructure, governance and finance functions which will enable the organisation to delivery its consumer champion activities.

9. Due to 'natural causes' such as retirement, maternity and job progression, there has been a high turnover of staff in recent months and this led to the additional appointment of the Chair to the interim role of Chief Executive. In January 2016 a recruitment campaign will be launched and new appointments made to Chair, Chief Executive, Engagement Leader and additional board member posts.

10. Volunteers are a valuable resource to Healthwatch County Durham. A review of volunteer activity has resulted in six new volunteer role descriptions: Enter & View Authorised Representative, Engagement Volunteer, Meeting Representative, Administrative Assistant, Mystery Servicer User and Healthwatcher. A volunteer event was held in September 2015 to reinvigorate the volunteer programme and learning from that continues to be applied.

Activities and outcomes, April to September 2015

11. Listening:

    - Healthwatch County Durham has engaged with 1,475 people through face-to-face, telephone or personal email contact (i.e. excluding social media 'broadcasts', e-bulletins or mail-outs).

- This engagement was through a variety of events, workshops, drop-ins etc., and included new activities with:

    - Mental health service users.
    - Willowburn Hospice service users.
    - A Bishop Auckland market stall to engage with members of the public.
    - Patient Reference Groups.
    - Dementia clubs.

- The use of the Healthwatcher 'comment box', operated by a volunteer in their community, supported by Healthwatch County Durham staff, has continued to develop and at the end of September there were 13 Healthwatchers. New venues for the comments boxes included Chester-le-Street library, the Education Centre for Children with Down Syndrome and Willowburn Hospice.

- Engagement at University Hospital of North Durham and at Bishop Auckland Hospital continues on a regular basis. Engagement at the county's community hospitals has been incorporated into the engagement programme where possible.

- Initial attempts have been made to have a named Healthwatch volunteer as a link person with each Area Action Partnership, especially those with health and wellbeing as a priority. Tentative success has been achieved with Teesdale and mid-Durham.

- Preparatory work is underway to begin engagement with offenders in County Durham's prisons.

- Engagement with employees of Durham County Council has been piloted, with lunch-time events at County Hall and at Spennymoor offices.

- Engagement Leaders have worked with Durham Foodbank and sought views from and offered help to foodbank clients on health and social care issues.

- A survey on patients' and carers' experiences of Patient Transport Service was launched as a result of consumer comments. Analysis will be completed and results published. Where appropriate, challenge will be made to the Chief Officers of the Clinical Commissioning Groups and the North East Ambulance Service (NEAS).

- On behalf of NHS England Healthwatch hosted an online survey of views on access to emergency dental service over the Christmas holiday period. The response rate was extremely low.

12. Speaking up:

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

    - Ambulance response times and delays (5 negative consumer comments). Correspondence and meetings are ongoing with North East Ambulance Service through the service's Healthwatch Forum and directly with the Chief Executive.
    - The content and tone of the Blue Badge renewal letter issued by Durham County Council was brought to the attention of Healthwatch by a frail, elderly resident.

- Healthwatch has worked directly with numerous stakeholders to champion consumers' views. For example: the County Durham and Darlington Foundation Trust (CDDFT) Patient Experience Teams has welcomed Healthwatch commenting on draft patient literature and on regular reports on complaints from each Care Group. Joint working to review to complaints process has been requested following the Care Quality Commission (CQC) inspection of CDDFT. Healthwatch provides input to the Local Dental Network, the Local Pharmacy Network and the Local Eye Health Network. In collaboration with other local Healthwatch in the Darlington and Tees Valley area, intelligence is fed to the Acute, Primary Care and general Quality Surveillance Groups of NHS England. Healthwatch County Durham has been invited to represent the patient interests on the Urgent and Emergency Care Network (including the Vanguard programme) and the Better Health Programme. Links have been established with both Clinical Commissioning Groups (CCGs) Research and Innovation committees in order to identify potential opportunities for consumer views to be sought and to feed in relevant intelligence. Healthwatch is actively involved in the Engagement Strategy development and commissioning intentions consultation of both CCGs. In preparation for our statutory input to Foundation Trust Quality Accounts, Healthwatch maintains contact with the relevant four trusts - CDDFT, North Tees and Hartlepool (NTH), Tees, Esk and Wear Valleys (TEWV) and NEAS and attends Quality Account in-year events.

