Health and Wellbeing Board

Date **Tuesday 31 January 2017**
Time **9.30 am**
Venue **Committee Room 2, County Hall, Durham**

Business

Part A

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

1. Apologies for Absence
2. Substitute Members
3. Declarations of Interest
4. Minutes of the meeting held on 17 November 2016 (Pages 5 - 14)
5. Membership of the Health and Wellbeing Board - Report of Head of Legal and Democratic Services, Durham County Council (Pages 15 - 18)
6. County Durham Youth Offending Service: Speech, Language and Communication Needs Strategy - Presentation of Strategic Manager County Durham Youth Offending Service, Children and Young People's Services, Durham County Council, and Practice Improvement Officer County Durham Youth Offending Service, Children and Young People's Services, Durham County Council (Pages 19 - 26)
7. Northumberland, Tyne and Wear and North Durham Sustainability and Transformation Plan - Report of Chief Clinical Officer, North Durham CCG (Pages 27 - 32)
8. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby Sustainability and Transformation Plan - Report of Chief Clinical Officer Durham Dales, Easington and Sedgefield CCG, and Clinical Chair Durham Dales, Easington and Sedgefield CCG (Pages 33 - 38)
9. North Durham CCG and Durham Dales, Easington and Sedgefield CCG Operational Plans - Report of Chief Operating Officer North Durham CCG and Durham Dales, Easington and Sedgefield CCG (Pages 39 - 48)

10. Better Care Fund Quarter 2 Performance 2016/17 - Report of Strategic Programme Manager Care Act Implementation and Integration, Adult and Health Services, Durham County Council (Pages 49 - 54)
11. Oral Health Strategy for County Durham - Report of Interim Director of Public Health, Adult and Health Services, Durham County Council (Pages 55 - 74)
12. County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 75 - 88)
13. Cardiovascular Disease Framework and Prevention Programmes - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 89 - 116)
14. Progress update of Director of Public Health Annual Report 2014 - All the Lonely People: Social Isolation and Loneliness in County Durham - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 117 - 130)
15. Healthwatch County Durham Work Plan 2016/17 - Report of Lay Chair, Healthwatch County Durham (Pages 131 - 142)
16. Such other business as, in the opinion of the Chairman of the meeting, is of sufficient urgency to warrant consideration
17. 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)

18. Pharmacy Applications - Report of Interim Director of Public Health County Durham, Adult and Health Services, Durham County Council (Pages 143 - 148)
19. 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
23 January 2017

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

Councillors L Hovvels, O Johnson and J Allen

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

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 **Thursday 17 November 2016 at 9.30 am**

Present:

Councillor L Hovvels (Chairman)

Members of the Committee:
Councillors J Allen and T Smith, G Curry, Dr S Findlay, L Jeavons, S Lamb, G O'Neill, P Scott, Dr D Smart, Dr J Smith and M Whellans

Also present:
B Jackson and N O'Brien

1 Apologies for Absence

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

2 Substitute Members

Councillor T Smith for Councillor O Johnson, P Scott for C Martin, G Curry for S Jacques and L Jeavons for J Robinson.

3 Declarations of Interest

There were no declarations of interest.

4 Minutes of the meeting held on 9 September 2016

The Minutes of the meeting held on 9 September 2016 were agreed as a correct record and were signed by the Chairman.

5 0-19 Healthy Child Programme County Durham

The Board considered a report of the Interim Director of Public Health County Durham which provided an update on the 0-19 Healthy Child Programme County Durham since the service transferred to Harrogate and District NHS Foundation Trust on 1 April 2016.

The Interim Director of Public Health County Durham was pleased to report that since the transfer of the service good progress was being made and a strong relationship with the new provider had been developed.

The Health and Wellbeing Board agreed to create the Healthy Child Programme Board as an additional sub-group which will bring partners together to work on specific pieces of work.

Councillor Allen stressed the importance of appropriate representation on the Healthy Child Programme Board and asked who would be involved. The Member was informed that although membership had not been agreed, it was envisaged that representation would include One Point, Social Care, the voluntary sector, Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) and the Child and Adolescent Mental Health Services (CAMHS). The Interim Director of Public Health County Durham outlined that the Healthy Child Programme Board would be a core group of agencies which would not replicate the work of the Children and Families Partnership.

The Board received a presentation from the Head of Children's Public Health and Nursing County Durham, Harrogate and District NHS Foundation Trust on progress with the transfer of the Healthy Child Programme and what was happening now with the 0-19, 0-5 and 5-19 Agenda.

In terms of what would happen next the Head of Children's Public Health and Nursing County Durham highlighted the following actions:-

- Development of the Healthy Child Programme Board in County Durham
- Youth awareness and mental health training
- Embedding 5 Emotional Resilience Nurses into Locality Teams
- Community Drop In Service for Children and Young People (including school holidays)
- Engage and consult with all Schools and Early Years Settings
- Engage and consult with parents, carers, children and young people
- Develop a patient/client experience and engagement tool.

The Interim Corporate Director, Children and Young People's Services, Durham County Council advised that positive comments had been received from Head Teachers about the new arrangements for links with schools, and the school nursing service.

Following a question from the Chief Clinical Officer of Durham, Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) about how primary care are engaged, the Board was informed that all health visitors were mandated to attend safeguarding meetings on a regular basis and were encouraged to continue to visit GP practices.

The Chief Clinical Officer DDES CCG noted the discrepancy in service provision between North Durham and DDES with regard to maternal smoking at delivery. The Head of Children's Public Health Nursing County Durham explained that communication between the midwife service and health visitors was excellent, however whilst maternal smoking was identified in ante-natal risk assessments health visitors and midwives were not involved until the later stages of pregnancy.

In response to a question from the Chairman, the Member was informed that the Programme picked up issues such as self-harm and mental health needs in young people through school drop-ins. For children in the older age range new links were being developed with colleges. Community drop-ins would also be a mechanism to pick up such issues and an 'app' was being developed.

Resolved:

That

(i) the contents of the report be noted and the presentation be received;
(ii) a Healthy Child Programme Board be developed as a Sub-Group of the Health and Wellbeing Board;
(iii) the continuation of the mobilisation/transition board to provide assurance of the safe and effective delivery of the specification for such a large contract, be noted.

6 Sustainability and Transformation Plans and Better Health Programme

The Board considered a report of the Chief Clinical Officer, North Durham Clinical Commissioning Group (CCG) which provided an update on Sustainability and Transformation Plans (STPs) and the Better Health Programme (for copy see file of Minutes).

The Chief Clinical Officer, North Durham CCG gave a presentation on the Northumberland, Tyne and Wear and North Durham (NTWND) STP that highlighted the following:-

- The Vision for 2021
- The evolving Health and Care Model
- Understanding the three gaps in Health and Wellbeing, Care and Quality, and Funding and Finance
- An overview of STP delivery priorities for the 3 transformational areas
- The approach to developing the Plan
- Engaging local people and stakeholders
- Examples of Local vs Scale Delivery
- Governance arrangements

The Chairman asked if local people understood STPs and what they would mean for County Durham. She also noted that the North STP had been published but publication of the South STP was awaited. The Board was informed that at this stage the public may not be aware of STPs due to the pace at which the plans had to be developed and submitted to NHS England. However national guidance had now been issued on public engagement.

The Chief Clinical Officer DDES CCG expected the South STP to be published before the end of November 2016 but much of the Plan was already known as the Better Health Programme. A public-facing version was being written prior to publication.

Councillor Allen emphasised the importance of consultation with members of the public and also of ensuring the Plans were communicated in such a way that would be easily understandable for people who needed to access health services.

Following a question from B Jackson of Healthwatch County Durham about the provision of Accident and Emergency in the University Hospital North Durham (UHND), the Board was informed that whilst there were no plans to change the service in Durham at present, the way in which acute services were delivered in UHND would be reviewed in the future.

In response to a question from the Interim Corporate Director, Children and Young People's Services about timescales, the Chief Clinical Officer North Durham CCG explained that the STPs must be delivered by 2021.

Resolved:

That the contents of the report be noted.

7 Healthy Weight Alliance

The Board considered a report of the Interim Director of Public Health County Durham which provided an update from the Healthy Weight Alliance, highlighting the strategic approach to obesity as a result of County Durham becoming a national pilot for obesity, working with Leeds Beckett University (for copy see file of Minutes).

The Interim Corporate Director, Children and Young People's Services asked how parents were helped to understand what constituted healthy weight in children. The Interim Director of Public Health County Durham explained that a change to the way in which weight was viewed in children from infancy to school age was needed, and the focus was on early years and preventing obesity from the antenatal period.

The Head of Children's Public Health Nursing County Durham outlined improvements proposed for engaging with mothers in pregnancy and parents of schoolchildren.

In response to a question from the Head of Adult Care, Durham County Council about wider partnership involvement the Board was informed by the Interim Director of Public Health County Durham of the importance of engaging with Partners to tackle the problem. She had addressed the County Durham Environment Partnership and the County Durham Economic Partnership, and had also engaged with Planners and businesses to address issues such as the cumulative impact of takeaways in a local area.

Councillor Smith made the point that physical activity played a big part in weight management and preventing obesity. She felt that Durham County Council had contributed to tackling this issue in schools. It was also important to encourage physical activity in families and was pleased to report the 'Beat the Street' project. The Councillor also considered that the control of takeaway premises on high streets would be welcomed.

Councillor Allen asked when the Physical Activity Framework would be reported to the Board and was informed that the Framework was currently being reformatted and would be submitted when this work was completed. However, the Board was reassured that work was ongoing whilst the Framework was being finalised.

Following a question from the Strategic Manager, Policy, Planning and Partnerships, Durham County Council the Board was informed that children who were identified as being underweight were not picked up within the Alliance but were signposted to other services. The Interim Director of Public Health explained that approximately 2% of the population were classified as underweight.

It was agreed that the Board undertake a development exercise in 2017 in relation to obesity and the work with Leeds Beckett University and the Strategic Manager, Policy, Planning and Partnerships agreed to liaise with the Interim Director of Public Health County Durham on this.

Resolved:

That

(i) leadership and support be provided to all partners in the continued delivery of the whole systems approach to obesity by actively participating in the LBU pilot work;
(ii) a 'leading by example' approach be adopted within organisations to improve staff and residents' health and wellbeing;
(iii) the public sector in County Durham be developed to make the healthy choice the easy choice within a health promoting environment;
(iv) building on local best practice be supported and countywide approaches be developed by scaling up what works;
(v) evidence led brief interventions around obesity in front line or patient contact within primary and secondary care be progressed.
(vi) a Board development session to take place in 2017 in relation to the obesity/healthy weight agenda.

8 Smoke Free Tobacco Control Alliance

The Board considered a report of the Interim Director of Public Health County Durham which updated the Health and Wellbeing Board on the tobacco control activity undertaken in County Durham throughout the year, and presented the latest tobacco control profile data used to monitor impact (for copy see file of Minutes).

The Interim Director of Public Health County Durham highlighted the key points within the report which included an update regarding the voluntary code implemented in 2015 making play areas in parks smoke free, and the implementation of TEWV's smokefree policy. Smoking at Time of Delivery had reduced since the introduction of the babyClear pathway and work would continue to develop the scheme further.

The report also advised of joint working with the Consumer Protection Team and Durham Constabulary to reduce the availability of illicit tobacco.

In response to a question from the Chief Clinical Officer DDES CCG the Interim Director of Public Health County Durham advised that she was not aware of the number of prosecutions since smoking in cars when children were passengers, however the Interim Corporate Director, Children and Young People's Service fed back that she understood it was one.

In response to a question from Councillor Allen about the link between quitting smoking and weight gain, the Member was informed that weight management advice was provided as part of the multi-component approach to helping smokers quit.

The Strategic Manager, Policy, Planning, and Partnerships, Durham County Council asked if the wide use of vaporisers encouraged take-up in young people. The Interim Director of Public Health County Durham explained that Public Health England endorsed e-cigarettes for adults but looked carefully at how they were advertised and promoted. For information there had been a decline nationally in stop smoking services which correlated with an increase in the use of vaporisers.

The Chairman asked what arrangements were in place to refer hospital patients to a stop smoking service and was informed that a joint approach was desired. If nicotine replacements were made available in hospitals, in-patients could be supported by trained hospital staff.

Resolved:

That

(i) the extent of tobacco control activity undertaken throughout the year be noted;
(ii) the reduction in smoking prevalence in County Durham be noted, however it be noted that this would not be equitable across the County;
(iii) the success of the babyClear pathway in increasing uptake and proportion of quitters be noted.

9 County Durham Drug Strategy Action Plan 2014/2017

The Board considered a report of the Interim Director of Public Health County Durham which provided an update on the County Durham Drugs Strategy 2014-2017 (for copy see file of Minutes).

The Interim Director of Public Health County Durham highlighted new objectives set within the Drug Strategy Action Plan for 2016/2017 and discussions that had commenced to explore the potential to merge the Drug Strategy (2014-2017) with the Alcohol Harm Reduction Strategy (2017-20) which would provide an opportunity to scope out a wider addictions prevention and treatment strategy which would look to include tobacco control.

Councillor Allen welcomed the proposals for a joint Strategy to provide a holistic approach to help those with addictive behaviour. Councillor Allen is involved in a national Local Government Association Group and felt there was value in looking at wider addictive behaviour relating to gambling.

In response to a question from the Interim Corporate Director, Children and Young People's Services about help for parents to identify the signs of addiction in their children, the Board was informed that signposting to services was undertaken but further actions would be explored to ensure that the issue remained high profile.

Resolved:

That

(i) the content of the report and associated action plan performance outcomes be noted;
(ii) the merger of the drug and alcohol strategies be agreed;
(iii) the development of an addictions prevention and treatment strategy be agreed which would be discussed at the Safe Durham Partnership.

10 Durham Local Safeguarding Children Board Annual Report 2015/16

The Board considered a report of the Independent Chair of the Durham Local Safeguarding Children Board (LSCB) which presented the Annual Report 2015/2016 and included a LSCB summary 2015-16 infographics poster (for copy see file of Minutes).

The Independent Chair highlighted the LSCB priorities for 2016-2019 and the achievements in 2015/2016. She was pleased to report on the successful work in raising awareness about child sexual exploitation. It was also pleasing to report that Durham LSCB had been rated as 'good' by Ofsted. The Young People's Annual Report had been launched the previous day which she hoped would be considered for a National Award.

The Chairman welcomed the report and congratulated all those on the LSCB for their work which was making a visible difference.

Resolved:

That

(i) the content of the report be noted;
(ii) the LSCB Annual Report be accepted for information as an overview of the work undertaken in 2015/2016 and priorities for action in 2016/2017.

11 Durham Safeguarding Adults Board Annual Report 2015/16

The Board considered a report of the Independent Chair of Durham Safeguarding Adults Board (SAB) which presented the Annual Report for 2015/2016 in line with statutory requirements (for copy see file of Minutes).

The Independent Chair provided information on the current position of the SAB together with achievements during the year 2015/2016 and was pleased to advise that the Board now engaged with Healthwatch County Durham. The SAB was fortunate to have the commitment of all of its key Partners.

Resolved:

That the Annual Report be received and the ongoing developments achieved be noted.

12 County Durham Health Profile/Child Health Profile 2016

The Board considered a report of the Interim Director of Public Health County Durham which summarised the County Durham Health Profiles 2016 and compared indicators against the previous time period (for copy see file of Minutes).

The Health Profiles provided a snapshot in time of health and wellbeing in County Durham and were cross-referenced with local statistics and action plans. The profiles had evolved to include an online interactive Health Profiles tool which allowed data to be updated regularly.

Resolved:

That

(i) the content of the report be noted;
(ii) it be noted that the priorities in the Joint Health and Welllbeing Strategy were being addressed and that strategies were in place to address the issues identified in the County Durham Health Profiles.

13 Joint Health and Wellbeing Strategy 2016/19 Performance Report

The Board considered a report of the Head of Planning and Service Strategy, Durham County Council which provided progress against the priorities and outcomes set in the County Durham Joint Health and Wellbeing Strategy 2016-2019 (for copy see file of Minutes).

The Strategic Manager, Policy, Planning and Partnerships, Durham County Council advised that the following areas had been identified for improvement under Objective 1:-

- the percentage of children classified as overweight or obese which was above the national average
- the proportion of five year old children free from dental decay which was lower than the national and regional averages. The Oral Health Strategy had been out to consultation and would be reported to the Board in January 2017.

Two of the actions under Objective 2 were behind target; the completion of the Health Equity Audit for cancer and the development of a local diabetes strategy to target those people most at risk. The Board was assured that the actions would be completed by the end of the financial year. The report included details of the successful completion of drug treatments for opiate and non-opiate use which were behind target.

With regard to performance in Objective 3 the Board was informed that there was currently a backlog of Deprivation of Liberty Safeguard applications but this should be cleared by the revised target date of September 2017.

Improving Access to Psychological Therapies (IAPT) Services was below target but was expected to improve following the future inclusion of current and historic data from relevant counselling services. P Scott of TEWV NHS expected an improvement in figures at the next time of reporting.

The suicide rate in County Durham had increased and remained above the national and regional average. The report set out ongoing work on suicide prevention in the County.

Councillor Smith suggested the use of the media to raise public awareness of health issues and encourage people to come forward with health concerns. The Interim Director of Public Health County Durham responded that the media was a useful tool and a sharp rise in referrals was usually experienced following a media campaign, however this was not generally sustained. Ongoing national campaigns were more successful.

Councillor Allen referred to the Alcohol Harm Reduction Strategy and noted the disparity in figures in different areas. The Councillor emphasised the importance of not only sharing best practice but also understanding issues which were particular to a locality.

Resolved:

That

(i) the performance highlights and areas for improvement identified throughout the report be noted;
(ii) the actions to improve performance be noted.

14 Exclusion of the Public

Resolved:

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

15 Pharmacy Applications

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

Resolved:

That the report be noted.

Health and Wellbeing Board

31 January 2017

Membership of the Board

Report of Colette Longbottom, Head of Legal and Democratic Services

Purpose of Report

1 To seek the views of members of the Board on inviting additional representatives to become voting members of the Health and Wellbeing Board.

Background

2 In November 2016 a letter was received by the Chair of the Health and Wellbeing Board from the Rt Hon Amber Rudd MP and the Rt Hon Jeremy Hunt MP to highlight and support some of the important benefits that can be realised through closer collaboration between policing and health partners.

3 The letter asks Health and Wellbeing Boards and Police and Crime Commissioners to consider how they can better work together by ensuring appropriate representation from both sectors on Health and Wellbeing Boards.

4 The integration of health and social care is already a shared agenda and there is a clear consensus that redesigning services around individuals with health and social care needs provides the best opportunity to improve people's wellbeing, reduce health inequalities and achieve better outcomes.

5 The Integration Board which comprises of Chief Officers from health and social care leads and directs the process of integration, it is supported by the Integration Steering Group and reports directly to the Health and Wellbeing Board.

6 Lesley Jeavons has recently been appointed as Director of Integration working for all statutory Health and Social Care organisations in County Durham and is the chair of the Integration Board.

Health and Wellbeing Board membership

7 Article 16 of the Constitution of the Council outlines the rules for governing the Health and Wellbeing Board and includes its composition, role and function.

8 As required in the Health and Social Care Act 2012, the composition of the Health and Wellbeing Board is as follows:

- Representatives nominated by the Leader of the Council (being currently:

    - Portfolio Holder for Adult and Health Services
    - Portfolio Holder for Safer Communities
    - Portfolio Holder for Children and Young People's Services;
- Representation from each Clinical Commissioning Group;
- A representative from Local Healthwatch;
- Corporate Director of Adult and Health Services
- Corporate Director of Children and Young People's Services
- Director of Public Health

9 In accordance with legislation additional members may be appointed and the Health and Social Care Act states that "at any time after a Health and Wellbeing Board is established, a local authority must, before appointing another person to be a member of the Board under s194 (2)(g), consult the Health and Wellbeing Board".

10 The value of collaborative working between police and health partners to achieve positive outcomes is recognised, especially in relation to mental health and drugs and alcohol, and it is recommended that a representative from the Office of the Durham Police, Crime and Victims' Commissioner is invited to become a voting member of the Health and Wellbeing Board and members of the Board are asked to provide their views. Alan Reiss, Chief of Staff, Office of the Durham Police, Crime and Victims' Commissioner has been identified as the Health and Wellbeing Board representative if this is agreed by the Board.

11 It is also recommended that Lesley Jeavons, Director of Integration is invited to become a voting member of the Health and Wellbeing Board in the capacity of a joint appointee of Durham County Council and Health partners and members of the Board are asked to provide their views.

Recommendations

12 The Health and Wellbeing Board is requested to:

- Agree that a representative from the Office of the Durham Police, Crime and Victims' Commissioner is invited to become an additional voting member of the Health and Wellbeing Board
- Agree that the Director of Integration is invited to become an additional voting member of the Health and Wellbeing Board.

Contact: Colette Longbottom, Head of Legal and Democratic Services
Tel: 03000 269732

Appendix 1: Implications

Finance – No direct implications

Staffing – No direct implications

Risk – No direct implications

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

Accommodation - No direct implications

Crime and Disorder - No direct implications

Human Rights – No direct implications

Consultation – As set out in the body of the report

Procurement - No direct implications

Disability Issues – No direct implications

Legal Implications – As set out in the body of the report

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Health and Wellbeing Board

31 January 2017

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

Report of Gill Eshelby, Strategic Manager, County Durham Youth Offending Service, Durham County Council

Purpose of the Report

1 To update members of the Health and Wellbeing Board on the progress and outcomes of County Durham Youth Offending Service (CDYOS) Speech, Language and Communication Needs (SLCN) Strategy.

2 The report presents the impact of the strategy, including identification of considerable unmet needs among young people in the youth justice system in County Durham, and makes recommendations for the wider system.

3 A presentation will be provided to the Board on 31 January 2017.

Background

4 National research suggests that 60-90% of young people who offend have speech, language and communication needs ('*Nobody Made the Connection: The prevalence of neuro-disability in young people who offend', Children's Commissioner, University of Exeter and University of Birmingham, October 2012*). This research was the catalyst for CDYOS work on SLCN.

5 CDYOS implemented its comprehensive SLCN Strategy in March 2014. Phase 1 took place March – September 2014; Phase 2 September 2014 – March 2015. Phase 3 commenced April 2015, initially until March 2017; it is currently being extended until March 2018.

6 Work to date has been funded by a range of sources: Phase 1 by CDYOS partnership budget/non-recurrent North Durham (ND) Clinical Commissioning Group funding (CCG) funding; Phase 2 by CDYOS/ Office of the Police Crime and Victims Commissioner (OPCVC); Phase 3 by CDYOS / North Tees and Hartlepool NHS Foundation Trust (NTHFT).

Summary of Phase 1

7 Phase 1 built staff capacity and capability (all staff trained in SLCN awareness); created a SLCN Champions group (staff successfully completed accredited Elkan training); started to develop (with the help of young people) an extensive

range of communication friendly resources for young people who offend; and enabled CDYOS to implement the Youth Justice Board (YJB) AssetPlus (new national youth justice assessment for all young people in the youth justice system) SLCN screen in July 2014 (a year ahead of schedule).

8 The seconded Speech and Language Therapist (SLT) worked with CDYOS staff and young people to develop the young people's SLCN screening tool to complement the YJB AssetPlus screen – unique to CDYOS. 89% of staff reported the training they received transformed their work with young people.

Summary of Phase 2

9 Phase 2 focused on the communication needs of young victims of youth crime. It helped CDYOS to 'unpick' the language of restorative justice and make the process communication and young people friendly. It developed a range of resources for young victims of youth crime (with the help of young people who had been victims) to help them (and their parents/carers) better understand and engage in restorative justice processes. This has played an important role improving outcomes for young victims, supporting the healing process.

Summary of Phase 3 (to date)

10 The Speech and Language Therapist is currently full time in CDYOS, funded by CDYOS (75%) and NTHFT (25%).

11 Phase 3 is focusing on:

- Providing specialist SLT assessments for all those young people who require them;
- Providing specialist SLT intervention in CDYOS for those young people who require it;
- Supporting case managers to adjust their practice following specialist assessment, if the young person does not require specialist intervention;
- Developing and implementing a robust pathway into mainstream SLT services for young people who offend and young victims;
- Leading further service development, both in CDYOS and NTHFT, to improve outcomes for young people in the youth justice system;
- Building the capacity and capability of staff in NTHFT to work with CDYOS client group;
- Analysing the communication needs of young people known to CDYOS to inform future commissioning.

12 The national implementation of AssetPlus across all Youth Offending Teams (YOTs), which makes SLCN screening of all young people who offend mandatory, will present mainstream SLT services with major challenges as they are not used to (or trained in) working with the Youth Offending Service (YOS) client group. If, as national research suggests, 60-90% of young people in the youth justice system have speech language and communication needs, this will result in a significant increase in referrals to mainstream services of a new, and very challenging client group. CDYOS SLCN Strategy and partnership work is

therefore of national significance, and the service is regarded as one of the national leaders in this important area of work.

13 CDYOS SLCN Strategy has significant implications for the whole system and for the commissioning of SLCN services in general. As a result of work to date, CDYOS is identifying young people with complex SLCN whose needs have not been identified by mainstream services prior to their involvement in the youth justice system. There is an evident under- provision of SLCN resources, and staff awareness of SLCN, in mainstream services.

Impact and Outcomes/Progress Update (1 May 2015 – 9 Dec 2016)

14 122 young people (aged 10 years 1 month to 18 years 3 months) have been referred (May 2015 – 9 December 2016) for SLT assessment following screening by CDYOS case managers, evidencing need and impact of work to date. 112 young people have been referred to our seconded SLT; 10 to core service.

15 The number of referrals and the unmet needs of CDYOS client group are staggering. Assessments indicate a range of very complex SLCN – often of older young people – which have not been identified by mainstream services, prior to involvement in the youth justice system.

16 98 young people (80%) of the 122 have had no previous involvement with SLT services, despite complex SLCN, which have not been identified by mainstream services. 24 young people (21%) have previously been known to Child and Adolescent Mental Health Services (CAMHS). 26 (23%) are currently known to CAMHS. 42 (37.5%) are known to have been excluded from school.

17 Lack of early identification and intervention is a significant issue for all staff working with children and young people, commissioners, the Health and Wellbeing Board, Children and Families Partnership and partners.

18 Initially (May 2015 – end Sept 2016) all young people requiring specialist SLT assessment were referred to our seconded SLT (average 6 referrals per month). Due to capacity, the pathway was revised. Since 1 October, post court cases are referred to CDYOS SLT; pre/out of court to core SLT service.

19 Due to numbers and capacity, the following young people have been identified as priorities by the SLCN steering group:

- Those with a pending court case (defendant or witness);
- Those with a pending Referral Panel meeting;
- Those undergoing an Education Health and Care Plan assessment;
- Those sentenced to custody/ remanded to youth detention accommodation;
- Those aged 17 plus;
- Those needing Social Communication Assessment Team Autism Spectrum Disorder diagnostic assessment;
- Those at risk of serious self-harm due to mental health needs.

20 Interventions to date have included direct therapy from our Speech and Language Therapist (SLT) and direct support/advice to young people to help them to understand the youth justice system. Interventions include: vocabulary; social communication; Dysfluency support; advice to panel for Referral Order contract; Police bail advice report; liaison with solicitors re Crown Court appearance; witness support liaison re Registered Intermediary; joint YOS intervention (peer relationships and breach process); advice for parents; and joint work with other services (e.g. wider Children's Services, Education, schools).

21 Approximately 100 other young people with identified SLCN are being appropriately managed by CDYOS case managers. This includes the use of our communication friendly resources, and the direct impact of the capacity and capability building in Phase 1. Our SLCN Strategy has transformed service delivery.

22 Key unique elements of CDYOS SLT service are: assertive outreach and development of specialist resources to enable young people with SLCN to better understand and engage in youth justice processes. Nationally there is a lack of adequate communication friendly resources for young people who offend, so a key part of the service has been the development of resources providing appropriate specialist intervention in a youth justice context for young people.

23 A robust Youth Justice SLT Pathway has been developed and implemented, covering referral, assessment and post assessment pathway. This is subject to on-going review.

24 Academic evaluation of Phase 3 via Northumbria University commenced late 2015. CDYOS is working with a PhD student (with a public health background) for the next 5 years to evaluate our SLT service delivery model.

ClearCut Communication

25 A wide range of unique communication friendly resources for young people who offend and young victims have been developed. Initially for CDYOS use, interest from other YOTs resulted in the decision to produce these commercially, copyright them to Durham County Council, brand them ClearCut Communication and market them to the youth justice sector. All income from ClearCut Communication is used by CDYOS to improve outcomes for young people who offend and young victims of youth crime in Co. Durham.

26 ClearCut Communication resources to date include:

- Young person's version of the AssetPlus SLCN screen, toolkit and Train the Trainers pack/training (unique resource);
- Wordbuster (83 youth justice words);
- Telling Your Story;
- Youth Caution in communication friendly language (approved by Durham Constabulary Solicitors);

- Going to Court booklets (with support of HM Court and Tribunal Service);
- Reparation leaflet
- Thinking about Victims (supported by the OPCVC)
- Referral Order resources.

27 ClearCut resources are being purchased by other YOTs nationally and are being used by all CDYOS staff. Feedback from young people, parents/carers, CDYOS partners and staff is very positive. Many of these resources are transferable to the wider system. Work with the OPCVC and RJ Coordinator to raise awareness of SLCN, and impact on adults' ability to understand/engage in restorative processes, will commence early 2017.

Risks to Future Delivery

28 A major risk to this important work is funding after March 2018. CDYOS is currently in negotiation to mainstream the work from April 2018.

Regional and National Developments

29 CDYOS SLT has established and chairs a regional peer supervision group for SLTs working in YOTs and youth justice secure estate across the North East.

30 CDYOS work is arousing significant national interest. To date CDYOS has:

- Had an article on our work published in Afaisic News (May 2015);
- Given a range of presentations e.g. to the youth justice sector, health partners, CEN network, Early Help forums, LSCB Early Help & Neglect subgroup;
- Met with the Royal College of Speech and Language Therapists;
- Given evidence to the APPG on young people and communication difficulties in the House of Commons (Oct 2015). The Chair, Lord Ramsbotham, and members commended our work. We were the only YOS in the country invited to give evidence;
- Showcased ClearCut Communication at the YJ Convention (Nov 2015)
- Led a workshop at the YJ Convention and launched our new Victims resource (Nov 2016);
- Provided awareness training to a range of partners regionally and nationally;
- Visit by Lord McNally (Chair of the YJB) and Colin Allars (Chief Exec) Sept 2016.

National Recognition

31 CDYOS SLCN Strategy has received national recognition. It was awarded 'Highly Commended' Innovation Award in the national Shine a Light Awards 2015; and was a finalist in the Children and Young People Now Awards 2015.

32 The two members of staff were awarded a Butler Trust Award 2015/16 – one of only 10 in the UK, and the only YOS in the country – in recognition of their work. This is a significant achievement. This prestigious award was presented by HRH The Princess Royal at Saint James's Palace in March.

Conclusion

33 CDYOS SLCN Strategy has significant implications for the whole system and the commissioning of SLCN services in general. CDYOS is identifying significant numbers of young people (many of them older) with complex SLCN, whose needs have not been identified or addressed by mainstream services prior to their involvement in the youth justice system.

34 There is an evident under-provision of SLCN resources, and staff awareness of SLCN, in mainstream services. This is a significant issue for partners, commissioners and the system as a whole.

35 Implications to be considered include:

- Early identification of SLCN and appropriate intervention;
- Building workforce capacity and capability to recognise SLCN;
- Links between SLCN, behaviour and exclusion;
- Links between SLCN and CAMHS.

Recommendations

36 The Health and Wellbeing Board is recommended to:

- Note the content of this report.
- Agree to receive further updates in due course.
- Refer CDYOS SLCN Strategy to the Healthy Child Programme Board to inform future developments and consider commissioners' implications.

Contact: Gill Eshelby, Strategic Manager, CDYOS
Tel: 03000 268 989

Appendix 1: Implications

Finance – Funding to mainstream this important area of work needs to be secured via commissioning.

Staffing – The Strategy has identified the need to build capacity and capability to recognise SLCN and meet the needs of children and young people by early identification and intervention.

Risk – SLCN and poor communication impact on a range of outcomes: educational achievement, employability, behaviour/vulnerability, criminality/offending, mental health and disadvantage

Equality and Diversity / Public Sector Equality Duty – SLCN is an equality issue and should be recognise as such. It is often a hidden disability.

Accommodation – Not applicable

Crime and Disorder – The Taylor Review of the Youth Justice System (12 December 2016) highlights the major role health/SLCN has in youth offending

Human Rights – Young people in the youth justice system, and their parents/carers, have a right to understand legal processes and language used.

Consultation – Young people who offend and their parents/carers; young victims of crime and their parents/carers have been consulted in the development and implementation of CDYOS SLCN Strategy

Procurement – This work needs to inform future commissioning

Disability Issues – Reasonable adjustments need to be made for young people with SLCN. This is often a hidden disability.

Legal Implications – Much of the youth justice system, particularly court and police processes, are indecipherable to young people and their families. This has legal implications for sentencers.

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Health and Wellbeing Board

31 January 2017

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

Report of Dr Neil O'Brien, Chief Clinical Officer, North Durham Clinical Commissioning Group

Purpose of the Report

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

Background

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

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

3 There are two STP planning foot prints in the North East. The North STP covers Northumberland, Tyne and Wear and North Durham. The North STP is led by Mark Adams, Accountable Officer, Newcastle Gateshead Clinical Commissioning Group (CCG). The South STP covers Durham, Darlington, Teesside, Hambleton, Richmondshire and Whitby. The South STP is led by Alan Foster, Chief Executive, North Tees and Hartlepool NHS Foundation Trust (NTHF).

4 Patient flow to services was considered in relation to STP foot prints. In North Durham the majority of patients use hospital services in Durham and to the north of Durham in Gateshead and Sunderland. Patient flow to specialist services is mostly to Newcastle rather than South Tees. To support the planning of hospital services local leaders have agreed that North Durham area should be part of the North STP planning foot print. North Durham will also continue to work closely with the South STP plan area to support service planning across the two footprints.

Current Position Sustainability and Transformation Plan

5 The draft STP was submitted to NHS England on 21 October 2016 in line with the national timetable. Copies of the draft STP plan, process for engagement and briefing materials were shared with HWB members individually.

6 The draft STP also responds directly to the issues highlighted in the recent Health and Social Care Commission from the North East Combined Authority around broader NHS system leadership and closing the significant health and wellbeing gap in the region.

7 Partner organisations have not formally 'signed off' the draft plan as there is no requirement to do so. A process of engagement on the draft will be undertaken following publication.

8 Engagement on the draft STP started on 23 November and will continue to Friday 20th January 2017 (8 weeks). The STP lead officer will be happy to receive and consider comments following the Health and Wellbeing Board meeting 31 January 2017.

9 As part of the STP engagement process a set of survey questions were publicised to seek feedback on specific aspects of the draft STP. The survey questions are shown in Appendix 2 for information.

10 Any future potential NHS service reconfigurations would still require their own case for change and formal consultation process in their local area in line with NHS statutory duties to engage and consult and other NHS policy guidance.

Recommendations

11 The Health and Wellbeing Board is recommended to:

- Note the contents of this report, and;
- Receive and comment on the draft Northumberland, Tyne and Wear and North Durham STP.

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

Appendix 1: Implications

Finance – N/A

Staffing – N/A

Risk – N/A

Equality and Diversity / Public Sector Equality Duty – N/A

Accommodation – N/A

Crime and Disorder – NA

Human Rights - NA

Consultation – N/A

Procurement - NA

Disability Issues - NA

Legal Implications – N/A

Appendix 2: Survey Questions: Sustainability and Transformation Plan for Northumberland, Tyne and Wear, and North Durham

Survey Questions

Sustainability and transformation plan for Northumberland, Tyne and Wear, and North Durham

The sustainability and transformation plan (STP) for Northumberland, Tyne and Wear, and North Durham sets out proposals for how the area will deliver the vision for a better NHS by 2021 as detailed in NHS England's Five Year Forward View.

1. What do you think about the STP vision for our area? Is there anything missing or more we should aim for?

- Everyone who lives, works, learns or visits the area will realise their full potential and equally enjoy positive health and well being
- Safe and sustainable health and care services that are joined up, closer to home and economically viable
- Local people are empowered and supported to play a role in improving their health and well being

2. What do you think about our ambitions for what health, well being and services should look like by 2021? Is there anything missing or more we should aim for?

- The health inequalities in our area will be have reduced to be comparable to the rest of the country
- We will have thriving out of hospital services that attract and retain the staff they need to best support their patients
- There will be high quality hospital and specialist care across the whole area, seven days a week.

3. The Five Year Forward View identifies three main gaps – health and wellbeing, care and quality, funding – what do you think about the proposed actions to address those gaps locally? Is there anything missing or other actions we should take?

- Scaling up work on ill-health prevention and improving well being
- Improving the quality and experience of care by increasing collaboration between organisations that provide out of hospital care and making the best use of acute or hospital based services
- Closing the gap in our finances which, if we do nothing we could be facing a funding gap in health of £641m by 2021 and could be as high as £904 million including social care

4. What do you think about the scale of the challenge facing us in making significant improvements to health and well being, services and efficiencies? Are there any other actions we could take to make these changes or speed up the rate of improvement?

5. **We will only achieve these ambitions for our area by engaging local populations, the people who use our service, and the staff that provide care. Have you any ideas of who we can effectively engage with the 1.7m people in Northumberland, Tyne and Wear, and North Durham?**

Thank you for taking the time to share your views on our draft sustainability and transformation plan. Your views will help to shape the final plan. Have you any additional comments?

Health and Wellbeing Board

31 January 2017

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

Report of Dr Stewart Findlay, Chief Clinical Officer Durham Dales, Easington and Sedgefield Clinical Commissioning Group, and Dr Jonathan Smith, Clinical Chair Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Purpose of the Report

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

Background

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

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

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

4 The NHS organisations involved in the DDTHRW STP are as follows:

Commissioning organisations:

- NHS Darlington Clinical Commissioning Group;
- NHS DDES Clinical Commissioning Group;
- NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group;
- NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group;

- NHS South Tees Clinical Commissioning Group.

Provider organisations:

- County Durham and Darlington NHS Foundation Trust;
- North Tees and Hartlepool NHS Foundation Trust;
- South Tees Hospitals NHS Foundation Trust;
- Tees, Esk and Wear Valleys NHS Foundation Trust.

Ambulance services:

- North East Ambulance Service NHS Foundation Trust;
- Yorkshire Ambulance Service NHS Trust.

The DDTRW STP is led by Alan Foster, Chief Executive of North Tees and Hartlepool NHS Foundation Trust.

4 Partner organisations may be familiar with aspects of this work, and may be involved in them. The DDTHRW STP remains draft, further work is being done within the NHS and with local councils and other partners including the voluntary sector.

Key Priorities

5 The DDTHRW draft STP identifies four key priorities:

Priority 1 – Preventing ill health and increasing self-care:

- Helping people look after themselves by providing information about self-care and encouraging use of services like local pharmacy;
- Identifying people who are at risk and take early action before illness or problems occur, and offer better support to help them stay healthy and take care of their own health;
- Increasing early diagnosis of cancer and quicker treatment, and improve survival rates.

Priority 2 - Health and care in communities and neighbourhoods:

- Sharing experience of community based services that have worked well, and extend to neighbouring areas;
- Improving community based support so patients have their care needs assessments at home, once medically fit, rather than in hospital (“discharge to assess”);
- Improving local access to mental health support;
- Improving local access to health, social care and voluntary services by developing community based care hubs in Darlington, Durham and Tees;
- In Hambleton, Richmondshire and Whitby, implement the proposals that have been consulted on in “Transforming our Communities”.

Priority 3 – Quality of care in our hospitals – “Better Health Programme”:

- Most routine hospital care as local as possible, including outpatients, diagnostic tests, urgent care, frail elderly assessment and children’s assessment;
- For serious emergencies and life threatening situations, care provided by senior consultants and experienced teams of staff 24/7 who see high numbers of patients with similar problems;
- Planned operations being provided in dedicated facilities, separate from emergency care, to offer a better patient experience, and to reduce cancellations.

Priority 4 – Use of technology in health care:

- Develop the “Great North Care Record”, so NHS and other care organisations can share patient records, with the patient’s permission;
- Use technology to support care in remote rural areas;
- Use technology so patients can maintain independence.

Finance

6 Across the STP footprint, around £2.4 billion is spent on health care every year. The local NHS could be over budget by around £281 million in 2021 (about 12% of our funding) if we do nothing. Individual organisations already identify opportunities for improving efficiency every year, but we now need to look at how we do this across the whole system. Our priority will be to invest in and protect high quality frontline services that deliver the best care for our patients.

Engagement

7 Significant public engagement has been undertaken including over 50 public events to date. In addition to this there have been three stakeholder events and 100 discussions with community groups.

Key issues raised across our engagement are:

- Safety and quality of services;
- Transport for patients and visitors;
- Communications and availability of information;
- Access to primary care;
- Access to mental health care;
- Experience of hospital discharge.

8 Additional stakeholder engagement has been undertaken including:

- Establishment of a leadership forum in August;
- A programme board meeting with officers of local authorities was held on 10 October 2016 to review governance;

- Monthly meetings with joint Overview and Scrutiny Committees with elected members of all local authorities in Better Health Programme area;
- Local authority member briefing events;
- CCGs/Trusts briefing MPs.

Next steps

9 The draft STP was submitted to NHS England on 21 October 2016 in line with the national timetable. A copy of the draft STP has since been published. Copies of the draft STP plan, process for engagement and briefing materials were shared with HWB members individually.

10 Next steps for the DDTHRW STP include:

- Further engagement with patients and public;
- Building on existing work with local authorities and other partners;
- Introducing the "discharge to assess" model across the STP, noting that this had already been introduced in County Durham and Darlington Foundation Trust;
- Developing an approach to integration;
- Submitting a draft business case to NHS England to seek support for capital requirements;
- Planning for public consultation on any significant changes.