- The Healthwatch County Durham team has been asked to contribute to a range of local, regional and national research projects and staff have been proud to do this. In July 2015 the report, 'Safely Home' from the Healthwatch England Special Inquiry into Unsafe Discharge from hospital, was published. Healthwatch County Durham coordinated and collated input to the Inquiry based on evidence gathered locally, and a board member was part of the Inquiry panel.

- A follow-up report on previous Children and Young People's survey work was sent to stakeholders in May 2015.

- Healthwatch County Durham has accepted non-voting roles on both CCGs' Primary Care Commissioning Committees.

- Healthwatch County Durham represents all Durham, Darlington and Tees Valley local Healthwatch on the Securing Quality in Health Services / Better Health programme board and is committed to working closely with the team working on pre-consultation engagement.

- Regular meetings for exchange of intelligence are held with: Tees, Esk & Wear Valleys Foundation Trust, Care Quality Commission, North East Ambulance Service and NHS England.

- Healthwatch is pleased to be involved with the Durham Dales, Easington and Sedgefield CCG's engagement strategy refresh.

- Healthwatch was invited to present on the Enter & View programme to all Practice Managers in the Durham Dales, Easington & Sedgefield CCG.

13. Advising:

- Healthwatch County Durham received 68 telephone calls to its Information and Signposting service between April and September.

- Work is in progress to update the two health and social care service directories for each of the two Clinical Commissioning Group areas. This work is in conjunction with Healthcare Publications Ltd. Consideration was given to producing a separate directory of mental health services, but the decision was made to contribute intelligence to and support and publicise the Locate web-based service in order to avoid duplication and to keep information current. Healthwatch will offer assistance to any consumer who would benefit from using Locate but are without internet access.

- Healthwatch has signposted people to a wide range of services for a wide range of issues, including: Independent Complaints Advocacy, GP practice managers, County Durham Carers, British Red Cross, Stroke Association, Durham Advocacy Service, Learning Support Team, Local Dental Network, Podiatry service, Cancer support, Age UK, Social Care Direct, Emergency Medical Transport, NHS England, Community Dental service, Care Quality Commission, Citizens Advice Bureaux, Prescription Exemption Service, Yoga classes, Autism Society and MIND advocacy.

- A loop presentation about Healthwatch County Durham is now displayed on waiting area screens throughout County Durham and Darlington Foundation Trust premises.

- Healthwatch County Durham fliers are being distributed by County Durham and Darlington Fire & Rescue Service at their 'Home Fire Safety Check' visits to vulnerable people and effectiveness of this awareness raising will be assessed through ongoing 'where did you hear about us' monitoring.

Recommendations

14. The Health and Wellbeing Board is recommended to:

- Note the activities and outcomes of Healthwatch County Durham's work in gathering views, advising people and speaking up for health and social care service users.
- Note that Healthwatch County Durham Community Interest Company became an independent social enterprise on 1 April 2015.

Contact: Judith Mashiter, Interim Chief Executive, Healthwatch County Durham
Tel: 01325 375960

Appendix 1: Implications

Finance
No implications

Staffing
No implications for Durham County Council

Risk
None

Equality and Diversity / Public Sector Equality Duty
No implications

Accommodation
No implications

Crime and Disorder
No implications

Human Rights
No implications

Consultation
No implications

Procurement
No implications for Durham County Council

Disability Issues
No implications

Legal Implications
No implications

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Health and Wellbeing Board

21 January 2016

Health and Wellbeing - Area Action Partnership Links

Report of Andy Coulthard, Area Action Partnership Coordinator, Assistant Chief Executive, Durham County Council

Purpose of Report

1 The purpose of this report is to provide an update in relation to the work taking place to enhance the interface between Area Action Partnerships (AAPs) and the Health and Wellbeing Board to improve the alignment of AAP developments and investments and the priorities of the Partnerships.

Background

2 The last report on the work of AAPs was presented to the Health and Wellbeing Board on 14 May 2015. This report forms part of a six monthly update to the Board that reviews joint working between health and wellbeing partners and the 14 AAPs.

Community Wellbeing Partnership

3 The May 2015 report highlighted the actions carried out by a working group including colleagues from Durham County Council (DCC), Clinical Commissioning Group (CCG), AAPs and the Voluntary and Community Sector (VCS) in relation to improving AAP/VCS interface with the Health and Wellbeing Board as well as the Children and Families Partnership.