Recommendations

11 The Health and Wellbeing Board are recommended to:

- Note the contents of this report, and;
- Receive and comment on the draft DDTHRW STP.

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

Appendix 1: Implications

Finance – N/A

Staffing – N/A

Risk – N/A

Equality and Diversity / Public Sector Equality Duty – N/A

Accommodation – N/A

Crime and Disorder – NA

Human Rights - NA

Consultation – N/A

Procurement - NA

Disability Issues - NA

Legal Implications – N/A

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Health and Wellbeing Board

31 January 2017

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

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

Purpose of the Report

1 To provide an update to the Health and Wellbeing Board (HWB) on the North Durham (ND) Clinical Commissioning Group (CCG) and Durham Dales, Easington and Sedgefield (DDES) CCG two year Operational Plans submitted in December 2016.

Background

2 The Operational Planning and Contracting guidance for 2017-19 was published in September 2016 and outlines the requirements of the NHS planning round over the two year period. The guidance includes:

- An outline of the nine must do's;
- How each operational plan links into the wider health economy as part of the Sustainability and Transformation Plan (STP) planning process;
- The need to plan activity, finance and workforce to ensure effective service delivery within a challenging climate;
- To ensure that risks are identified and mitigated against;
- The needs to demonstrate whole scale transformation of care to meet demand, in particular demonstrating how commissioning organisations are preparing to deliver new models of care i.e. Multi-speciality Community Provider models.

A Planning and Contracting Timetable is attached at Appendix 2.

Operational Plan

3 The operational plans for DDES and ND CCGs follow a similar format although they are aligned to different STPs; the key relationships with providers are the same.

4 Each plan highlights the key challenges and transformation schemes to be delivered which is shown as a **Plan on a Page.** ND CCG's Plan on a Page is attached at Appendix 3, DDES CCG's Plan on a Page is attached at Appendix 4. Transformation Schemes are attached at Appendix 6.

5 The **nine must do's** (Appendix 5) include requirements relating to the STP, finance, primary care, urgent and emergency care, referral to treatment times, cancer, mental health, Learning Disabilities (LD) and improving quality.

6 Each plan outlines projected **activity** for key points of delivery i.e. A&E admissions, outpatient appointments etc. and shows the position if CCGs "did nothing" vs implementing key transformational programmes and the effect this would have on reducing the need for secondary care.

7 Each commissioning organisation has a duty to deliver key **constitutional standards** which include;

- Diagnostic tests waiting times;
- Referral to treatment waiting times;
- A&E waiting times;
- Cancer two week, 31 day and 62 day waits;
- Ambulance indicators – telephone advice and proportion of incidents resolved without the need of A&E;
- Diagnosis rates for dementia;
- Mental health indicators – Improving Access to Psychological Therapies (IAPT) roll out and access, early intervention in psychosis, access to children and young people's services;
- Extended access to primary care;
- Personal health budgets;
- Percentage of children waiting more than 18 weeks for a wheelchair;
- E-referral service utilisation.

The plans demonstrate how each CCG will deliver the required standards for each year.

8 Each CCG has demonstrated a number of **transformation programmes** (appendix 6) which will be delivered within the next two years. These cover prevention, commissioning out of hospital models of care, optimising the use of acute care and commissioning effective mental health and LD services.

9 The major programmes across both CCGs include the development of the **community hub** concept and the development of an Accountable Care Network. This will ensure that out of hospital services are delivered as part of a joined up approach with the person of the centre.

10 Another ongoing development is in relation to **primary care** services, ensuring equity of access, enabling a resilient workforce and using technology to ensure care pathways are seamless.

11 There is also an extensive **mental health** programme which includes improving access to 24/7 services, improving dementia detection and treatment services and developing services designed specifically for children and young people.

Alignment of Plans

12 The CCGs operational plans reflect the STP and Better Care Fund plans.

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

Next Steps

14 The two operational plans were submitted to NHS England before the 23rd December deadline.

15 The next phase is about ensuring that the plan is now realised through delivery. The operational plans are now being transformed into delivery plans with agreed milestones, targets and governance which will be monitored on an ongoing basis to ensure effective implementation.

16 The operational plans will also be translated into public documents which set out our respective visions and work programmes to be delivered and will be published on our CCG websites.

Recommendations

17 The Health and Wellbeing Board are recommended to:

- Note the content of this report, and;
- Note the nine must-do's to be delivered
- Note each CCG's plan on a page

Contact: Rachel Rooney, Commissioning Manager
Tel: 0191 389 8579
Lorrae Rose, Commissioning Manager
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 and the delivery of QIPP.

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 AAPs, PRGs 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: Planning and Contracting Timetable

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Planning Guidance published	**22 September 2016**
Technical Guidance issued	**22 September 2016**
Commissioner Finance templates issued (commissioners only)	22 September 2016
Draft NHS Standard Contract and national CQUIN scheme guidance published	22 September 2016
National Tariff draft prices issued	22 September 2016
Provider control totals and STF allocations published	30 September 2016
Commissioner allocations published	21 October 2016
NHS Standard Contract consultation closes	21 October 2016
Submission of STPs	**21 October 2016**
National Tariff section 118 consultation issued	31 October 2016
Final CCG and specialised services CQUIN scheme guidance issued	31 October 2016
Provider finance, workforce and activity templates issued with related Technical Guidance (providers only)	1 November 2016
Submission of summary level 2017/18 to 2018/19 operational financial plans (commissioners only)	1 November 2016 (noon)
Commissioners (CCGs and direct commissioners) to issue initial contract offers that form a reasonable basis for negotiations to providers	4 November 2016
Final NHS Standard Contract published	4 November 2016
Providers to respond to initial offers from commissioners (CCGs and direct commissioners)	11 November 2016[1]
Submission of full draft 2017/18 to 2018/19 operational plans	**24 November 2016 (noon)**

Timetable Item (applicable to all bodies unless specifically referenced)	Date
Weekly contract tracker to be submitted by CCGs, direct commissioners and providers	Weekly from: 21/22 November 2016 to 30/31 January 2017
National Tariff section 118 consultation closes	28 November 2016
Where CCG or direct commissioning contracts not signed and contract signature deadline of 23 December at risk, local decisions to enter mediation	5 December 2016
Contract mediation	5 – 23 December 2016
National Tariff section 118 consultation results announced	w/c 12 December 2016
Publish National Tariff[2]	20 December 2016
National deadline for signing of contracts	**23 December 2016**
Final contract signature date for CCG and direct commissioners for avoiding arbitration	23 December 2016
Submission of final 2017/18 to 2018/19 operational plans, aligned with contracts	**23 December 2016**
Final plans approved by Boards or governing bodies of providers and commissioners	By 23 December 2016
Submission of joint arbitration paperwork by CCGs, direct commissioners and providers where contracts not signed	By 9 January 2017
Arbitration outcomes notified to CCGs, direct commissioners and providers	Within two working days after panel date
Contract and schedule revisions reflecting arbitration findings completed and signed by both parties	By 31 January 2017

North Durham CCG – Plan on a Page Appendix 3

"A place-based system ensuring North Durham is the best place for health and social care"

STP Transformation Areas

- Scaling up prevention, health and well being to improve the physical and mental health of our population and reduce inequity
- Out of hospital collaboration to develop alternative service models, reduce variation and raise quality of care in community settings
- Optimal use of the acute sector to improve experience of care, achieve better outcomes and create a sustainable model

CCG Transformation Programmes

- Cancer
- Lifestyle, Early Intervention and Prevention
- Providing every child with the best start in life
- Urgent Care
- Primary Care
- Out of Hospital Model
- RightCare
- Acute pathway review
- MH 5 year Forward view strategy

Activity & Demand programme

	Activity	% mov't
Non-elective spells		
2016/17 Forecast outturn	28,522	
Growth (2.4%)	685	*2.4%*
Impact of Identification Rules change	-66	*-0.2%*
Out of Hospital model	-685	*-2.4%*
2017/18 Planned Activity	28,456	*-0.2%*
Growth (2.5%)	711	*2.5%*
Out of Hospital model	-1,099	*-3.9%*
2018/19 Planned Activity	28,068	*-1.6%*
Elective Spells (Day Case & Ordinary)		
2016/17 Forecast outturn	38,983	
Growth (2.4%)	936	*2.4%*
Impact of Identification Rules change	2,848	*7.3%*
Rapid Specialist Opinion scheme	- 952	*-2.4%*
MSK pathway change and threshold review	- 275	*-0.7%*
2017/18 Planned Activity	41,540	*6.6%*
Growth (2.5%)	1,038	*2.5%*
Out of Hospital model	- 883	*-2.1%*
2018/19 Planned Activity	41,695	*6.9%*
All First Outpatient Attendances		
2016/17 Forecast outturn	81,729	
Growth (2.4%)	1,961	*2.4%*
Impact of Identification Rules change	610	*0.7%*
Rapid Specialist Opinion scheme	- 2,560	*-3.1%*
MSK pathway change and threshold review	- 1,015	*-1.2%*
2017/18 Planned Activity	80,725	*-1.2%*
Growth (2.5%)	2,018	*2.5%*
Out of Hospital model	- 2,095	*-2.6%*
2018/19 Planned Activity	80,648	*-1.3%*
All subsequent outpatient attendances		
2016/17 Forecast outturn	176,819	
Growth (2.4%)	4,244	*2.4%*
Impact of Identification Rules change	2,570	*1.5%*
Rapid Specialist Opinion scheme	- 3,190	*-1.8%*
MSK pathway change and threshold review	- 802	*-0.5%*
2017/18 Planned Activity	179,641	*1.6%*
Growth (2.5%)	4,491	*2.5%*
Out of Hospital model	- 4,520	*-2.5%*
2018/19 Planned Activity	179,612	*1.6%*
A&E attendances all types		
2016/17 Forecast outturn	101,350	*38,983*
Growth (2.4%)	2,432	*2.4%*
2017/18 Planned Activity	103,782	*2.4%*
Growth (2.5%)	2,595	*2.5%*
Out of Hospital model	-3,591	*-3.5%*
2018/19 Planned Activity	102,786	*1.4%*
Total referrals		
2016/17 Forecast outturn	92,819	
Growth (2.4%)	2,228	*2.4%*
Rapid Specialist Opinion scheme	- 2,560	*-2.8%*
MSK pathway change and threshold review	- 1,015	*-1.1%*
2017/18 Planned Activity	91,472	*-1.5%*
Growth (2.5%)	2,288	*2.5%*
Out of Hospital model	- 2,095	*-2.3%*
2018/19 Planned Activity	91,664	*-1.2%*

QIPP Programme

QIPP Target over next 2 years

£16m
Financial challenge

Summary Solutions

	2017/18 £'000	2018/19 £'000
Transformational programmes / pathway redesign	4,700	4,300
Productivity / transactional efficiencies	2,092	500
Prescribing	1,223	1,200
Demand management	1,189	
Unidentified		500
	9,204	6,500

Workforce	Information Technology – Great North Care Record	Estates – One Public Estate	Accountable and outcome-based systems

Operational Plan on a Page 2017-2019

'Working together for excellent health for the local communities'

NHS
Durham Dales, Easington and Sedgefield Clinical Commissioning Group

Appendix 4

Health & Wellbeing Gap

Early Intervention and Prevention

Transformation Scheme	CCG Initiatives
Cancer	Develop with Public Health and our local health networks audience appropriate messages that target all age groups/sectors with the aim of encouraging healthier lifestyles and early access to diagnostics/ screening for lung, breast, bowel and cervical cancer. There will be a particular emphasis on seldom heard and young people .
Lifestyle, Early Intervention and Prevention	Work with public health in a targeted approach in key areas of deprivation across the DDES communities. Continued implementation of the national diabetes prevention programme. Increase and improve training and development across working practice to improve secondary prevention in primary care and secondary care
Providing every child with the best start in life	Work with public health to improve maternal care including maternal mental health, breastfeeding, maternal obesity, maternal smoking, parental drug and alcohol issues, parenting programmes, school readiness and narrowing the gap. Working together with others to reduce Child poverty which is part of much broader indicator set; Improve the first 1,001 days of a childs life to support the reduction in long term illnesses.

Quality & Care Gap

Integration

Transformation Scheme	CCG Initiatives
Urgent Care	Provide an improved service to meet the urgent care needs of our local population, resulting in some changes to services currently being delivered. Continued provision of minor injury and GP out of hours services will be complemented by extended and enhanced GP services. GP services will be extended from 6:00 pm-8:00 pm weekdays as well as extended weekend provision on a Saturday and Sunday morning . In addition to this there will be enhanced availability of same day urgent appointments with GP practices.
Primary Care	The four key objectives are; to develop seven day services; to develop disease specific pathways for integration of services and budgets; to develop and implement the GPFYFV concepts; to wrap services around primary care through the development of community hubs .
Mental Health	Key priorities are to; expand IAPT by extending the scope to include Children and Young People; improve the appropriateness of prescribing of anti-psychotics, reduce the impact on long term health problems; improve our response to crisis by improving ambulance response times; develop a intensive Home Treatment service for children and young people.
Learning Disabilities	Increase the uptake of cancer screening within the learning disability population (breast, cervical, bowel); work with the regional Learning Disabilities Network to implementing a tool for non-psychologists to recognise the possibility/probability of a patient having a learning disability and putting procedures in place to assist the expectant mother; reduce the number of patients with a learning disability in a hospital bed
Right Care	We will continue to reduce variation across a number of key areas e.g. respiratory; MSK; unintentional injuries in children; neurology; dementia and falls
Not In Hospital	DDES are developing community hubs which are integrated teams working together to cover a population's health and care needs. We will improve access, continuity and community based health and care services.

Funding & Efficiency Gap

Reconfigure Hospital Based Services

Transformation Scheme	CCG Initiatives
Better Health Programme	Through the development of community hub models the integration of providers within health and social care our population will benefit from; Integration of information systems; A developed workforce that delivers care as part of a care planning approach; A care model that is based around a triangulation of needs, incorporating: Highest needs model supported by multidisciplinary team, with risk stratification to identify patients who will benefit most from intensive support; Ongoing care needs – Integrated primary and community care MDTs, based around population hubs, working closely with specialists, carers, other sectors and with a care co-ordinator. GPs ensuring continuity of responsibility for patients on their list, supported by standardised tools for LTC management.

Technology

Transformation Scheme	CCG Initiatives
Digital Health and Technology	We will support our Sustainability and Transformation Planning footprint in the development of technology which will support the: Reduction in admissions to hospital; Reduction in duplicate medications and tests; Reduction in duplicate back office resources; Increased capacity in services through patient self management

The Nine Must Do's

Appendix 5

'Must dos'	Requirements of the STP	STP Commitment
1. STPs	Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.	✓
	Achieve agreed trajectories against the STP core metrics set for 2017-19.	
2. Finance	Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals.	✓
	Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.	
	Delivery of demand reduction measures.	
	Delivery of Provider efficiency measures.	
3. Primary care	Implementation of the General Practice Forward View.	✓
	Ensure local investment meets or exceeds minimum required levels.	
	Tackle workforce and workload issues.	
	Improve access by no later than March 2019.	
	Support general practice at scale, the expansion of MCPs or PACS, and improving health in care homes.	
4. Urgent and emergency care	Deliver the four hour A&E and Ambulance response standard	✓
	Meet the four priority standards for seven-day hospital services for all urgent network specialist services.	
	Implement the Urgent and Emergency Care Review.	
	Deliver a reduction in the 999 calls that result in avoidable transportation to an A&E department.	
	Prepare for waiting time standard for urgent care for those in a mental health crisis.	

'Must dos'	Requirements of the STP	STP Commitment
5. Referral to treatment times and elective care	Deliver the 18 weeks from referral to treatment (RTT)	✓
	Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals	
	Streamline elective care pathways	
	Implement the national maternity services review, Better Births, through local maternity systems	
6. Cancer	Implement the cancer taskforce report.	✓
	Deliver the 62 day cancer standard	
	Make progress in improving one-year survival rates	
	Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.	
	Ensure all elements of the Recovery Package are commissioned.	
7. Mental health	Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages, including:	✓
	Ensure delivery of the mental health access and quality standards	
	Increase baseline spend on mental health to deliver the Mental Health Investment Standard.	
	Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.	
	Eliminate out of area placements for non-specialist acute care by 2020/21.	
8. People with learning disabilities	Deliver Transforming Care Partnership plans	✓
	Reduce inpatient bed capacity.	
	Improve access to healthcare for people with learning disability.	
	Reduce premature mortality	
9. Improving quality in organisations	All organisations should implement plans to improve quality of care, particularly for organisations in special measures.	✓
	Measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.	
	Participate in the annual publication of findings from reviews of deaths.	

	Transformation Schemes	CCG Joint Plan with STP Appendix 6
Scaling up prevention, health and well being	Cancer	Develop with Public Health and VCSE audience appropriate messages/ with particular emphasis on seldom heard and young people – that target all age groups/sectors to encourage healthier lifestyles and early access to diagnostic/ screening for lung, breast, bowel and cervical cancer
	Lifestyle, Early Intervention and Prevention	Work with public health in a targeted approach in key areas of deprivation across the North Durham communities Increase and improve training and development across working practice to improve secondary prevention in primary care and secondary care
	Providing every child with the best start in life	Improve Maternal care - mental health, infant mental health, breastfeeding, maternal obesity, maternal smoking, parental drug and alcohol issues, parenting programmes, school readiness and narrowing the gap. Working together with others to reduce Child poverty which is part of much broader indicator set; Improve the first 1,001 days of a childs life to support the reduction in long term illnesses.
Out of hospital collaboration	Urgent Care	To ensure urgent care needs are met by a robust service model which includes in and out of hours provision for minor injuries and ailments. This includes extended access to primary care on weekdays (6-8pm) and weekends.
	Primary Care	North Durham has a primary care strategy which focuses on extending access to general practice through federated working and integrated systems. The aim is to ensure primary care is sustainable and is transformed to become the basis of our out of hospital model of care.
	Right Care	We will continue to reduce variation across a number of specialties key to North Durham.
	Out of Hospital Model	Agree an MCP model of care which ensures the sustainability of primary and community care now and in the future. To deliver high quality care which is person centred, irrespective of organisational boundaries. People will receive continuity of care that is effectively co-ordinated and delivered where possible close to home. • Discharge to assess • Develop frail elderly rapid access clinics. • Intermediate care plus • MSK community service • Accountable Care Network development • Implementation of extended access to primary care for vulnerable adults • Development and implementation of community hub model and place based budgets
Optimal use of the acute sector	• Acute pathway review	Optimal Use of Acute Sector through collaboration across clinical pathways. Shape services based on need and clinical standards and elective pathway redesign in conjunction with Newcastle/Gateshead Integrated urgent and emergency care centre (UHND site)
Mental Health	• Five year MH Forward View Strategy	Delivery of the mental health prevention as part of the Five Year Forward View. Implementation of Children and Young Peoples Mental Health and Wellbeing Plan Implementation of the Mental Health Five year Forward View Alignment of mental health and talking therapies to community hubs

Health and Wellbeing Board

31 January 2017

Better Care Fund Quarter 2 Performance 2016/17

Report of Paul Copeland, Strategic Programme Manager – Care Act Implementation and Integration, Adult and Health Services, Durham County Council

Purpose of the Report

1 The purpose of this report is to provide an update on the high level metrics and deliverables on the Better Care Fund (BCF) Quarter 2 2016/17.

2 The BCF Quarterly Data Collection template for Q2 2016/17 is available on request.

Background

3 The total amount of the BCF for Durham in 2016/17 increased to £44.579m from £43.735m in 2015/16.

4 The BCF Policy Framework and Planning Guidance for 2016/17 issued by NHS England signalled a need for stability.

5 In view of the above, BCF planning in Durham was based upon maintaining equilibrium and rolling forward all of the programmes and projects from 2015/16 in agreement with partners.

6 Payment for performance was replaced by two new national conditions:

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

7 BCF planning requirements for 2016/17 required Health and Wellbeing Boards to continue collecting information on four key metrics which are identified below:

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

8 In addition, the BCF plans had to include two locally determined metrics which are identified below:

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

Performance Update

9 Performance against the six key metrics and deliverables are measured against the 2015/16 position. Q2 2016/17 denotes positive performance in three of the indicators with the majority of data on track to meet their target going forward, with the exception of admissions to residential or nursing care where some improvement in performance is expected but unlikely to meet the full target.

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

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

Indicator	Historical	Actual	Targets		Performance against target
	2015/16	Q2 2016/17	Q2 2016/17	2016/17	
Permanent admissions of older people (aged 65yrs+) to residential / nursing care homes per 100,000 population	**736.3**	**367.8**	**362.2**	**750.8**	

11 The Q2 2016/17 rate for older people aged 65+ years admitted to residential or nursing care homes per 100,000 population on a permanent basis was 367.8 This did not meet the Q2 2016/17 target of 362.2 and remains challenging. It is expected that performance will improve but not sufficiently to meet the full target for the year.

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

13 The average age of those admitted to residential care has increased from 84.7 years in 2005/06 to 86.5 years in 2015/16; and from 83.5 years to 84.3 years in nursing care.

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

Indicator	Historical	Actual	Targets		Performance against target
	2015/16	Q2 2016/17	Q2 2016/17	2016/17	
Percentage of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation	**87.2%**	**86.0%**	**86.0%**	**86.0%**	

14 Performance in Q2 2016/17 at 86.0% is completely on target for the year which is expected to continue going forward.

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

Indicator	Historical		Actual	Targets	Performance against target
	Q2 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
Delayed transfers of care (delayed days) from hospital per 100,00 population (per 3 month period)	**391.0**	**369.0**	**285.0**	**387.6**	

15 Delayed transfers of care (delayed days) have exceeded the target set for Q2 2016/17 of 387.6. Delayed transfers of care have reduced significantly from Q1 2016/17 (369.0) and are lower than the same period in 2015/16 (391.0).

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

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

Indicator	Historical		Actual	Targets	Performance against target
	Q2 2015/16	Q1 2016/17	Q2 2016/17	Q2 2016/17	
Non Elective Admissions per 100,000 population (per 3 month period)	**2924**	**2993**	**2962**	**2961**	

17 The Q2 outturn figure for non-elective admissions was 2962 per 100,000 population against a target of 2961. Performance was extremely close to target and an improvement on the Q1 figure of 2993 per 100,000 population.

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

Indicator	Historical		Actual	Annual Target	Performance against target
	2012/13	2014/15		2016/17	
Percentage of carers who are very / extremely satisfied with the support services they receive	**48.1%**	**54.4%**	**No data available**	**48.0-53.0%**	

18 Provisional results from the National Carer's Survey undertaken in October 2016 are expected in January 2017.

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

Indicator	Historical		Actual	Annual Target	Performance against target
	2014/15	2015/16	Q2 2016/17	2016/17	
The number of people in receipt of telecare per 100,000 population	292	474	508	454	

19 The number of people recorded as in receipt of telecare for Q2 was 508 per 100,000 population which has exceeded the target and demonstrates a continued upward trend of people utilising telecare in Durham.

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

Recommendations

21 The Health and Wellbeing Board is recommended to:

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

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

Appendix 1: Implications

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

Staffing – No direct implication.

Risk – A risk sharing agreement has been agreed between partners.

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

Accommodation – None.

Crime and Disorder – None.

Human Rights – None.

Consultation – As required through the Health and Wellbeing Board.

Procurement – None.

Disability Issues – See Equality and Diversity.

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

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Health and Wellbeing Board

31 January 2017

Oral Health Strategy For County Durham

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

Purpose of the Report

1 The purpose of this report is to present the Health and Wellbeing Board with the Oral Health Strategy for County Durham for agreement. The strategy is attached at Appendix 2.

Background

2 The National Institute for Health and Care Excellence (NICE) Public Health 55 Guidance makes 21 recommendations to improve the oral health of our communities. The first recommendation is the development of a stakeholder group that in turn will assist in the development of a strategy to deliver the majority of the other recommendations. The Oral Health Strategy Group has been established and has developed an Oral Health Strategy.

Oral health strategy development

3 The development of this strategy has been led by a multi-disciplinary steering group consisting of members taken from the local dental network, paediatricians, dental anaesthetists, Durham County Council Children's Services, Health Visiting Services, Durham County Council Commissioning for Adult Services, Public Health and Public Health England (PHE).

4 The 21 recommendations can be applied to a 'settings based' approach. The strategy sets out the intentions for how the Oral Health Strategy and Action Plan will be pragmatically applied by working with existing partners and stakeholders to embed oral health over the next three years.

5 Whilst the Oral Health Strategy is implemented, work is ongoing in partnership with PHE to explore the possibility of water fluoridation.

6 An Oral Health Strategy Plan on a Page has been developed, attached at Appendix 3.

Consultation response

6 The consultation sought the views of the public, including being disseminated by the Area Action Partnerships, key stakeholders, partnership groups and

Overview and Scrutiny Committees across County Durham. The consultation process is attached at Appendix 4.

7 There was significant support for the Oral Health Strategy and its aims to improve oral health in County Durham.

8 There was a common emphasis on; the need to ensure targeted approaches in areas of deprivation; retaining a focus on the oral health of children and vulnerable groups; utilising the range of stakeholders who could have a positive impact upon oral health; and the continued efforts to explore fluoridation in County Durham.

9 Feedback from consultation suggested amendments to the Action Plan. This included the possible expansion of certain actions to include a wider cohort of people, or amendments to terminology to reflect the current provision of dental health within County Durham. These amendments have been made to the Action Plan, and will be analysed and progressed by the Oral Health Steering Group once the Action Plan is operational.

Next steps

10 The Oral Health Steering Group will implement the Action Plan and ensure a partnership approach to the agenda. Water fluoridation will continue to be explored.

Recommendations

11 The Health and Wellbeing Board are requested to:

- Agree the Oral Health Strategy attached at Appendix 2
- Note feasibility study on fluoridation is underway awaiting results which will inform action plan at a later date.

Contact: Chris Woodcock, Public Health Portfolio Lead
Tel: 03000 267682

Appendix 1: Implications

Finance - Identified from Public Health reserves. Fluoridation feasibility study includes contributions from NHS England.

Staffing - None

Risk - Timeline for fluoridation and stakeholder and community opinion surrounding the activity.

Equality and Diversity / Public Sector Equality Duty - To reduce oral health inequalities.

Accommodation - N/A

Crime and Disorder - N/A

Human Rights - N/A

Consultation - Oral Health Strategy has been consulted upon. Consultation not required for fluoridation feasibility study.

Procurement - DCC to commission targeted interventions.

Disability Issues - None

Legal Implications - Linked to procurement. Linked to the legislative process surrounding fluoridation.

Oral Health Strategy

County Durham

2016-2019

DRAFT

Aim of Oral Health Strategy

1. To reduce the population prevalence of dental disease – and specifically levels of dental decay in young children and vulnerable groups.
2. To reduce the inequalities in dental disease.
3. To ensure that oral health promotion programmes are evidence informed and delivered according to identified need.

Background

Oral health is important for general health and wellbeing. Poor oral health can affect someone's ability to eat, speak, smile and socialise normally, for example due to pain or social embarrassment[1]. Oral health problems include gum (periodontal) disease, tooth decay, tooth loss and oral cancers. Many risk factors – diet, oral hygiene, smoking, alcohol, stress and trauma are the same as for many chronic conditions, such as cancer, diabetes and heart disease.

Tooth decay is the most common oral disease affecting children and young people in England, yet it is largely preventable. While children's oral health has improved over the last twenty years, almost a third (27.9%) of five year olds still had tooth decay in 2012[2]. Children who have toothache or who need treatment may have to be absent from school. Tooth decay was the most common reason for hospital admissions in children aged five to nine years old in 2012 – 13. Dental treatment under general anaesthesia presents a small but real risk of life threatening complications for children[3].

People living in deprived communities consistently have poorer oral health. However, it is noted that deprived areas with fluoridated water have better oral health than comparator communities without fluoridated water.

Vulnerable groups in society are also more likely to suffer from poor oral health. NICE guidance[4] identifies a list of vulnerable groups who require specific support to improve their oral health. These include those who are:

- Socially isolated
- Older and frail
- Physical or mental disabilities
- From lower socio economic groups
- Live in disadvantaged areas
- Smoke or misuse substances (including alcohol)
- Have a poor diet
- Some Black, Asian and minority ethnic groups
- Who are, or who have been in care

[1] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE
[2] PHE 2014 commissioning better oral health for children
[3] PHE 2014 commissioning better oral health for children
[4] NICE 2014 Oral health: approaches for local authorities and their partners to improve the oral health of their communities PH55 NICE

Diseases affecting the oral cavity

The mouth is affected by diseases such as dental caries and periodontal disease and other conditions, such as trauma, mouth cancer and developmental abnormalities, all of which can have an adverse effect on an individual's wellbeing.

Dental caries (tooth decay)

Dental caries is the most common disease of the dental tissues and affects the majority of the population. It is caused by bacteria in the mouth utilising sugars in the diet as a source of food and producing acids as a by-product. The acids dissolve away the tooth substance leading to dental decay, abscess formation and eventually tooth loss.

There is substantial evidence to show that people from socially deprived backgrounds experience considerably more dental disease than other members of the population due to lack of opportunities that would enable them to improve their oral health. The main issues are poor diet and limited access to fluorides and dental care.

Periodontal disease

Periodontal disease affects the structures which support the teeth; these are the tissues and ligaments which secure the teeth to the jaw bones. This disease is caused by a build-up of plaque around the teeth leading to the development of inflammation. The gums become swollen and bleed spontaneously. In susceptible individuals the disease progresses by destroying the supporting structures of the teeth, the teeth become loose and if unchecked the disease results in tooth loss.

Trauma

Teeth may be traumatised as a result of accidents and participation in contact sports. The upper incisor teeth are at greatest risk and experience most damage.
The most recent data for England was published in March 2015[5] using a survey of 15 year olds which found the proportion of 15 year olds affected is very similar across the three countries (England, Wales, Northern Ireland), at around 4% of the population and there are no significant differences related to sex, free school meals, brushing or school attendance.

Mouth cancer

Mouth cancer is the major fatal condition which affects the oral tissues. There is a high risk of developing mouth cancer in people who smoke and those who consume excessive amounts of alcohol.

[5] Children's dental health survey 2013, Health and social care information centre, March 2015

Developmental abnormalities of the oro-facial tissues

Although not the result of disease processes, defects in the development of oral tissues and facial skeleton may result in teeth being displaced sufficiently that the malocclusion produced impacts on oral health. Significantly adverse alignment of children's teeth makes them more susceptible to physical disease, trauma and also impacts on personal appearance, leading to potentially low self-esteem. There are a large number of rare genetic conditions which affect the teeth and facial skeleton. The most common are clefts of the lip and/or palate.

Roles and responsibilities for oral health

With the fragmentation of the NHS in April 2013 the responsibility for dental services and oral health dispersed across various organisations. The table below briefly highlights which local organisations have responsibility for which parts of the system.

Table 1: Local organisations roles and responsibilities

Organisation	Key responsibility
NHS England (Area Teams)	Commissioning all NHS dental services – both primary and secondary care Direct and specialised commissioning
Public Health England (centres)	Provide dental public health support to NHS England and Local authorities Contribute to JSNAs, strategy development, oral health needs assessment Supporting local authorities to understand their role in water fluoridation
Local authorities (Public Health)	Jointly statutorily responsible for JSNA Conducting and/or commissioning oral health surveys to monitor oral health needs to an extent that they consider appropriate in their areas Planning, commissioning and evaluating oral health improvement programmes Leading scrutiny of delivery of NHS dental services
Local dental networks	Providing local professional leadership and clinical engagement
Provider services	County Durham and Darlington Foundation Trust hold a block contract for dental services which includes the oral health promotion team

National recommendations

Within the latest public health NICE guidance 'Oral health: approaches for local authorities and their partners to improve the oral health of their communities', there are 21 recommendations for Health and Wellbeing Boards to consider. Table 2 below provides a list of the recommendations.

Table 2: NICE recommendations

Recommendations
1. Ensure oral health is a key health and wellbeing priority 2. Carry out an oral health needs assessment 3. Use a range of data sources to inform the oral health needs assessment 4. Develop an oral health strategy 5. Ensure public service environments promote oral health (e.g. plain drinking water available, healthy vending options, promoting breastfeeding etc.) 6. Include information and advice on oral health in all local health and wellbeing policies 7. Ensure front line health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9. Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 10. Promote oral health in the workplace 11. Commission tailored oral health promotion services for adults at high risk of poor oral health 12. Include oral health promotion in specifications in all early years services 13. Ensure all early years services provide oral health information and advice 14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health 16. Consider fluoride varnish programmes for nurseries in areas where children are at high risk of poor oral health 17. Raise awareness of the importance of oral health as part of 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at high risk of poor oral health 19. Consider supervised tooth brushing schemes in primary schools in areas where children are at high risk of poor oral health 20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health 21. Promote a whole school approach to oral health in all secondary schools

Fluoridation

Fluoride has made an enormous contribution to the decline in dental caries over the past 60 years since research in the United States discovered that people living in an area of naturally fluoridated water had much better dental health than those who did not and, furthermore, water fluoridated at a concentration of 1 part per million did not cause significant mottling of the teeth (dental fluorosis) nor any other health related adverse effects. Fluoride produces an effect on the teeth in a number of ways that combine to slow and help prevent the decay process.

There is compelling evidence that fluoride is effective in reducing decay and that water fluoridation is the most effective way of using fluoride to reduce decay. Other fluoride interventions, such as fluoride toothpaste and fluoride varnish, are also important, effective ways of reducing tooth decay and there is an even greater reduction in decay levels when, for example, fluoride toothpaste is used together with water fluoridation. Consequently this oral health strategy for County Durham includes due consideration of water fluoridation as part of a series of oral health promotion initiatives – including other fluoride based interventions and initiatives aimed at improving diet and nutrition.

Fluoride tooth brushing schemes

The use of fluoride toothpaste has been shown to reduce levels of dental decay by 37% and the increased use of fluoride toothpaste has been largely responsible for the reductions in dental decay that have been observed over the last 20-30 years.

Published research has indicated that supervised tooth brushing schemes are effective in reducing levels of dental decay and that there remains a significant reduction in decay levels between children in test and control groups at 30 months after the programme ended.

Evidence also shows that the introduction and uptake of a tooth brushing program contributed positively to the dental health of children and reduced dental health inequalities.

Tooth brushing schemes are to be established in targeted early year's day care facilities in County Durham whilst promoting dental registration with families through universal health visitor services.

Fluoride varnish

Fluoride varnish is one of the best options for increasing the availability of topical fluoride, regardless of the levels of fluoride in the water supply. High quality evidence of the caries-preventive effectiveness of fluoride varnish in both permanent and primary dentitions is available and has been updated recently. A number of systematic reviews conclude that applications two or more times a year produce a mean reduction in caries increment of 37% in the primary dentition and 43% in the permanent. Schemes will be explored during the implementation of this strategy.

County Durham: oral health current picture

Access to dental services

A study on access to dental services carried out in 2010/11 (most recent data available) showed significant variations across the wards in the county with populations living in the poorest wards having the lowest uptake.

Perceptions surveys have been undertaken to understand why adults do not register with dentists. Two of the most significant barriers include complexity of the forms to fill in and dentist phobias.

NHS England are leading a review of the national general dental contract. Part of the consultation is regarding how primary dental health services can deliver more on oral health promotion activities and reduce oral health inequalities. The outcomes of the consultation are awaited.

Oral health status

Children: Data from the last large scale dental survey (2012) of five year old children's oral health in County Durham shows wide variations in dental disease experience between different wards, from 61% of children having had decay experience in Woodhouse Close (Bishop Auckland) to just 6% in Chester-Le-Street South. This highlights a need to narrow the gap in oral health inequalities. Oral health of five year olds is part of the children's public health outcomes framework.

Adults: There are no regular local surveys undertaken of adult dental health at a local authority level. The best data available is from the last national adult health survey which took place in 2009. The smallest geography available is at a North East level. The survey showed that 92% of the North East population had some teeth. 82% had 21 or more teeth which is the limit allowed by dentists to demonstrate functionality. 65% of North East residents participating in the survey reported regular dental attendance above the England average of 61%.

Elderly population: With an aging population, the increase in dementia and older people retaining their teeth, there is a need to consider how the oral health of this growing vulnerable population will be managed. The challenge this group presents is the support required to maintain their oral health and how health and social care provide supportive environments to maximise their oral health and avoid unnecessary and expensive dental treatment. A recent local evaluation completed within County Durham care homes[6] has identified the complex oral health care needs of those living in residential care. The system must come together to support this vulnerable group and reduce escalating costs which are preventable.

Partnerships and governance

The development of this strategy has been led by a multi-disciplinary steering group consisting of members of the local dental network, paediatrician, dental anaesthetist, Durham County Council children's services, health visiting services, Durham County Council commissioning for adult services, public health and Public Health England.

There has also been a consultation process to ensure the views of stakeholders have been taken into consideration.

The Oral Health Steering Group is accountable to the Children and Families Partnership and the Health and Wellbeing Board.

Outcome measures for strategy

Percentage improvement: child population averages for decayed, missing and filled teeth, proportion of children with no decay experience.

[6] Ahmad, B., 2015 oral health care provision for the elderly in residential care homes in County Durham: An evaluation of need and strategy document

Challenges going forward

The gap in oral health inequalities between children living in deprived communities and those in less deprived communities needs to reduce and the action plan will be targeted accordingly. Targeted work must also continue with vulnerable groups such as those with poor physical and mental health and the frail elderly population.

Due to the overlap with other health promotion messages for many other preventable conditions, such as diabetes, there is benefit in combining approaches and making sure oral health is embedded into other health promotion work rather than a stand-alone topic.

The strong and newly emerging evidence[7] regarding the impact on sugar on the obesity epidemic is an opportune time to combine efforts on tackling obesity and oral health inequalities.

The 21 NICE recommendations can be applied to a 'settings based' approach. The remainder of this strategy sets out the intentions for how the oral health strategy will be delivered practically by working with existing partners and stakeholders to embed oral health over the next three years while we remain committed to progress the feasibility of fluoridation.

The first four NICE recommendations refer to actions already underway such as the development of a strategy and reviewing the available epidemiological data.

[7] Public Health England, 2015. Sugar Reduction 'The evidence for action'

ORAL HEALTH STRATEGY ACTION PLAN

Early years settings **ACTION**	**Lead**	**Timeline**	**NICE Recommendations**
1. Increase breast feeding initiation by 5%	HDFT – lead of the system	March 2018	5. Ensure all public service environments promote oral health 6. Include information on oral health in local health and wellbeing policies 7. Ensure frontline health and social care staff can give advice on the importance of oral health 8. Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 12. Include oral health promotion in specifications for all early years services 13. Ensure all early years services provide oral health information and advice
2. Increase breastfeeding at 6 – 8 weeks by 5%	HDFT – lead of the system	March 2018	
3. Breastfeeding friendly venues – UNICEF accreditation maintain status	HDFT – lead of the system	June 2017	
4. Increase in families accessing the dentist in 30% most deprived MSOAs	Children Centre Lead AB	March 2018	
5. Plain drinking water in public sector venues is main drink available	Public Health – Chris Woodcock	March 2018	
6. Provide a choice of sugar free foods – including vending machines	Public Health – Chris Woodcock	March 2018	
7. Oral health part of early years strategy and included within current practice in order to identify need early	HDFT – lead of the system	March 2018	
8. Training on oral health promotion given to front line practitioners	CDDFT – Julie King	March 2018	

9. Targeted oral health promotion work for vulnerable groups: SEND and vulnerable parent pathway	HDFT – lead of the system	March 2018	14. Ensure early years services provide additional tailored information and advice for groups at high risk of poor oral health 15. Consider supervised tooth brushing schemes for nurseries in areas where children are at high risk of poor oral health
10. Align dental practices to children centre cluster areas in targeted communities	Children Centres – Karen Davison	March 2018	
11. Deliver and evaluate a three year tooth brushing scheme in targeted nurseries, working with local dental network	Early Years – Helen Nixon	April start	

Primary school setting (age 5 – 11 years)	**Lead**	**Timeline Review**	**NICE Recommendation**
1 Increase number of schools following national school food plan: ensure plain drinking water available and sugar free snacks	Education - Alison Young	March 2018	17. Raise awareness of the importance of oral health, as part of a 'whole school' approach in all primary schools 18. Introduce specific schemes to improve and protect oral health in primary schools in areas where children are at risk of poor oral health 19. Consider supervised tooth brushing schemes for primary schools in areas where children are at high risk of poor oral health
2 Encourage schools to include oral health as part of the curriculum – PSHE resources easily available	Education - Alison Young	September 2017	
3 School Nurses to promote dental access at parent sessions	HDFT 0-19 Team	March 2018	
4 School nurses to assist with dental practices regularly visiting schools to facilitate the uptake of dental care in targeted communities	HDFT – lead of the system	March 2018	

5	Oral health promotion team to work with special schools through the academic year	CDDFT	March 2018	20. Consider fluoride varnish programmes for primary schools in areas where children are at high risk of poor oral health
6	Training sessions delivered to special school support staff on oral hygiene and health promotion	CDDFT	March 2018	
7	Deliver and evaluate a three year targeted tooth brushing scheme working with the local dental network to deliver intervention	PH – stage 2	March 2019	

Workplace and community setting ACTIONS		**Lead**	**Timeline review**	**NICE Recommendations**
1	Make plain drinking water available in community venues	Public health to lead the system	March 2018	5. Ensure public services promote oral health 6. Ensure front line health and social care staff can give advice on the importance of oral health 10. Promote oral health in the workplace
2	Provide a choice of sugar free food, drinks and snacks, including from vending machines	Public health to lead the system	March 2018	
3	Encourage and support breastfeeding with work places and communities	Public health to lead the system	March 2018	
4	Healthy living pharmacy – SMILE campaign delivered annually	Claire Jones – PH Pharmacist	September 2017	
5	Oral health in Health at Work campaigns	PCP lead	March 2018	

Vulnerable group (children and adults at high risk of poor oral health)	Lead	Timeline Review	NICE Recommendations
1 Oral health promotion team to work specifically with special schools and those educated outside of mainstream	CDDFT	March 2018	7 Ensure front line health and social care staff can give advice on importance of oral health 8 Incorporate oral health promotion in existing services for all children, young people and adults at high risk of poor oral health 9 Commission training for health and social care staff working with children, young people and adults at high risk of poor oral health 12. Commission tailored oral health promotion services for adults at high risk of poor oral health
2 Explore feasibility of minimum set of standards for oral health within care home contracts, and those in receipt of adult social care e.g. oral health assessment on admission to care home, oral health care plan established and regularly reviewed – quality metrics	DCC Commissioning	April 2018	
3 Include training and support in residential care homes on importance of oral hygiene and dual training on dementia care as part of contract	CDDFT	March 2018	
4 Implementation of labelling dentures to reduce loss and cost of replacement	NHS England	2017/18	
5 Align dental practices to each residential care home to ensure a general dentist is available for advice/guidance	NHS England	2017/18	

Workforce	Lead	Timeline	NICE Recommendations
HENE – oral health promotion training course. Evidence based advice and guidance to early years and care homes	NHS England	2017/18	

Appendix 3: Oral Health Strategy Plan on a Page

See separate document

Appendix 4: Consultation Timeline For Oral Health Strategy

Meeting	Date	Purpose
Health and Wellbeing Board	26th July 2016	Agree draft for wider consultation
Six week public consultation: • Including targeted consultation with Foundation Trusts and NHS England • Disseminated by the Area Action Partnerships	1st August – 12th September 2016	Consultation
Children and Families Partnership	13th September 2016	Consultation
CYP Overview and Scrutiny committee	29th September 2016	Consultation
AWH Overview and Scrutiny committee	4th October 2016	Consultation
Health and Wellbeing Board Big Tent Event	5th October 2016	Consultation
Health and Wellbeing Board	31st January 2017	Agreement of strategy

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APPENDIX 3

County Durham Oral Health Strategy 2015-2020

Issues

Oral health is important for general health and wellbeing.