4 These actions naturally aligned themselves with the work of the Community Wellbeing Partnership (CWP). So to avoid duplication and improve joint working the outstanding actions from the plan were amalgamated into the agenda of the CWP.

5 As a part of these actions the CWP have started to examine a communications strategy which interlinks with the Health and Wellbeing Board's strategy and those of the other partners. AAPs have become key communication conduits accessed by CCGs (Urgent Care and Patient Transport), Public Health (Smoking and Mental Health support) and our third sector partners (Wellbeing for Life and various social inclusion schemes). Mid Durham AAP have recently produced a multi service info byte leaflet aimed at older people support provision, whilst several AAPs have developed local information or what's on guides which again promote a variety of health and wellbeing services. The AAPs have been working with the Locate website team to help update and promote the site with partners and residents.

6 The potential to develop joined up funding bids or progress existing projects through external funding streams is also part of the CWP agenda. Funds such as the Big Lotteries 'UK accelerating Ideas' pilot, the Coalfields Community grant and the recent release of a the Virgin Money Fund have all being circulated to partners for potential access. We are aware of several AAP supported projects seeking to access these funds. AAPs are also seeking to use these external funding pots to match against the £10K Public Health funding allocated to each Board as well as the Durham Dales, Easington and Sedgefield (DDES) CCG funds aligned to their associated AAPs. This enables the AAP to work with partners to develop larger and more accessible schemes which can last longer so that greater impact can be measured.

Wellbeing for Life

7 There are several delivery programmes which come under the umbrella of 'Wellbeing for Life'. The Wellbeing in Targeted Communities programme has specific links to several AAPs including Mid Durham (Older People), Stanley (Tobacco), Bishop Auckland & Shildon and East Durham Rural Corridor (General Health), with an overarching remit of supporting those with learning disabilities, mental health issues, travellers and armed forces personnel and veterans. The various consortium partners have all established good working relationships with their respective AAPs and are working together to promote the schemes across the targeted villages. Where possible existing services are being linked up to the programme and if gaps are identified then potential support is being looked at collectively to address the gap.

8 The overall Wellbeing for Life Service has started to work with existing health and wellbeing groups in the 3 hub areas to look at local delivery and direction. In the North the service is linking into the Community Health Alliance alongside their associated local working groups. In the East the service will link in to the Healthworks steering group, whilst in the South the link will be with the CCG commissioned Health Networks, ensuring an all-round joined up approach. AAPs are represented at all of these groups.

Health and Wellbeing as an AAP priority – Measuring Outputs

9 10 AAPs have identified health as a priority. In addition to this Mid Durham, Bishop Auckland and Shildon (BASH), Trimdon and Stanley AAP's, as previously indicated in paragraph 7, are taking part in the Wellbeing in Targeted Communities pilots. Therefore all 14 AAPs have a work stream linked to health and wellbeing.

10 As part of the AAP project development process all projects are asked to complete a '**What Difference Will Your Project Make'** section – This enables applicants to identify the main project Outcomes and Milestones as well as Performance Indicators that are grouped under the 'Altogether Themes' of the Council. The information gathered is then used to track how funding is aligned to the Altogether Themes and projects are monitored on their delivery against these stated outputs and indicators throughout the delivery of the project.

11 Appendix 2 lists the performance indicators from AAP funded projects (both Area Budget and Neighbourhood Budget) from 2013/15 which relate to Health and Wellbeing. These outputs include achieved and forecast figures that are factual as of September 2015.

Shared Work

12 AAPs have, and will be working closely with our Culture and Sport colleagues to help shape and consult on the development of a Physical Activity Strategy for County Durham. As part of this, and linked to simple localised 'quick wins' the Public Health funding linked to AAPs has been targeted at addressing solutions to getting residents more physically active and improving their mental wellbeing. An update on how the AAPs have delivered on the Public Health funding will be provided in the next AAP Health and Wellbeing Report.

13 The AAPs and especially East Durham Rural Corridor have worked closely with Public Health and Relate North East colleagues to develop the Suicide Safer Communities website; www.suicidesafercommunities.uk

14 Staff and members of all 14 AAPs attended and supported the 2015 Big Tent Event. Support was provided through a variety of means – promotion of AAP work, input into each workshop theme and support in facilitation and note taking.

15 The AAPs are working with the Prevention Task and Finish Group to examine how AAPs can support, the currently in development, Prevention Plan.