Tooth decay is the most common oral disease affecting children and young people, yet is largely preventable.

People living in deprived communities consistently have poorer oral health

Vulnerable groups are more likely to suffer from poor oral health.

Other risk factors include poor nutrition, high consumption of sugar and lack of access to fluoride

Vision

Our vision is that "every child grows up free from tooth decay as part of every child having the best start in life". The oral health of local communities is important for their general health and wellbeing and their quality of life. It may be improved by adopting a 'common risk factor' approach and by providing evidence-based oral health promotion programmes and interventions.

National Policy Context

NICE guidance 'Oral health: approaches for local authorities and their partners to improve the oral health of their communities', states 21 recommendations for Health and Wellbeing Boards to consider. This guideline covers improving oral health by developing and implementing a strategy that meets the needs of people in the local community. It aims to promote and protect people's oral health by improving theirdiet and oral hygiene, and by encouraging them to visit the dentist regularly.

Local Policy Context

The County Durham Joint Health and Wellbeing Strategy

This sets out the way in which every child can have the best start in life and includes a focus on improving oral health

Aims and Objectives

- To reduce the population prevalence of dental disease – and specifically levels of dental decay in young children and vulnerable groups.
- To reduce the inequalities in dental disease.
- To ensure that oral health promotion programmes are evidence informed and delivered according to identified need.

The gap in oral health inequalities between children living in deprived communities and those in less deprived communities needs to reduce and the action plan will be targeted accordingly. Targeted work must also continue with vulnerable groups such as those with poor physical and mental health and the frail elderly population.

Due to the overlap with other health promotion messages for many other preventable conditions, there is benefit in combining approaches and making sure oral health is embedded into other health promotion work rather than a stand-alone topic. The aim is to improve people's:

- diet – this includes reducing the amount of sugar consumed
- oral hygiene
- access to fluoride products

The NICE guidance provides 21 recommendations which can be applied to a 'settings based' approach. The strategy sets out the intentions for how the Action Plan will be pragmatically applied and collectively delivered by partners and stakeholders, to embed oral health over the next three years.

- ***Early Years Settings***

Establishing good oral health routines in early life is crucial and health practitioners and early years workers can provide a key part by providing evidence based information and advice.

- ***Primary School Settings***

Promote a 'whole school' approach to oral health by ensuring the school environment promotes and protects oral health.

- ***Workplace and Community Setting***

Workplace is an environment where oral health can be promoted and the public sector can positively impact upon its communities.

- ***Vulnerable Group (children and adults at high risk of poor oral health)***

Frontline health and social care staff working with groups at high risk of poor oral health need to be appropriately trained to meet the needs of vulnerable groups.

- ***Workforce***

It is therefore important to make every contact count and support our residents to make healthier choices.

Key Areas of Focus 2016-2019

Early Years Settings

- Increase breastfeeding initiation by 5%
- Increase breastfeeding at 6 – 8 weeks by 5%
- Breastfeeding friendly venues – UNICEF accreditation maintain status
- Increase in families accessing the dentist in 30% most deprived MSOAs
- Plain drinking water in public sector venues is main drink available
- Provide a choice of sugar free foods – including vending machines
- Oral health part of early years strategy and included within current practice in order to identify need early
- Training on oral health promotion given to front line practitioners
- Targeted oral health promotion work for vulnerable groups:
- Align dental practices to children centre cluster areas in targeted communities
- Deliver and evaluate a three year tooth brushing scheme in targeted nurseries, working with local dental network

Primary School Settings

- Increase number of schools following national school food plan: ensure plain drinking water available and sugar free snacks
- Encourage schools to include oral health as part of the curriculum
- School nurses to promote dental access at parent sessions
- School nurses to assist with dental practices regularly visiting schools to facilitate the uptake of dental care in targeted communities
- Oral health promotion team to work with special schools through the academic year
- Training sessions delivered to special school support staff on oral hygiene
- Deliver and evaluate a three year targeted tooth brushing scheme working with the local dental network to deliver intervention

Workplace and Community Settings

- Make plain drinking water available in community venues
- Provide a choice of sugar free food, drinks and snacks, including from vending machines
- Encourage and support breastfeeding with work places and communities
- Healthy living pharmacy – SMILE campaign delivered annually
- Oral health in Health at Work campaigns

Vulnerable Group (children and adults at high risk of poor oral health)

- Oral health promotion team to work specifically with special schools and those educated outside of mainstream
- Explore feasibility of minimum set of standards for oral health within care home contracts, and those in receipt of adult social care e.g. oral health assessment on admission to care home, oral health care plan established and regularly reviewed – quality metrics
- Include training and support in residential care homes on importance of oral hygiene and dual training on dementia care as part of contract
- Implementation of labelling dentures to reduce loss and cost of replacement
- Align dental practices to each residential care home to ensure a general dentist is available for advice/guidance

Workforce

- Health Education North East – oral health promotion training course. Evidence based advice and guidance to early years and care homes

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Health and Wellbeing Board

31 January 2017

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

Report of Gill O'Neill, Interim Director of Public Health, Adult and Health Services, County Durham and Margaret Whellans, Interim Corporate Director of Children and Young People's Services

Purpose of Report

1 This report provides an update to the Health and Wellbeing Board on progress on implementing the County Durham Children and Young People's (CYP) Mental Health, Emotional Wellbeing and Resilience Transformation Plan. A revised plan on a page is set out at Appendix 2.

Background

2 The multi-agency County Durham Transformation Plan for Children and Young People's Mental Health, Emotional Wellbeing and Resilience (2015-2020) was approved by the Health and Wellbeing Board in November 2015.

3 The plan reflected the vision and principles of the national "Future in Mind" strategy and guidance, and also met requirements for Clinical Commissioning Groups (CCGs) and Local Authorities to develop transformation plans. The core aims are to:

- Facilitate greater access and standards for mental health services;
- Promote positive mental health and wellbeing for children and young people;
- Have greater system co-ordination and a significant improvement in meeting the mental health needs of children and young people from vulnerable backgrounds.

4 Additional NHS funding to support the implementation of the plan was made available from NHS England through the CCGs. Establishing clear accountability and governance arrangements was a fundamental requirement for local planning systems.

5 The oversight of co-ordination and delivery of the plan is under the Children and Young People's Mental Health and Emotional Wellbeing Group, which is accountable to the County Durham Mental Health Partnership Board. This group meets bi-monthly and oversees progress which is delivered by a number

of collaborative workstreams, as set out in the Terms of Reference previously considered by the Health and Wellbeing Board. For the future, governance and links into the children and young people's health agenda, will be also considered within the remit of the Healthy Child Programme Board, the establishment of which is in progress.

6 The overall plan was reviewed and refreshed at a well-attended workshop for key stakeholders on 15 November 2016. This process provided a reflection on progress in the first year of the plan, and identified continuing gaps and challenges, along with priorities for focus in 2017/18. This information is covered later in the report.

7 The progress on implementing the transformation plan is also reported into NHS England's assurance process, which required the CCGs to publish an updated plan by the end of October 2016. This publication responded to specific lines of enquiry and set out action on defined elements relating to the development of specialist care and recovery services which are led by the North Durham CCG (on behalf of both North Durham and Durham Dales, Easington and Sedgefield CCGs). Within this there is a particular focus on specific nationally driven elements which aim to improve the way that children and young people's mental health services are organised, commissioned and provided. These include, for example, improving access and waiting time standards and strengthening crisis care. The CCGs provide regular monitoring reports to NHS England. A copy of the plan submitted by the CCGs is available online (Link).

8 A further context for the development of the CYP Mental Health, Emotional Wellbeing and Resilience Plan is the move under the Mental Health Partnership Board towards a single "whole system" mental health strategy for County Durham. This will encompass the whole life span and include actions across the promotion, prevention, intervention, treatment, and recovery spectrum. To fit the format of this emerging plan, the CYP Mental Health, Emotional Wellbeing and Resilience Plan has been presented as a Plan on a Page for 2017/18 (Appendix 2).

Overview of progress in year one

9 Within the first twelve months the CYP Mental Health and Emotional Wellbeing Group has focussed on delivering a number of priorities, including those which were specifically determined through consultation with local children, young people and their families, schools and local agencies. Within this period, it was noted that children and young people's mental health has continued to receive much public attention and has been reiterated nationally as a priority in the NHS Five Year Forward View for Mental Health – which highlights priority and re-emphasises need for partnership, commissioning plans, and workforce and defined requirements for crisis access, reduce waiting times and reduce inpatient admissions. The back drop of ongoing austerity, poverty and health inequalities was recognised as providing a potentially challenging context, with pressures on statutory and voluntary sector services and a negative impact on the mental health and wellbeing of children, young people and families.

10 In spite of the challenging context, some solid progress was made in the first year of delivering the plan. Work has been organised under specific workstreams. Progress on some of the key initiatives has now been made, along with future plans as highlighted in the following sections.

Prevention and early intervention workstream –progress in year one, and next steps:

11 The prevention and early intervention subgroup noted a number of areas of progress in year one. Within the under 5 age group, this includes work to strengthen the Solihul approach (parenting skills) and strengthen the antenatal pathway to identify vulnerable children and families and areas of concern in infant attachment with the initiation of early response. The 0-5 Healthy Child Programme (HCP) also provides a context for identification of areas of concern and development of integrated assessment and closer working across health visitors and early years staff at the integrated 2 – 2.5 year check.

12 A significant number of developments focused on promoting resilience and emotional wellbeing in schools. Work is well advanced, led by Public Health and Durham County Council Education, to roll out a resilience programme for 75 schools in County Durham based on 25 per year target. To complement this, the Youth Aware Mental Health (YAM) programme will be rolled out in early adopter schools from January 2017. Fifteen individuals have been trained in early November in order to become YAM instructors. YAM will be evaluated through an innovative co-production collaboration between Teesside University and Durham County Council. The YAM programme is being implemented in County Durham drawing on evidence from the results of a large scale multi-site trial, which demonstrated that the programme shows a clear association with reduced levels of suicide attempts and severe suicidal ideation among young people.

13 As part of the 0-19 Healthy Child Programme specification, five emotional wellbeing and resilience nurses have been appointed to work across County Durham, employed by Tees, Esk and Wear Valley Mental Health Trust and embedded in the 5-19 school nursing service based in Durham County Council premises.

14 Looking ahead to 2017/18, the CYP Mental Health Emotional Wellbeing and Resilience Group will continue to focus on strengthening the work to support schools in delivering the resilience and YAM programmes. It will also work to improve capacity in schools and pathways between services to support young people. This includes identified pathways for vulnerable young people including care leavers, young people known to the youth offending service, young carers, teenage parents and those with special educational needs.

Care and recovery – overview of progress in year one, and next steps

15 The Care and Recovery Group have predominately focused on delivering the priorities as required by NHS England. Regular submissions detailing progress on the local priority schemes are sent to NHS England on a quarterly basis.

Community Eating Disorder Service for Children and Young People

16 Enhancement of the community eating disorder service for children and young people is being supported by new investment. Building capacity in the community eating disorder team will support access to evidence-based treatment at the earliest possible stage of the illness and delivery of the new access and waiting time standards (i.e. by 2020/21, 95% of children and young people in need receive treatment within one week for urgent cases and four weeks for routine cases).

17 Throughout 2016/17 the service will baseline current performance against the new standards and plan for improvement, in advance of measurement against the standard in 2017/18.

Child and Adolescent Mental Health Service (CAMHS) - Crisis Service

18 Following the successful evaluation of the CAMHS Crisis Service pilot, the CCGs have continued to invest in the service, which operates 08:00-22:00, seven days per week. All three CCGs have recently committed to increase funding to deliver a 24/7 crisis service model.

19 The CAMHS Crisis Service is responsive to needs of children and young people with mental health conditions, such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses.

20 The nurse-led service currently offers:

- Comprehensive mental health and risk assessments;
- Time-limited intervention, tailored to meet individual needs;
- Intensive support within the home/appropriate setting, where appropriate, for up 72 hours post assessment or until risks are contained;
- Constructive advice-problem solving and solution-focused resolutions;
- Collaborative working with the young person, their family and/or carers and other relevant professionals and agencies to develop a crisis care plan;
- Liaison and consultation with other professionals and members of the children's workforce;
- Telephone support for parents, carers, service users and other professionals, such as NHS 111, GPs, the police and social services;
- Training to other services and professionals (including GPs, Police; local authority care home staff, teachers), to help to identify children and young people with mental health needs earlier;

- Post suicide support including joint working with schools and police, supervision and support to professionals affected by suicide;
- Assertive engagement with young people and their families;
- A targeted approach, working with 'hard to reach' groups.

21 The CAMHS Crisis Service has received national recognition and has been selected as a national case study by NHS England[1]. From May 2014 to January 2016, the service carried out 686 mental health assessments at the University Hospital North Durham and Darlington Memorial Hospital and an additional 444 assessments outside the hospital premises. Of 341 assessments undertaken in A&E, just 51 children and young people went on to be admitted to a paediatric ward. Furthermore, 770 assessments were undertaken within two hours, with more than half completed within 60 minutes.

CAMHS Intensive Home Treatment / Support

22 A successful bid to pilot a CAMHS Intensive Home Treatment Service was made to the Accelerator Project to Improve Children and Young People's Mental Health Care in a Crisis Funding Allocation.

23 Non-recurrent funding will allow development of a model for intensive home treatment for children and young people with complex needs; extending the period of intensive support beyond the current 72 hours offered by the CAMHS Crisis Service. There are further opportunities to explore an integrated service model with CAMHS Crisis and Liaison, and develop clear pathways with in-patient services to support appropriate admission and timely discharge.

Improve access and waiting times in CAMHS

24 There will be an ongoing focus to improve access and reduce waiting times. Non-recurrent investment in 2016/17 will be used to increase capacity to reduce the wait to treatment, with particular focus on, but not exclusive to, children and young people waiting an assessment for Autism Spectrum Disorder (ASD).

Transitions for people with Learning Disabilities

25 A regional task and finish group has developed the North East and Cumbria Care Transforming Care Model for People with Learning Disability and Autism. The regional model will need to be implemented at local level. Moving forward, an implementation group will be established to oversee local delivery. The group will ensure that implementation cross references with the Local Transformation Plan for improving children and young people's mental health and emotional wellbeing and the Special Education Needs and Disability (SEND) agenda.

[1] https://www.england.nhs.uk/mentalhealth/case-studies/durham-camhs/

Children and Young People's Improving Access to Psychological Therapies (CYP IAPT)

26 County Durham has been involved in the national Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) service transformation programme since 2012. CYP IAPT is a whole service transformation model that seeks to improve the quality of children and young people's mental health services. The programme supports the use of evidence-based treatments with services rigorously focused on outcomes with improved supervision, and also supports the development of leadership and team management skills.

27 The County Durham IAPT Partnership has completed quarterly updates and an annual self-assessment, which demonstrates compliance with the requirements of NHS England's values and standards criteria 'Delivering *With*, Delivering *Well*'.[2]

28 To date, a number of NHS staff have completed training in Cognitive Behavioural Therapy, Parenting, Systemic Family Practice, Enhanced Evidence Based Practice and Service Leadership. Funding has allowed backfill for staff to access training and supervision.

29 Looking ahead, there are opportunities for all organisations within a local area who provide mental health services for children and young people to be involved, including local authority, health visitors, staff in children's centres, education and voluntary and independent sector organisations.

Social Emotional and Wellbeing Pathway

30 An initial scoping exercise has been undertaken to start to explore the capacity in the social emotional and wellbeing pathway with the aim of understanding where there are pressure points in the system. This work will be taken forward with partners in 2016/17 and beyond. Opportunities to strengthen links with education, voluntary and community services will be explored. CAMHS new single point of access will also need to be taken into consideration.

Parent Support Network

31 A parent support network is being funded which aims to build a peer support network for parents and carers with children that are experiencing mental health problems. The network will be based on a range of mechanisms including personal peer networks, social media and the development of an e-network and website. The project will seek to expand existing networks where possible and link in with national campaigns, working closely with Youngminds, Time to Change and other national programmes as well as promoting the use of MindEd resources for parents.

[2] https://www.england.nhs.uk/wp-content/uploads/2014/12/delvr-with-delvrng-well.pdf

32 An element of the work will be to reduce stigma and discrimination around mental health, thereby encouraging access to support when needed. The project will ensure that parent, children, and young people's support is linked to interventions that promote mental wellbeing such as social prescribing, physical activity, and the arts.

33 £20,000 has been allocated for one year initially by the CCG to commission this service. Continuation funding is being considered in the CCG's current commissioning planning and prioritisation process.

Bereavement Support

34 A new bereavement support service for children and young people is being commissioned. The overall aim of this service is to improve access to culturally appropriate bereavement and postvention (after suicide) support for children and young people. Activities delivered will help children and young people build resilience to be able to better cope with bereavement. The programme will offer a number of activities aimed at building capacity and awareness within schools, young peoples' services and community settings, as well as provide a specialist bereavement and postvention counselling service which is recognised as the main place to turn in County Durham for children and young people when bereaved. It will offer individual support as well as group work.

35 The service will be provided by appropriately qualified counsellors, trained staff and volunteers. It will also support schools and education providers to manage the impact of death including suicide on young people.

36 £49,000 has been allocated for one year initially by the CCG to commission this service. Continuation funding is being considered in the CCG's current commissioning planning and prioritisation process.

Perinatal Mental Health

37 A multi-agency steering group will be established to refine the business case for a community specialist perinatal mental health service to deliver care to more women in the period immediately before and after birth. An application will be made for Wave 2 perinatal mental health community services development funding in 2017/18.

Early Intervention Psychosis

38 As part of the work towards implementing the access and waiting time standards for first episode psychosis, the young person's pathway will be explored.

Self-harm and suicide prevention

39 Suicide prevention cannot be undertaken in isolation by the local authority but requires working in partnership with the police, CCGs, NHS England, coroners and the voluntary sectors to be effective.

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

41 Within County Durham an audit of suspected deaths by suicide is completed on a three year pool of data annually. Through this systematic collection and analysis of local data valuable information on emerging themes can be identified and are used to inform Suicide Prevention Plans. Under this protocol each death which may potentially be attributed to suicide is reviewed by a multiagency group and recommendations made.

42 An integral part of the Suicide Prevention Programme is the early alert system. This allows partners (e.g. police) to alert the system to a potential death by suicide as soon as it is reported. As well as providing information to the system this importantly allows early support to be offered to next of kin.

43 The Suicide Prevention Protocol is currently under review and will develop into a discrete plan as per national guidance. Additionally, a visit is planned to The Wirral to learn from an area where the trend in the rate of deaths by suicide has been downwards.

44 The Self Harm and Suicide Prevention Workstream and Subgroup has operated as a subgroup of the Local Safeguarding Children Board (LSBC), led by Dr Stephen Cronin.

45 A Self Harm Pathway was agreed by LSCB in October 2016, and published on the LSCB website. A number of Education packages have been agreed, based on nationally available resources, and are being delivered across a number of settings including Universal Services and GP's.

46 A review of coding in primary and secondary care is planned in order to improve the monitoring of self-harming incidents.

47 Further work is needed in relation to developing better systems of monitoring and response in schools and promoting best practice in schools linked to resilience and mental health awareness programmes. These actions are being added to the 2017/18 work plan.

Additional areas of focus going forward: Communication and engagement

48 Fundamental to implementation of the Local Transformation Plan is effective ongoing communication and engagement with children, young people, their families and wider stakeholders.

49 A number of areas are identified to support the delivery of the plan:

- A joint communication plan needs to be developed about: services/pathways, key messages about mental health, linking into the Time to Change Campaign;
- A more joined up approach will be developed to ensure effective engagement and feedback mechanisms with children, young people and their parents and carers;
- An easy read version of the plan will be developed to accompany the updated plan on a page version.

Workforce planning

50 Implementing the Five Year Forward View for Mental Health (2016) recognises that an expansion of the workforce is needed to deliver the increase in access to mental health.

51 A joint agency workforce was required to be in place by December 2016. These plans will maximise opportunities to build capacity and effective pathway and links across CAMHS and services able to provide early help and early intervention, and will include continued professional development of existing staff over the next five years.

52 Professional development to further the implementation of the Children and Young People Improving Access to Psychological Therapies programme (as referenced in paragraphs 26-29) will be included in the workforce development plan.

Governance

53 The current governance structure is represented at page 35 in the published plan (link to this is in paragraph 7). The Terms of Reference are being reviewed in early January 2017 to ensure that the membership, remit and reporting arrangements are updated. The establishment of the new Healthy Child Programme Board provides an opportunity to establish links and consider joint reporting arrangements with the Mental Health Partnership Board. The chair of the group will remain with the lead consultant in public health and a vice chair remit for the Commissioning Manager from the CCG to be established. This arrangement will reflect the joint accountability for the delivery of the plan. Going forward, the relationship with the new Healthy Child Programme will be explored.

54 It should be noted that as part of the development of a single “whole system” mental health strategy for County Durham, consideration will also be given to the wider governance arrangements for mental health to ensure they remain fit for purpose and reduce any areas of duplication.

55 This report of progress of year one delivery is being brought for consideration to the Health and Wellbeing Board in the light of the continuing national priority

given to improving outcomes for children and young people's mental health and the NHS England assurance requirements.

Recommendations

56 The Health and Wellbeing Board is recommended to:

- Note the information provided in the report about new services currently being progressed
- Agree the refreshed County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan and priorities for action in 2017/18.

Contact: Carole Wood, Locum Consultant in Public Health
Tel: 03000 267 680
Kate Harrington, Commissioning and Development Manager
Email: kate.harrington@nhs.net

Appendix 1: Implications

Finance – The County Durham Children and Young People's Mental Health, Emotional Wellbeing and Resilience Transformation Plan is funded through a range of funding streams from the County Council and Clinical Commissioning Groups, and some derived from national NHS allocations for mental health services. Additional funding release is required from NHS England to CCG's for the full implementation of the Transformation Plan.

Staffing – No implications

Risk – Risk areas are being monitored by the Children and Young People's Mental Health and Emotional Wellbeing Group.

Equality and Diversity / Public Sector Equality Duty – Obligations for equality and diversity are addressed in the plan**.**

Accommodation - No implications

Crime and Disorder - No implications

Human Rights - No implications

Consultation - No implications-this is under consideration by the group, along with a communications plan

Procurement - No implications

Disability Issues - Target populations include those described as having a disability including learning disability

Legal Implications - No implications

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APPENDIX 2

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

Issues

- Young People want to find help more easily, more choice, peer support and better access
- Tackling stigma and discrimination
- Increasing demand
- Parity of esteem between mental and physical health
- Multiple commissioning organisations
- Financial challenges
- Workforce

Vision

We want Children, Young People and their Families in County Durham to be supported to achieve their optimum mental health and wellbeing. Every child and young person will have access to early help in supporting their emotional and mental health needs. We want to develop children and young people's resilience and coping strategies. We will transform the quality and availability of our services from early help through to specialist provision. Local services will be locally delivered within communities, closer to home, targeted to the most vulnerable ensuring fewer children and young people require specialist mental health services.

National Policy Context

The *Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing*which emphasised the crucial importance of early intervention in emerging emotional and mental health problems for children and young people.

The Five Year Forward View for Mental Health: Sets of the case for transforming mental health care in England; and includes improving the mental health of children, young people and young people.

Local Policy Context

The County Durham Joint Health and Wellbeing Strategy
This sets out the way in which every child can have the best start in life and includes a significant focus on improving emotional health and resilience.

The County Durham Children, Young People and Families Plan 2016–2019
This outlines a three year vision for improving services for children and young people and includes children and young people's mental health services.

Objectives

Promoting resilience, prevention and early intervention

Improve public awareness and understanding about mental health issues for children and young people and to reduce stigma and discrimination.

Promote good mental health, build resilience and identify and address emerging mental health problems in children and young people, as soon as possible.

Improve access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.

Improving access to effective support

Children, young people and their parents/carers will have timely access to high quality, evidence-based support and treatment when in need.

Improve care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible.

Caring for the most vulnerable

Improve the experience and outcomes for the most vulnerable and disadvantaged children, ensuring they are adequately supported at key transition points

Reduce the rate of self-harm and provide a better response to young people who are self harming.

Accountability and transparency

Improve transparency and accountability across the whole system, to drive further improvements in outcomes.

Workforce development

Continued development of the local workforce to ensure staff have the right knowledge, skills and competencies to respond to the needs of children, young people and their families.

Engagement and communication

Ensure children, young people, parents and carers to have a voice via meaningful engagement throughout the redesign process.

Ensure effective two-way communication with stakeholders.

Key Areas of Focus 2017/18

Promoting resilience, prevention and early intervention

- Support 'Time to change' anti-stigma campaign
- Promote Solihul antenatal infant attachment programmes and parenting support and promote nurturing information within 0-19 service growing healthy programmes
- Implement the vulnerable parent pathway alongside the Healthy Child Programme
- Increase capacity within all aspects of the social, emotional and wellbeing pathway in community, early years and school settings; exploring education, and voluntary and community sector contribution
- Deliver the Resilience in Schools Programme, along with Youth Aware Mental Health (YAM) pilot
- Improve the capacity for prevention and early intervention in schools / education settings by embedding the emotional health and resilience nurses into the 0-19 growing healthy service.
- Subject to a successful funding application, develop a community specialist perinatal mental health service to deliver care to more women in the period immediately before and after birth
- Develop support to meet the needs of young carers in line with the County Durham Young Carers charter
- Ensure pathways are in place to support other vulnerable young people including young people who offend / young parents / educated outside of mainstream education / LAC / care leavers
- Implementation of a Bereavement Support Service for children and young people
- Provide a 'universal offer' to schools of quality assured and reviewed programmes.
- Ensure education staff have appropriate professional development opportunities and access to approved on line support tools e.g. Mind-Ed

Improving access to effective support

- Embedding of the Single Point of Access (SPA) for specialist mental health services
- Implementation of the dedicated Community Eating Disorder Service for Children and Young People, in line with the access and waiting time standards, service model and guidance
- Implementation of a responsive 24/7 crisis (urgent and emergency) mental health service for children and young people; this service links with the liaison service that provides immediate access to mental health support for people with physical health problems, in general hospitals
- Pilot and evaluation of an Intensive Home Treatment/Support for children and young people with complex mental health needs
- Deliver initiative to improve access, including assessment for Autism Spectrum Disorder (ASD)
- Development of the Early Intervention Psychosis pathway, with specific regard to young people
- Ongoing development of the Parent Peer Support Network

Caring for the most vulnerable

- Optimise model of specialist care and support for vulnerable young people particularly those in transition between services and those with complex behavioural and mental health needs
- Implementation of the Care and Treatment Reviews for children and young people with Learning Disabilities
- Through the Local Safeguarding Children's Board, deliver training in schools and Primary Care to recognise and respond to self harm; ongoing development of pathways of care between schools and GPs
- Develop collaborative commissioning plans with NHS England - Specialist Commissioning.

Accountability and transparency

- Multi-agency steering group to continue to oversee delivery of the Local Transformation Plan
- Ongoing work to data quality and transparency, including accurate data reporting for all routine collections
- Develop a framework to measure change /monitor outcomes
- Annual refresh of the Plan to include a statement on investment

Workforce development

- Participation in the Children and Young People Improving Access to Psychological Therapies (CYP IAPT) workforce capability programme, with staff released for training courses
- Development of a joint agency workforce plan

Areas to consider for 2018/19 and beyond

- Continue to strengthen links with education
- Others to be confirmed, following current planning round

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Health and Wellbeing Board

31 January 2017

Cardiovascular Disease Framework and Prevention Programmes

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

Purpose of Report

1 The purpose of this report is to update the Health and Wellbeing Board on the progress made on the Cardio-Vascular Disease (CVD) Framework and associated programmes. The Strategic Framework for the Prevention of Cardiovascular Disease identifies a number of risk factors for heart disease and other related conditions that may, through lifestyle and other forms of intervention, be reduced.

2 There are a number of programmes that Public Health leads or contributes to which are designed to influence these risks. These programmes include:

- NHS Health Checks;
- Smoking cessation programmes;
- National diabetes prevention programme;
- Change4Life.

Summary

3 The CVD Framework – The Strategic Framework for the Prevention of CVD 2014/19 sets out the direction of evidence based CVD prevention initiatives in County Durham. It identifies modifiable risk factors for: CVD risk; diabetes; chronic kidney disease; chronic obstructive pulmonary disease (COPD); and some cancers. These risk factors are: over weight / obesity; high cholesterol; smoking; high blood pressure; failure to meet exercise guidelines; hazardous and harmful drinking; Type 2 diabetes.

4 NHS Health Checks – Health Checks are part of a national risk assessment and management programme for those aged 40 to 74, who do not have an existing CVD and are not being treated for its risk factors. It therefore addresses the points raised within the CVD Prevention Framework. Work is ongoing to ensure equitable access and efficient delivery across the county. The more targeted approach will focus on those at a greater risk of CVD, this will tend to be an older age group and people with risk behaviours such as smoking and obesity.

5 As of September 2014 the local delivery of Health Checks became more targeted towards those at greatest risk of CVD. This has allowed an efficient service delivery and will be reflected in future delivery models (e.g., targeting those with high estimated CVD or Diabetes risk scores).

6 The programme has recently been reviewed and GP federation and community outreach models designed. These will follow national standards and National Institute for Health and Care Excellence (NICE) guidelines to provide a high quality service, with the GP based programme offering broad access on a federation footprint and the community programme supporting those who do not engage with primary care.

7 We are currently seeking additional funding from the British Heart Foundation to compliment the community health check programme with additional capacity to provide an extra 2000 blood pressure measurements per year above those conducted as part of an NHS Health Check.

Diabetes Prevention

8 The local roll out of the national NHS Diabetes Prevention Programme (a joint initiative led by NHS England, Public Health England and Diabetes UK, together the National Programme Team) has been underway since April 2016. This is led by North Durham and Durham, Darlington, Easington and Sedgefield Clinical Commissioning Groups (CCGs) with advice from the Public Health team and replaces the Just Beat It programme. The programme aims to identify people at high risk of developing Type 2 diabetes and offer them a behavioural intervention designed to lower their risk.

9 Diabetes prevention is also crucial not just for the health economy but in the protection of the health of the population. For this reason Durham County Council continues to provide advice to the local CCGs and national providers regarding the roll out of the first wave of the national prevention programme locally.

Smoking Alliance and Data

10 County Durham delivers tobacco control within an evidence based framework via the County Durham tobacco control alliance. Durham County Council is also the lead commissioner of the regional tobacco programme ‘Fresh’. County Durham has experienced a steady drop in smoking prevalence over the last three years, resulting in a 3.2% drop since 2012. However 18.1% of women in County Durham continue to smoke in pregnancy. Whilst data shows a reduction for County Durham since 2009/10, this is not equal across the two CCG areas and further work is needed to address this unwanted variation.

Obesity

11 In County Durham it has been estimated that 72.5% of adults, 24% of children aged four to five years, and 36% of children aged 10 to 11 years have excess

weight. If the significant upward trend is not reversed there will shortly be an untenable cost in terms of population health and economic costs to the NHS and wider economy. If we fail to halt the rise in obesity then 60% of adult men, 50% of adult women, and 25% of children in England will be obese by 2050. A life course approach must be taken to reducing the prevalence of excess weight. As such it is a cross cutting theme in several strategies and plans:

- County Durham Plan;
- County Durham Children Young People and Families Plan;
- County Durham Joint Health and Wellbeing Strategy;
- County Durham Healthy Weight Framework;
- County Durham Physical Activity Framework.

12 These multiagency plans, strategies, and programmes which each address different aspects of CVD must be supported and co-ordinated to efficiently reduce the overall risk. The detailed report can be found at Appendix 2.

Recommendations

13 The Health and Wellbeing Board is requested to:

- Note the multifaceted approach to reducing the risks of CVD and associated conditions as identified in the CVD prevention framework;
- Note the experience of delivering the Health Check programme in County Durham;
- Endorse the changes to the health check programme that will be included in the revised services specifications from April 2017.
- Note the work being undertaken by the CCGs to increase uptake of the diabetes prevention programme;
- Support partners to deliver evidence based tobacco control interventions.
- Note that a bid of £99,200 over two years has been submitted to the British Heart Foundation to complement the community health check programme.

Contact: Dr Mike Lavender, Consultant in Public Health Medicine
Tel: 03000 267681

Appendix 1: Implications

Finance
Smoking cessation and health check programmes are paid for via the Public Health grant. Note bid submission to BHF for £99,200.

Staffing
Not applicable.

Risk
Not applicable.

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

Accommodation
Not applicable.

Crime and Disorder
Not applicable.

Human Rights
Not applicable.

Consultation
Not applicable.

Procurement
The NHS Health Check programme has been recently reviewed in order to support the current redesign and procurement of new services.

Disability Issues
Reasonable adjustments should be made to allow equity of access to services.

Legal Implications
- Provision of NHS Health Checks is a mandated function.
- A memorandum of understanding has been signed between NDPP partners.

Update of CVD Framework: Health Checks, Diabetes prevention programme, tobacco and obesity

Purpose of the Report

1. The purpose of this report is to summarise activity in the context of The Strategic Framework for the Prevention of Cardiovascular Disease (CVD) 2014 – 19. These early findings will feed into commissioning reviews and inform the revision of specifications and assessment of proposals. This is of particular interest for the review of NHS Health Checks.

Background

2. The Strategic Framework for the Prevention of Cardiovascular Disease (CVD) 2014 – 19 was written to set out the direction of CVD prevention initiatives in County Durham. The framework was consistent with NICE guidance and sought to address modifiable risk factors, through evidence-based interventions at the population, community and individual levels.

3. Although the framework is focused on the prevention of CVD, the overall approach also helps to prevent other non-communicable diseases. Therefore this paper presents ongoing work which addresses: CVD risk; diabetes; chronic kidney disease; chronic obstructive pulmonary disease (COPD); and some cancers.

4. The CVD framework identified and estimated the prevalence of modifiable risk factors for CVD in County Durham, they were: over weight / obesity; high cholesterol; smoking; high blood pressure; failure to meet exercise guidelines; hazardous and harmful drinking; types 2 diabetes. Detailed below are several programmes which address these risks.

Check4Life Health Check programme – interim evaluation report

5. Health Checks are part of a national risk assessment and management programme for those aged 40 to 74, who do not have an existing cardiovascular disease (CVD), and who are not currently being treated for CVD risk factors. It is a rolling programme offering everyone in the target group a Health Check every 5 years. The aim of the programme is to identify anyone in the eligible population who has a high risk of developing CVD.

6. That risk is communicated to the patient and lifestyle advice offered. Other clinical interventions to reduce risk may also be used. By addressing the main risk factors for CVD, this will contribute to the prevention of heart disease, stroke, diabetes, and kidney disease, in line with the CVD prevention framework.

7. In September 2014 the Health and Wellbeing Board endorsement of the Strategic Framework for the prevention of CVD saw the beginning of the a plan to replace the standard NHS Health Check programme in GP practices with a locally developed Check4Life programme. The main changes introduced in the Check4Life programme in GP practices include:

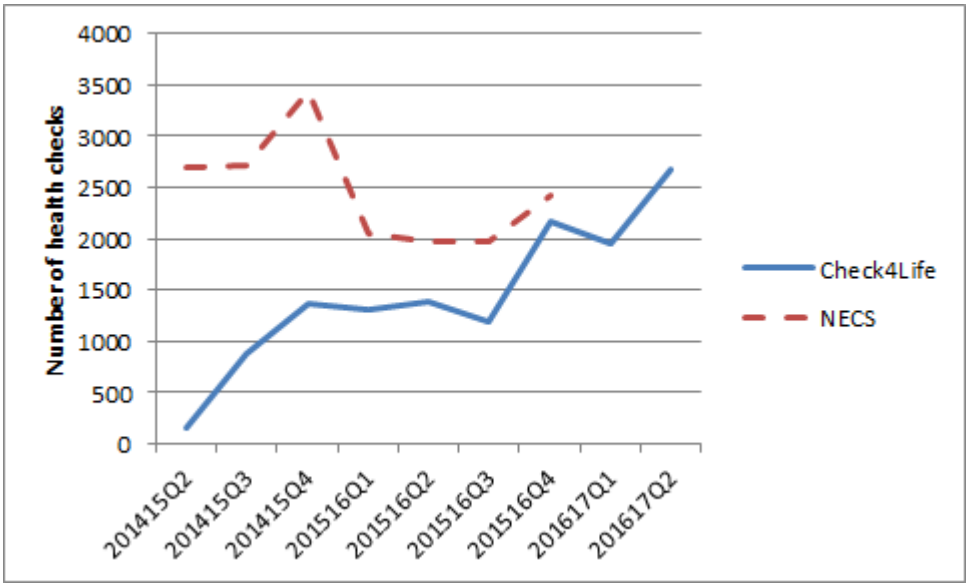
    - Targeting the invitations from GP practices for a Health Check toward those patients with an estimated high risk of CVD
    - Improving the quality of all Health Checks through the Check4Life Quality Assurance programme
    - Health Checks carried out at a single appointment by carrying out blood cholesterol checks using portable equipment in the practice
    - Providing practices with a software package that collects all the information from the Health Check and provides a structured risk communication programme
    - Introducing new risk assessment tools such as the AUDIT-C to assess alcohol intake, the Diabetes UK Risk Score and the QRisk Heart Age calculator.

8. In November 2015 the Health and Wellbeing Board received a report on a review the first five years of the NHS Health Check programme in County Durham. The conclusions in that report highlighted:

    - The wide variation in coverage between practices, practice groups and CCGs.
    - The inconsistency in the data recorded at a Health Check in the GP records.
    - The difficulty in obtaining reliable data on the outcomes following a Health Check.

9. Figure 1 shows the number of Health Checks carried out in GP practices by quarter. The dotted line is quarterly data provided by NECS on all Health Checks carried out combining standard NHS Health Checks and Check4Life health checks. The solid line is the number of Check4Life health checks only provided by Health Diagnostics. It should be noted that the data from NECS is from all 72 practices, and the Check4Life data is from an increasing number of GP practices between July 2014 and March 2016 and a total of 62 practices from then until September 2016. This shows the steady take up of the new Check4Life programme by GP practices.

Figure 1: The number of Health Checks carried out by GP practices by quarter



10. The current GP contracts for health checks ends in March 2017. The service has been reviewed and a new contract with a revised service specification will be commissioned from April 2017 onward. The Check4Life programme has provided Public Health with an almost complete data set on every health check carried out in GP practices. Health Diagnostics provided an anonymised record of each Check4Life health check carried out in GP practices between July 2014 and September 2016, a total of 13,381 records. This report summarises the key findings from the Check4Life data set to inform the recommissioning process.

Findings

CVD risk assessment

11. The primary purpose of the NHS Health Check programme is to identify people with a CVD risk of 20% or more (the risk of a CVD event such as a heart attack or stroke over the next 10 year). In the Check4Life programme this measured by using the recommended QRisk2 calculator. There were 13,080 valid records of a health check carried out among people in the eligible age range of 40 to 74.

12. Table 1 summarises the number and proportion of health checks by age, gender and CVD risk score of 20% or more. It shows that in the eligible population for a health check, 11% of all health checks identified someone with a high risk of CVD, 5% of women and 18% of men. This is strongly age dependent with the proportion of people with a high CVD risk score ranging from 0% among those aged 40 to 44 and 61% among those aged 70 to 74.

13. Table 1 shows that of the 4,715 health checks carried out among people aged 40 to 49, only 27 were found to have a CVD risk of 20% or more. This equates to approximately £4,400 per person with high CVD risk found. In contrast, of the 8,365 health checks carried out among people aged 50 to 74, 1,441 were found to have a CVD risk of 20% or more. This equates to approximately £170 per person with high CVD risk found. This supports the intention to target the health check programme toward people with a higher risk of CVD (via CVD risk score, of which age is a significant factor).