Emerging Issues for Health and Wellbeing

16 Examples of emerging issues identified through AAP Task and Finish groups in 15/16 include:

- Mental health and emotional wellbeing of children and young people, including suicide, self-harm, safeguarding and personal safety.
- Risky behaviour of young people, including underage drinking and the use of energy drinks.
- Increase in food poverty, use of Foodbanks, and holiday hunger; as well as availability and affordability of opportunities for children and young people.
- Transport issues related to access to health services including GPs, pharmacists, dentists.

17 The AAPs will explore these further with the CWP and examine how local examples of good practice could be extended and delivered county wide. Examples such as the Social Resource Centres Health Appointment Car scheme (with current funding from Public Health due to finish March 2016) is a prime example. However, there are a variety of other schemes which tackle social isolation, mental health and general wellbeing which are in danger of being lost if we do not collectively discuss.

18 Another emerging issue for discussion at the CWP is communication between services. This needs to be linked to the communications plan, previously mentioned, so that officers/workers delivering the services on the ground can be made more aware of what other services are available to them and the people they are working with. Recent discussions with partners such as police, fire, housing and the voluntary sector, alongside the whole Wellbeing for Life service, has highlighted a lack of understanding of a variety of services available. Durham Community Action as part of the Wellbeing for Life programme are seeking to tackle this issue with a series of events aimed at paid workers, volunteers and community residents. Each grouping will come together to discuss and highlight their services delivery. Paid workers met last November (this included AAP representatives) with events planned during December and January for the other 2 groupings. The outcomes from these will be examined with the hope of developing and delivering them in the future across the county.

Recommendations

19 The Health and Wellbeing Board is recommended to note:

- The work that is taking place.
- The improved alignment of work of the AAP's to the Health and Wellbeing Board.
- That work will progress through the Community Wellbeing Partnership.
- The impacts being made on Health and Wellbeing targets by the AAPs. (Appendix 2)
- The emerging issues and the need to collectively address these.

Contact:	**Andy Coulthard, Area Action Partnership Coordinator, Durham County Council**
Tel:	**07818 510370**

Appendix 1: Implications

Finance
Not applicable

Staffing
Not applicable

Risk
Not applicable

Equality and Diversity / Public Sector Equality Duty
Not applicable

Accommodation
Not applicable

Crime and Disorder
Not applicable

Human Rights
Not applicable

Consultation
Not applicable

Procurement
Not applicable

Disability Issues
Not applicable

Legal Implications
Not applicable

Performance Indicators for AAP's Area Budget 2013/15

Ref	Performance Indicator	13/14 Forecast	13/14 Monitored to date	14/15 Forecast	14/15 Monitored to date	15/16 Forecast
CYP5	No of C&YP involved in health improvement initiatives	***3560***	3745	***4891***	1268	***510***
AH1	No of people involved in initiatives aimed at improving health	***9567***	536	***203***	180	***0***
AH2	No of people involved in initiatives aimed at improving wellbeing/mental health	***5736***	35	***1254***	6	***1***
AH5	No of people benefitting from schemes aimed at reducing health inequalities and early deaths	***0***	0	***692***	228	***0***
Totals	**No of people only**	**18,863**	**4,316**	**7,040**	**1,682**	**511**

Totals for 13/15 Forecast: 26,414 residents

Totals for 13/15 Monitored to date: 5,998 residents

Performance Indicators for AAP's Neighbourhood Budget 2013/15

Ref	Performance Indicator	13/14 Forecast	13/14 Monitored to date	14/15 Forecast	14/15 Monitored to date	15/16 Forecast
CYP5	No of C&YP involved in health improvement initiatives	***1714***	710	***1845***	109	***2220***
AH1	No of people involved in initiatives aimed at improving health	***3786***	505	***1093***	0	***0***
AH2	No of people involved in initiatives aimed at improving wellbeing/mental health	***3130***	641	***490***	3	***8***
AH4	No of schemes aimed at improving the quality of life, independence, care and support for people with long term conditions	***0***	1	***10***	25	***2***
AH5	No of people benefitting from schemes aimed at reducing health inequalities and early deaths	***0***	73	***157***	0	***0***
Totals	**No of people only**	**8,630**	**1,929**	**3,585**	**112**	**2,228**

Totals for 13/15 Forecast: 14,443 residents

Totals for 13/15 Monitored to date: 2,041 residents

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By virtue of paragraph(s) 1, 2 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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