Table 1: Health checks by age, gender and CVD risk score

	All C4L health checks			Number with high CVD risk (QRisk 20% or more)			% high CVD risk		
Age	F	M	All	F	M	All	F	M	All
40-44	1258	1120	2378	0	5	5	0%	0%	0%
45-49	1182	1155	2337	0	22	22	0%	2%	1%
50-54	1153	1110	2263	2	62	64	0%	6%	3%
55-59	1003	914	1917	4	99	103	0%	11%	5%
60-64	904	754	1658	34	187	221	4%	25%	13%
65-69	891	712	1603	104	383	487	12%	54%	30%
70-74	474	450	924	175	391	566	37%	87%	61%
All	6865	6215	13080	319	1149	1468	5%	18%	11%

14. In a Check4Life Health Check CVD risk is also given as ‘heart age’. This estimates the age of someone’s heart relative to someone of the same age and gender. Table 2 shows the number and proportion that have a high heart age (five years or more than their actual age). This is less dependent on age and gender and highlights the high proportion of younger adults with modifiable lifestyle factors (such as smoking and obesity) that will eventually lead to an increased risk of CVD as they grow older.

Table 2: Health checks by age, gender and ‘heart age’

	All C4L health checks			Number with a high heart age (QAge difference of 5y or more)			% high heart age		
Age	F	M	All	F	M	All	F	M	All
40-44	1258	1120	2378	288	311	599	23%	28%	25%
45-49	1182	1155	2337	238	289	527	20%	25%	23%
50-54	1153	1110	2263	246	254	500	21%	23%	22%
55-59	1003	914	1917	151	189	340	15%	21%	18%
60-64	904	754	1658	134	127	261	15%	17%	16%
65-69	891	712	1603	95	102	197	11%	14%	12%
70-74	474	450	924	49	57	106	10%	13%	11%
Total	6865	6215	13080	1201	1329	2530	17%	21%	19%

15. Table 3, appendix 3, (summarising the number of health checks with valid measurements recorded) shows that of the 1468 people identified with a high risk of CVD of 20% or more, only 48% were referred to the GP for further assessment. Similarly, of the 647 people identified as having a very high risk of type 2 diabetes, only 39% were referred to the GP for further assessment. There were similar referral rates for people identified with high blood pressure and high total cholesterol levels. Of particular concern is the low referral rate (16%) to stop smoking services and alcohol brief interventions (2%).

Conclusions

16. The Check4Life programme is quality assured with an enhanced specification for health checks. This has been successfully implemented in most but not all practices in County Durham. As the GP practice staff have been trained and equipped to carry out health checks to this specification, coverage has steadily increased.

17. The Check4Life programme has provided the first comprehensive data set to assess the impact of the programme. The key findings are:

- carrying out health checks among younger adults (under 50) cannot be justified on economic grounds,
- introducing new assessment tools such as the Diabetes UK risk score and QAge heart age tool is possible with appropriate training and supervision,
- more work is needed on the care pathway to ensure that people identified with modifiable risk factors are fully assessed and appropriately referred.

Next steps

18. We are currently undertaking a commissioning process, supported by the Health Checks project board, to provide an efficient programme in place from April 2017. This will be formed of two arms, a GP centred contract and a community based one. While these build on the experience gained and standards set in previous contracts there are a number of key differences.

- The GP centred contract is based on working with GP federations. This will allow us to have a single contract with a lead federation rather than individual contracts with each GP across the county. While we will expect each health check to be done to national standards we will also now require that the provider supply information regarding checks directly to the local authority, rather than Health Option software currently supplied by Health Diagnostics. This will allow efficiencies to be made.
- Working with GP federations should provide equitable access to health checks across the county, as patients will be able to access health checks from their own or other participating practices within the federations.

- The community outreach portion of the programme will address the need of those people who do not engage with primary care to receive a health check, again to ensure equity of access.

19. We are currently seeking additional funding of £99,200 over two years from the British Heart Foundation to complement the community health check programme with additional capacity to provide 2000 blood pressure measurements per year above those conducted as part of an NHS Health Check. This will allow a greater number of at risk individuals to be identified and signposted to primary care.

Diabetes prevention - NHS Diabetes Prevention Programme Background

20. The NHS Diabetes Prevention Programme (DPP) was announced in the NHS Five Year Forward View, published in October 2014, which set out the ambition to become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new NHS Health Check.

21. In 2014/15 there were 31,056 patients aged 17 years and over with diabetes mellitus (Types 1 and 2), as recorded on practice disease registers. As approximately 90% of diagnosed cases are type 2 this would give approximately 27,950 patients aged 17 years and over with type 2 diabetes mellitus recorded on disease registers.

22. The NHS DPP is a joint initiative led by NHS England, Public Health England ("PHE") and Diabetes UK, together the National Programme Team. The programme aims to deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk. Building on its experience as a demonstrator site Durham County was selected as a first wave site for implementation of the NHS DPP national programme. This lead to several changes in diabetes prevention within the county, whereas previously Durham County Council (DCC) commissioned the intervention "Just Beat It" the implementation of the local NHS DPP is a partnership lead by DDES and ND CCGs with advice given by DCC's Public Health team as necessary. As the national programme was due to provide an intervention to prevent those at risk of diabetes from developing the condition from April 2016 the Just Beat It contract was not renewed at that time. Those referred to the national programme should receive personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

23. The partnership, consisting of Lead and Partner Organisations committed to deliver referrals in line with table 4, with the understanding that any changes to this profile would be dealt with through an agreed variation process. Table 4 also shows the actual referrals made to date. They reflect a slower than anticipated roll out of the new programme locally.

Table 4:Expected and actual NHS DPP referral levels												
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Expected 2016/17	0	15	15	25	25	25	40	40	40	50	50	50
Achieved 2016/17	0	0	0	6	20	21	3	71				

24. There are now weekly meetings between CCG leads and the national provider (Living Well Taking Control), supported by Public Health. Furthermore a recruitment plan to increase referrals has recently been agreed within these meetings, with Public Health providing intelligence regarding eligible population. This sees a mix of location based delivery centres as well as GP lead interventions. Currently central delivery venues have been agreed in Derwentside and Chester le Street GP federations with a number of practices signed up to refer into the programme. In Durham Dales and Sedgefield federations a GP practice delivery model has been agreed with the national provider. The provider is also in the process of establishing central venues within Durham, Sedgefield and East Durham GP federations. Furthermore the national provider is identifying which GP practices have maintained a register of at risk of developing diabetes. This latter piece of work is expected to be completed imminently.

Tobacco Control

25. Smoking is the primary cause of preventable illness and premature death and is the single biggest cause of inequality in death rates between rich and poor in the UK.

26. Each year in County Durham smoking is estimated to cost society approximately £155.0m, that's £1,801 per smoker per year. Tobacco is a key contributor to poverty and with roughly 61,279 households in County Durham with at least one smoker. This means 33% of these households fall below the poverty line. If these smokers were to quit, nearly 6,688 households would be lifted out of poverty.

27. County Durham delivers tobacco control within an evidence based framework via the County Durham tobacco control alliance with local partners. Durham County Council is also the lead commissioner (on behalf of all 12 North East councils) of the regional tobacco programme 'Fresh'.

28. County Durham along with Fresh and the North East councils deliver a tobacco control package of eight key strands (building infrastructure, skills and capacity and influencing decision making through advocacy; media and communications; motivating and supporting smokers to stop; reducing exposure to tobacco smoke; tobacco regulation; reducing availability and supply e.g. on illicit tobacco; reducing advertising and promotion; research, monitoring and evaluation).

29. County Durham has experienced a steady drop in smoking prevalence over the last three years, resulting in a 3.2% drop since 2012 (table 5).

Table 5: Smoking prevalence in County Durham 2012 - 2015

All Adult smoking prevalence (APS Survey)	2012	2013	2014	2015	Change since 2014	Change since 2012
County Durham	22.2%	22.1%	20.3%	19.0%	-1.3%	-3.2%

Stop Smoking Services

30. A total of 5,333 clients set a quit date with the service in 2015/16. Of which 54% (n=2,903) were quit at 4 weeks. The number of clients setting a quit date are down by 10% in comparison to 2014/15 and quitters are down by 5% in comparison to last year. This drop in access has been experienced over the years at both the national and regional level. The drop in numbers accessing the Durham service has however been smaller this year (10%) in comparison to previous years (2013/14, 16%) and (2014/15, 27%). The percentage of quitters achieved this year has increased to 54% from 52% last year. This trend has continued over a five year period.

31. Public Health England guidance recommends that in a given year services should aim to treat at least 5% of their smoking population (NICE guidance for smoking cessation 2014). In County Durham this year the service treated 6.2% of the smoking population. The target was also to achieve 2,774 quitters. The service has seen 2,903 quitters, this is 129 above target.

32. A key factor of stop smoking services is to ensure they are having an impact in relation to reducing health inequalities and that services are delivered equitable. Compared to the 2007 stop smoking service Health Equity Audit (HEA), the 2014 HEA demonstrates a higher rate of people setting a quit date and quitting smoking in the more deprived Middle Super Output Areas (MSOAs) of County Durham. This indicates that the County Durham Stop Smoking Service is contributing to a reduction in health inequalities.

Smoking in pregnancy

33. Smoking at Time of Delivery (SATOD) hospital data 2015/16 reported 18.1% of woman in County Durham continue to smoke in pregnancy.

34. SATOD data is showing a reduction for County Durham since 2009/10. However this reduction is not equal across the two CCGs (table 6). There is a noticeable 5.6% difference in SATOD data between North Durham CCG and Durham Dales, Easington and Sedgefield (DDES) CCG (table 7).

Table 6: Smoking at time of delivery over time

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Change since 2011/12 (pre-babyClear)
England	14.0%	13.5%	13.2%	12.7%	12.0%	11.4%	10.7%	-2.5%
North East	22.2%	21.1%	20.7%	19.7%	18.8%	18.0%	16.7%	-4.0%
County Durham	22.2%	22.9%	21.3%	19.9%	19.9%	19.0%	18.1%	-3.2%

Table 7: SATOD by CCG

Clinical Commissioning Group	2015/16
North Durham	15.1%
DDES	20.7%
Total average	**18.1%**

Pregnant smokers and access to stop smoking services

35. The number of women setting a quit date with the service has fluctuated over the last five years. However since the implementation of the babyClear pathway, which supported training and resources for maternity staff across all eight North East Foundation Trusts to support activity at the initial booking appointment and 12-week dating scan, as well as clarifying referral pathways into stop smoking support, the number of quitters has increased and the percentage of pregnant smokers quitting with the service has increased.

36. Prior to babyClear, the drop off rate in County Durham between referral and attending first appointment was 84%. In 2014/15 this reduced to 66% and in 2015/16 reduced to 57%. Although the funding has now ceased, the legacy of babyClear has become embedded within both maternity and the stop smoking service.

Excess weight

37. Obesity is a priority area for Government. The Government's "Call to Action" on obesity (published Oct 2011) included national ambitions relating to excess weight in adults, which is recognised as a major determinant of premature mortality and avoidable ill health. The World Health Organisation (WHO) regard childhood obesity as one of the most serious global health challenges for the 21st century.

38. If we fail to halt the rise in obesity then by 2050, obesity, in England is predicted to affect 60% of adult men, 50% of adult women and 25% of children. Recently reported modelling suggests that by 2030 41-48% of men and 35-43% of women could be obese, if the trends continue. NHS costs attributable to overweight and obesity are projected to reach £9.7 billion by 2050, with wider costs to society estimated to reach £49.9 billion per year.

39. In County Durham it has been estimated that 72.5% of adults, 24% of children aged 4 to 5 years and 36% of children aged 10 to 11 years have excess weight. County Durham also has an adult obesity rate higher than the England average.

40. Overweight and obesity needs to be tackled by a life course approach from pre-conception through pregnancy, infancy, early years, childhood, adolescence and teenage years, as weight once gained is difficult to lose and health trajectories can be set at an early age. In childhood, excess weight can directly cause mobility problems, hypertension and abnormalities in glucose metabolism (Department for Children Schools and Families and Department of Health, 2009). In addition there may be emotional issues related to low self-esteem.

41. The 2015 County Durham Director of Public Health Annual Report on obesity was clear that tackling obesity requires a focus on multiple projects and levels, in a wide variety of settings settings and for many groups of people. Expecting behaviour change by solely focusing on the individual is unlikely to be successful. There is strong evidence to support that a whole systems approach is the most effective way to tackle obesity.

42. Reducing unhealthy weight and the poor outcomes associated with it is a cross cutting theme which is reflected and referenced in many strategies and plans for County Durham. For example:

- County Durham Plan
- County Durham Children Young People and Families Plan
- County Durham Joint Health and Wellbeing Strategy
- County Durham Healthy Weight Framework
- County Durham Physical Activity Framework

43. Durham County Council has recently started a programme to develop part time 20mph speed limits in areas of County Durham. The purpose of this scheme is to reduce traffic speeds around schools during drop off and pick up times. This will improve road safety for vulnerable road users as well as making walking, cycling and outdoor play more attractive.

44. The Families Initiative in Supporting Children's Health (FISCH) programme provided by Durham County Council, Leisureworks, and Harrogate and District NHS Foundation Trust is effectively operating in schools across County Durham. This has led to a reduction in both excess weight and obesity prevalence in the participating schools. However work is ongoing to reprioritise this resource to achieve a larger impact for a greater number of obese children whilst also attempting to have a longer term impact upon the wider school environment.

45. County Durham's Wellbeing for Life Service also presents a holistic approach to support people to live well which encompasses not only the person but the wider community, including empowering individuals to improve their health through, for example, healthy eating.

46. Change4Life is a national initiative that brings together a range of stakeholders with the shared aims to improve diets and levels of activity. In County Durham this has expanded to not only include marketing programmes but cooking courses, sports clubs in schools, fun runs and other events. Currently the branding is also shared with the NHS Health Check programme, Check4Life.

47. The most recent Director of Public Health Annual Report presents a number of ways of tackling the obesogenic environment at the local level. Subsequently County Durham has become a national pilot site for obesity reduction. The healthy weight strategic framework (2014-2020) was developed through the multi-agency County Durham healthy weight alliance. This is supported through a variety of work in Count Durham, based on NICE guidance that obesity be tackled as a whole system. These programmes include:

    a. **Leading by example** - Durham County Council has a significant workforce and the overwhelming majority live in County Durham. Any efforts to impact the health of Durham County Council's workforce will have the dual benefit of a healthier workforce and residents. This is also an opportunity to work with wider partner organisations who are also interested in improving their workforces and County Durham residents' health. Efforts are underway across County Hall to make the healthy choice the easy choice. This includes access to healthier food choices and supporting physical activity during the day (e.g. Stepjockey).
    b. The food offer has been reviewed within County Hall and branding removed from vending machines.
    c. Holiday hunger was addressed through a programme funded by Public Health in the east of the county in 2015. This was further developed and funded in 2016 through a number of AAPs and saw several holiday schemes across the county incorporate the ethos of holiday hunger into their activities. This programme will be academically evaluated in 2016/2017.
    d. **Best start in life and schools -** This approach focuses on the early years and the potential impact upon the National Child Measurement Programme (NCMP) levels of overweight and obesity.
    e. Breastfeeding remains a priority in County Durham and its impact on obesity is critical. UNICEF accreditation, breastfeeding cafes, and peer supporters are examples of the ongoing efforts to improve rates across the county.
    f. In partnership with Harrogate and District NHS Foundation Trust we are exploring opportunities to improve the distribution and reach of the Healthy Start voucher scheme. A submission has been made to NHS England for County Durham to be a national pilot to increase uptake of the Healthy Start programme.
    g. A new project is being developed with Newcastle University which will assist in understanding the cultural challenges of weight gain in infancy. This programme will aim to develop new ways to assist early year's

health professionals to successfully address the challenges of healthy weight in the first 1001 critical days.

h. Schools are also able to have a significant impact on the health of children, currently the school food plan is being rolled out across the county with 64% uptake of school meals across primary schools. Additionally education and public health colleagues developed a physical activity grant scheme to help further encourage physical activity in our schools. This is targeted towards increasing activity and vulnerable groups.
i. **Play well** – Again a multifaceted approach has been taken to increase safe play within the activity framework. This includes the successful slow to 20 for safer streets programme, supported by several AAPs a number of which have also supported physical activity programmes for their residents.
j. Communities have also been engaged through activities such as Beat the Streets set to be piloted in areas of County Durham in 2017. This will see whereby friends, schools, workplaces or communities take part in a game against each other through levels of physical activity.
k. **Engaging with the system** – In collaboration with Leeds Beckett University (LBU) a workshop was delivered with the healthy weight alliance to begin to explore the working culture of County Durham. Efforts will be made to explore how obesity contributes to a variety of our corporate priorities. A development session is planned with the healthy weight alliance to attempt to develop further approaches to tackle obesity in County Durham.
l. We are also working with partners in primary care to identify and refer clients of community pharmacists to Slimming World, after assessment. Healthy living pharmacies were identified in target communities to deliver this.
m. Obesity and planning
n. Closer working with planning colleagues led to a workshop in July which assessed the County Durham Plan against the Town and Country Planning Association's healthy weight framework. Such collaborations are essential in addressing the obesogenic environment and health inequalities and should include provision to access green space.

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Appendix 3

Table 3: Key findings and actions following a health check

	Health checks carried out			Referred to GP and other services for further assessment						
All C4L HC	Number of valid readings	Number of cases	%	No	Yes	Declined	Blank	No	Yes	Declined
Absolute CVD Risk Score 20 and above	13080	1468	11%	745	703	20		51%	48%	1%
Diabetes UK risk score 16 - 24	12756	3706	29%	2524	1102	49	31	68%	30%	1%
Diabetes UK risk score 25 and above	12756	647	5%	385	253	5	4	60%	39%	1%
Total Cholesterol 7.5 and above	13114	792	6%	416	365	10	1	53%	46%	1%
BP - Systolic 140 and above	13222	2489	19%	1418	1031	21	19	57%	41%	1%
BP - Systolic 140 and above and CVD Risk Score 20 and above	13222	532	4%	240	289	3	0	45%	54%	1%
Smokers	13248	2140	16%	1531	338	250	21	72%	16%	12%
AUDIT-C 5 and above	13235	4630	35%	4371	93	124	42	94%	2%	3%

Appendix 4 Summary of the County Durham GP Health Check contract 2014/15

These are the key elements of a revised specification for the Health Check component of the public health contract with GP practices:

- Tariff based at £35 per Health Check
- An upper limit for the number of checks carried out by all GP practices combined
- A quarterly lower limit for each practice. If the practice falls below this level then the option is for other practices/providers to be allowed to carry out health checks for the practice population
- Contract limits to be based on a submission of a list of the patients in the target eligible population to NECS.*
- The target population will be those with an estimated CVD risk of 20% or more using QRisk2.*
- The practice will allow NECS to access an agreed minimum data set with a limited amount of patient identifiable information that will be compliant with the data sharing agreement we have for the Health Equity Audit.*
- Practices take part in the Check4Life Quality assurance scheme. This involves:
    - Using the supplied Health Options software to collect information on every Health Check
    - Practices will work toward the quality standards set out in the operating procedures for invitations, conducting the health check, risk communication and follow up
    - The Health Check will be conducted in a single appointment using the supplied LDX machine for cholesterol testing
    - Practice staff take part in the C4L QA audit
    - Practices comply with the external QA for the LDX machine supported by the C4L QA team
    - The Health Option software licence and LDX machine remain the property of Durham County Council Public Health through the C4L QA service and loaned to the practice while they have a Health Check contract
    - The practice uses the consumables supplied by the C4L QA programme in proportion to the number of Health Checks Carried out. This means the practice can use the machine for other patients but will need to pay for the cassettes.
    - The cost of the LDX machine and software is £1900 per practice paid for by the Check4Life programme. In addition the programme will pay for the cholesterol testing cassettes. Practice staff will be able to take part in any of the C4L training sessions run throughout the year in different venues. These are accredited and free.
- Practices will be paid monthly in arrears based on data supplied by Health Diagnostics. There will be no need for invoices or data validation by NECS.
- High performing practices will be invited to carry out health checks in high risk patient from other practices in the area at the same tariff of £35 per check.
- High performing practices in selected areas will be invited to carry out a defined number of health checks in low risk patients at £25 per check.

* We are working with Apollo Medical Systems Ltd to carry out data extraction and risk stratification as part of a call/recall system.

Health Option Software

Key features:

- Supplied by Health Diagnostics, the company that provides a range of support for the Check4Life community health check programme.
- Local experience over 4 years
- Backed up by training, telephone support
- Regularly reviewed and updated to local specification
- Provides a well-structured interface to communicate CVD risk and lifestyle advice
- Incorporates local information on lifestyle programmes
- Collects a standard data set on every health check
- Web based transfer of data to the practice system

Advantages over the current system of GP system templates:

- Ensures complete data collection
- Added value of risk communication (heart age) and lifestyle advice
- Easier to modify and regular updates QRisk2 risk calculator
- Consistency across the whole programme
- Training and support available
- Monthly reporting
- Potential for automatically adding cholesterol/HDL readings from POCT machine
- Includes Type 2 diabetes risk assessment

Possible developments:

- Identifying the cohort of patients among those who are eligible for a health check and have an estimated CVD risk of 20% or more,
- Pre-populating the Health Options software with patient data to avoid unnecessary data entry and avoid errors,
- Link the cohort identification with a standardised way of inviting patients though Docmail or similar.

Disadvantages:

- Cost to the commissioner
- Training needed
- Delay in data transfer to the practice system (up to 24 hours)
- Fitting in with current practice approach to health checks with two appointments

Point of Care Testing

Advantages:

- One appointment for a full CVD risk assessment
- Accurate risk assessment to inform risk communication
- Capillary v venous blood sample

Disadvantages

- Cost to commissioner
- Training
- Full blood test needed in those with risk > 20%

Appendix 5:
Frequently Asked Questions

CVD Risk

Q. Do we only get paid for 20% risk?

A. Practices will be paid £35 for a health check for a patient identified as having a CVD risk 20% or higher. In selected areas practices will be invited to carry out health checks in individuals with an estimated CVD risk below 20%. If the CVD risk is below 20% then the practice will be paid £25 per check.

Q. Can we do health checks on people outside of 20%?

A. For all practices, the new contract will be based on the assumption that you will invite people with an estimated CVD risk of 20% or more. For patients registered with the practice who have not been invited because their estimated risk is below 20% but ask to have a health check, then the practice will be paid the tariff based on the risk score. For some practices in certain areas, we will offer in addition to the standard contract an option to carry out a number of Health Checks in people with a CVD risk below 20%.

Q. The NHS Health Checks only utilises QRISK scores and not Framingham scores. Is this right? Can Framingham not be used?

A. The Health Diagnostic Software can calculate the CVD Risk Score using Framingham, modified Framingham, JBS2, ASSIGN, and QRisk2. NICE does not recommend any particular CVD risk model. We standardised on QRisk on the recommendation of the LMC and it is the best risk engine for our population as it takes into account deprivation based on the Townsend score.

Invitation/Identification/Eligibility

Q. How do we identify people who will be at a greater than 20% risk with the new software?

A. We are looking into the best way of doing this. The ideal solution is to access practice systems and extract the necessary data, apply the QRisk algorithm and identify those with a risk of 20% or more. We are running a pilot to test this approach working with Health Diagnostics and Apollo Medical systems. This includes populating the practice Health Options software with the people identified. The alternative solution is for the practice to run a query using a set of instructions provided by the North of England Commissioning Support Unit.

Q. Will the Practice continue to invite patients for a Health Check?

A. Yes. In the new contract we want practices to limit their invitations to people with an estimated CVD risk of 20% or more. We are also looking at way of standardizing all practice invitations using Docmail.

1.

Q. Will the 20% risk be based on old data, 2008?

A. No. The CVD risk assessment will be based on current clinical records.

Q. Will we still be using RAIDR to identify patients?

A. Practices can still use RAIDR to identify patients. This will not be linked to the Health Options software. The aim is to link the new Apollo system with Health Options software to identify patients and populate the Health Options software with relevant patient data.

Q. Will Practices be conducting mini health checks?

A. No. This is limited to the Check4Life Community Programme.

IG/Data Management/Patient details

Q. Can you confirm that the software is compatible with EMIS and EMIS web?

A. The Health Options software is a standalone programme. It is not the same as the current EMIS templates that are part of the practice system. The data collected by the software is turned into READ codes based on the national minimum data set for health checks and should be the same as the current templates. Any read code conflicts/errors will be addressed during the early implementation process. The data transferred to the practice system by the Health Diagnostics server is compatible with all GP Practice Systems.

Q. How sure do you think this data will be compatible?

A. See response above

Q. How will the patient data transfer from clinical system onto Health Options and back onto clinical system?

A. These are the steps in the data collection and transfer system:

- Apollo create query based on Health Diagnostics/Commissioner specification
- Complex queries run remotely by Apollo on practice list
- Cohort identified and file imported into Health Options®
- Health Options® run risk stratification algorithm
- Client attends GP. Client's details already in Health Options®
- Health Check completed and data automatically uploaded to Health Diagnostics central data repository
- Indigo 4's Keystone Enterprise converts this data into the correct format for the practice system and transfers the information to the practice through an adaptation of existing practice links and pathology messaging
- The data collection and transfer back to the practice occurs within 24 hours.

Q. Regarding the time difference between the data being entered on the Health Diagnostics tool and then being sent back to the practice and put onto the clinical system this may mean that for this period of time there is a prescription issued for a patient where their record doesn't look like this is relevant/necessary, or a chronic disease code may be recorded but the measures that lead to the disease diagnosis (e.g. cholesterol or BP) may not be present straight away in the patient clinical record.

A. The time difference is up to 24 hours between a Health Check recorded on Health Options Software and that record sent to the Practice In-Box (i.e. similar to Lab Links). This assumes that the computer with the Health Options Software is connected to the internet. It is unlikely that the findings at a Health Check would necessitate a prescription for high blood pressure or raised cholesterol without further investigation and assessment. However, it

would be sensible to make an entry on the patients practice record that a Health Check had been carried out and to record anything that needed follow up.

Q. Can the Practices be assured that Health Diagnostics have permission to extract, store and manage patient identifiable information and whether they are then subject to FOI or are able to sell or to share this information with other organisations?

A. Health Diagnostics are a registered ISO 27001:2005 Company; Certification Number ISM7799129. The Company has completed the NHS Connecting for Health Information Governance Statement of Compliance (IGSoC) process. The Company are bound by the provisions of the N3 Code of Connection and NHS Information Governance and Data Protection Act 1988. Details of the IT system and the protocols for confidentiality and data security are available on request.

Q. Will patient confidentiality be protected involving the clinical systems?

A. See response/s above

Q. How does this fit into confidentiality when patients don't want their personal information shared with other data users?

A. A patient's personal information will not be accessed by any other user. The data handling process hosted by Health Diagnostics is compliant with the highest standards for data protection. No-one other than the staff within the practice who have legitimate access to patient records will be able to use this data. Nearly all of the data provided by Health Diagnostics to Public Health will be in the form of summary tables. Once a year Health Diagnostics will provide Public Health anonymised individual records with a limited data in order to audit the programme. This will be carried out under the terms of the information sharing agreement with the practice and Public Health.

Q. Can Practice Managers have administration access to software to check synching for reports

A. Will confirm this as soon as possible.

Q. Can Practices input the patients NHS number into the software to access the patient records/details? Will the software be pre-populated?

A. The aim is to pre-populate the records on the software with a limited set of patient details including NHS number, name, gender and date of birth.

Read Codes

Q. Can the Practices be assured that the Read codes that are held within the Health Diagnostics tool are those that are nationally mandated (e.g. for QOF etc.) to ensure that when the data is uploaded onto the clinical system from Health Diagnostics there won't be anything that affects other areas. I know that there are various screening codes available and only some are accepted for other LES/DES/QOF indicators.

A. As a national company Health Diagnostics have worked closely with the NHS Health Check Data leads to ensure that the Read Codes in the Health Options Software are consistent with the nationally agreed minimum data set. If we identify any inconsistencies, then Health Diagnostics will make the necessary changes.

Q. Will read codes be able to be updated as and when required?

A. See response above

CVD Diagnostic Equipment

Q. If the Practice has more than one site will there be a machine for all sites?

A. Possibly. This will be decided (by the Commissioner) on a case by case basis depending upon the size of the practice and likely number of health checks on each site.

Q. Can Practices have more than one LDX machine?

A. See response above

Q. Who would be responsible for the up-front costs of purchasing the machines? Would they be provided to practices free of charge?

A. The CVD Diagnostic Equipment (POCT LDX machines and Health Options Software) is loaned to the Practices at no cost and remains the property of Durham County Council Public Health managed through the Check4Life Quality Assurance (QA) Programme. Practices can use the equipment as long as they have a contract to provide Check4life Health Checks.

Q. Who is responsible for the maintenance and on-going running cost for the machine? Hope it is not the practices?

A. The C4L QA Programme which oversees the maintenance and replacement of the equipment if required. The practice is responsible for calibrating the LDX Machine every two months.

Q. How is calibrating defined? How is calibration different to maintenance?

A. The C4l QA Scheme includes an agreement with an external laboratory to check that the LDX machines are functioning effectively (calibrated). The laboratory sends serum samples to the Practice every two months and the Practice will be required to run the Quality Control Tests on the LDX machines to ensure that the machine is calibrated and is providing accurate readings/test results. Whilst no formal maintenance is required, Practices will be provided with and expected to abide by specific LDX Equipment standard operating procedures supplied by Health Diagnostics and will be required to apply a ‘duty of care’ in terms of good housekeeping; storage; handling and usage of the LDX Equipment in-line with CDDFT Medical Devices Policy and procedures.

Q. If the machine breaks or is non-functional for a period what is the ‘plan B’? Can practices do lab blood test then? Why can't practices not also use lab cholesterol results to do NHS Health Checks as well?

A. The C4l QA Programme will provide a replacement machine within a day or so. There is no need to cancel appointments. If the LDX machine is not available then carry out a health check as normal and save the results, take a venous sample for blood lipids and complete the health check with the results when they become available. The point of near patient testing is completing the risk assessment and risk communication during the single appointment.

Q. What would be the cost of disposables for near patient tests? Would this cost be met by Practices or would kits be provided/reimbursed?

A. The Practice is not liable for the cost of consumables. The practice will be provided with a phone number of the supplier to request consumables as required. The cost of this is covered by the C4l QA Programme. Consumables will consist of TC/HDL Cassettes; Heparin Tubes/Plungers; Unistick 3 single use Lancets and one Optics Check Cassette. Approx cost per check £7.61.

Q. Will Practices receive colour printers to print out patient results sheets and QRisk Page?

A. No. If the practice does not have a colour printer then the print out will be black and white and then included in the packs provided.

Training

Q. Would there be other training apart from the training provided by Health Diagnostics?

A. Mandatory training will be provided covering the essential knowledge, skills and competencies required to deliver the new C4l Health Check Programme. The training programme has been designed to meet the workforce competency requirements outlaid in DH Putting Prevention First Workforce Competency Framework and is specifically tailored to skill staff to effectively deliver a C4l Health Check, including use of the new C4l Health Options Software. All identified practice staff who will be delivering the C4l Health Check Programme will be required to attend the mandatory training. The training is FREE and will be 2.5-3 hours duration and delivered in a central location to facilitate access for all practices across County Durham.

The C4l QA Programme will also provide a C4l Training Calendar with a range of additional PDP training opportunities, for example, making every contact count (MECC); brief intervention for stop smoking; weight management; physical activity etc. Individual practices and staff will be able to self-select the most appropriate training to meet their individual requirements. The training calendar will provide greater flexibility in terms of choice, accessibility and time management for practice staff to be released at an appropriate time which meets the individual learner and practice capacity demand requirements.

Q. How long will the training take?

A. See response above

Q. Who would need to be at the training? Can it be cascaded to other staff?

A. All identified practice staff who will be delivering the C4l Health Check Programme will be required to attend the mandatory training. The initial mandatory C4l Health Check Training cannot be cascaded as the training is designed to meet the competency outcomes outlaid within DH Putting Prevention First Workforce Competency Framework and in accordance with the C4l QA Programme requirements to ensure all staff delivering C4l Health Checks are delivering standardized, consistent quality assured health checks across County Durham. **5.**

However we actively encourage in-house coaching and mentoring ‘post’ mandatory training as part of your individual practice ‘whole team’ approach to creating a learning environment and supporting each other by sharing practice and lessons learnt. We also recommend that

individual practices assign a 'lead' C4I Practice Champion who will work closely with the C4I QA Support Team to enable practices to achieve the C4I GP QA Mark.

Q. When will the pilots start?

A. The initial C4I Health Check pilot practices will be implemented after approval is confirmed via LMC (4th February 2014) and expressions of interest are received by individual practices wishing to take part in the early adopter pilots following a series of awareness raising engagement briefing events. It is anticipated that pilot implementation will commence March 2014 with a view to inform any additional service improvements prior to full roll out across all GP's in County Durham.

Practices will be invited to sign up to the new C4I GP Contract. The new C4I GP QA Programme will be gradually rolled out and implemented due to the enormity and scale of the programme. The current contract will be extended until Practices are fully recruited; trained and resourced to deliver the new C4I GP QA Programme.

Point of Care Testing (POCT)

Q. With the proposed move to near patient tests for cholesterol, do you have any information on the reliability/accuracy of these tests? Presumably you are happy with the evidence base?

A. POC Testing LDX equipment provides readings that are good enough for estimating cardiovascular risk. For follow up and management of people identified at a high risk of CVD and considered suitable for statins, then the clinician will probably want to have laboratory readings based on a venous sample. This could be taken at the time of the health check based on the CVD risk score and risk management plan agreed with the patient (**please view national guidance on POCT at www.improvement.nhs.uk**).

Q. Will practices need to confirm the blood cholesterol results following a health check using POCT equipment?

A. The POCT LDX machine provided by the programme provides blood cholesterol results that are accurate enough for calculating a CVD risk score. Before making any shared decision about the suitability of statins to reduce CVD risk, the more comprehensive results from a laboratory on a venous blood sample will be needed. Similarly, a venous blood sample to check HbA1c levels in people who are identified as having a high risk of developing diabetes is also appropriate. The venous blood sample can be taken at the time of the Health Check and followed up in accordance with the normal practice protocol. The advantage is that the need for venous blood samples is reduced to patients with a proven high risk of CVD and Diabetes.

Q. How accurate is the POCT test compared to fasting blood results for total cholesterol?

A. A fasting blood test is not necessary for a CVD risk assessment. Non-fasting total cholesterol and HDL from a capillary sample are sufficient to calculate the TC/HDL ratio in CVD Risk Calculators. In addition, we have conducted vast market research to find out what the barriers are for people who do not attend a health check despite numerous invitations. The fear of blood tests and the inconvenience of fasting have been cited as reasons for not taking up the offer.

In terms of accuracy, the external Quality Assurance Scheme ensures that the LDX Equipment produces accurate TC/HDL test results. The machines are calibrated against

laboratory gold standard tests every two months. If there is a wide difference between a fasting venous sample and non-fasting capillary sample then it will not be due to the equipment. The effect of fasting on total cholesterol could be the reason which is why the risk assessment is made on the TC/HDL ratio rather than single result.

Q. Diagnosis of Diabetes.

A. For the Health Check programme the recommendation for identifying those at high risk of developing and having undiagnosed diabetes is to use HbA1c. Only those identified as at higher risk should be tested as part of their NHS Health Check risk assessment and it is not considered clinically effective or cost effective to test everyone. There is no single accepted way of identifying people who are at risk of diabetes or who have existing undiagnosed diabetes. There are a number of ways of determining who is at high risk and the guidance for Health Checks is to use BMI (adjusted for ethnicity) and blood pressure to identify people at high risk. Using these factors as a filter, those at higher risk can be identified and go on to have an HbA1c test.

Q. Why are Practices not doing blood glucose? Can we not do it at the same time as testing cholesterol?

A. It is up to the practice how they want to investigate patients who are at a high risk of diabetes. The recommendation is to follow NICE guidance and use a non-fasting HbA1c test to assess risk.

Implementation of C4L GP Programme

Q. If a practice has only 1 HCA who has other duties to do she/he may not be able to just solely focus on NHS Health Checks using the machine approach only. Has this been considered?

A. The new contract makes no assumption about how much time an HCA is allocated to health checks. The only difference is that each health check will last up to 30 minutes to complete with the near patient testing.

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Health and Wellbeing Board

31 January 2017

Progress update of Director of Public Health Annual Report 2014 - All the Lonely People

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

Purpose of the Report

1 The 2014 Annual Report of the Director of Public Health entitled *'All the lonely People'* focused on social isolation and loneliness and its effects on health and wellbeing. The purpose of this paper is to update the Health and Wellbeing Board on the response in tackling social isolation and how to have a more coordinated response. The focus of this paper is on older people.

Background

2 'All the lonely People' outlined the causes and consequences of social isolation and loneliness and set a challenge for partners to take action to address the issues highlighted therein.

3 Taking action to reduce social isolation and loneliness in local communities can reduce the impact and cost on local health and care services, whilst improving the health and wellbeing of the population. The detrimental impacts on physical and psychological health are well documented.

4 The challenges are therefore:

- To identify those who are, or who are at risk of, becoming isolated or lonely and may often be hidden in plain sight
- To give appropriate support that helps to build and improve social connections in communities, working across partnerships, in order to protect those most at risk of isolation and loneliness
- To create an environment through co-production where people can connect with their neighbours, communities or people of the same interest.
- To develop programmes and interventions that actively identify through, a brief intervention approach, those who are at risk and to ensure programmes are working to the current evidence base.

Definitions

5 Social isolation and loneliness are not the same thing, but are often used interchangeably. People can feel lonely without being isolated and isolated without being lonely. Whilst there is a strong and complex relationship between social isolation and loneliness, one does not necessarily follow the other, although many of the risks or triggers are shared and there is a large overlap between the two.

Loneliness prevalence in County Durham

6 To highlight the scale of the issue, *'All the Lonely People'* estimated the prevalence of loneliness to be around 19,000 people aged 65+.

7 Public Health England (PHE) estimates that 7% of the 18-64 population is socially isolated. For County Durham this would mean around 22,000 people aged 18-64 being socially isolated.

8 Across the age groups and the two areas of concern this amounts to 41,000 people in County Durham that could be affected by loneliness, that's about 9% of the County Durham population over 18yrs.

Effects on health and the National Health Service

9 The links between isolation and loneliness and poor physical and mental health are strong. Effects can include depression, decreased immunity and longer recovery from illness, poor nutrition, increased anxiety, fatigue, social stigma and ultimately increased morbidity and (premature) mortality. Recent studies suggest isolation:

- Has a more negative effect on wellbeing than physical inactivity, obesity or smoking 15 cigarettes a day;
- Can increase an older person's chances of premature death by 14%;
- Increases the likelihood of admission into residential or nursing care; and
- Increases morbidity, depression and suicide as well as health service use.

The Director of Public Health Report recommendations

10 The Annual Report *'All the lonely People'* made a number of recommendations, which would start to address the challenges identified previously in this report. These are:

- **Identification**: Partner organisations should identify those who are, or who are at potential risk of becoming socially isolated. There is a role for communities and individuals to support isolated people at a local level, and to build resilience and social capital in their communities.
- **Signposting**: Front-line professionals and community members should consider the impact of social isolation on their patients/clients and signpost or support them to sources of help.

- **Networking:** Organisations should support the building of local connectedness in communities, working across partnerships in order to protect those most at risk of social isolation.
- **Local Connectivity**: Organisations, including the voluntary and community sector and Action Area Partnerships (AAPs) should work towards creating an environment where people can connect with their neighbours, communities or people of the same interest.
- **Policy and Training:** Appropriate policies and training should be in place to support volunteers in County Durham communities to understand, recognise and identify those at risk.
- **Future Developments:** Service developments, new commissions and contract specifications should consider the impact of social isolation on client / patient groups.

The next few sections of the report we will use the above recommendations to show how the Council and its partners have responded and intend to move this subject forward in the future.

Responses to Recommendations

Identification and professional signposting:

11 The key to start addressing the issues of social isolation and loneliness is to identify those residents who are, or could be 'at risk'. Frontline services are recognising the need to work more closely to enable residents to be identified sooner rather than later. For example Housing Associations, Fire and Emergency and Police come into contact with older, vulnerable residents on a day to day basis and they have started to identify, signpost and support those residents to access the services they need.

Vulnerability

12 Potentially anyone can be or become socially isolated or lonely. Key factors, especially in older people can be:

- Bereavement;
- Reduced mobility and long term health conditions;
- Lack of social participation;
- Loss of useful role;
- Sensory impairment;
- Limited income;
- Loss of contact with family members and children.

First Contact Schemes – eyes and feet on the ground

13 First contact schemes train individuals who are most likely to come into contact with people experiencing social isolation and loneliness and in turn can make appropriate referrals. First contact programmes are based on making every contact count (MECC). These programmes can be general or targeted at a certain population.

14 There are a number of first contact schemes which are currently running in the county:

- **Agency Based Referral** - County Durham and Darlington Fire and Rescue Service (FRS) have recently implemented a safe and wellbeing visits (S&WBV) programme across the county. This is based on the idea of MECC or the 3 As' – ***Ask, Advise, Assist***, and can include one or more of the following; giving individuals information, directing them where to go for further help, raising awareness of risks and providing encouragement and support for change.
- The MECC approach focuses on a number of health issues such as alcohol, smoking, dementia, social isolation, winter warmth and slips, trips and falls. These are health issues identified in the Joint Strategic Needs Assessment. Between 15th February (when the visits were first introduced) and 31st August a total of 9,255 visits were carried out. 3,506 people agreed to answer the lifestyle related questions. 1352 referrals were made to partner agencies. The highest numbers of referrals made were regarding loneliness and isolation.
- Agent based referral - 'community' or 'village' agents are paid staff or volunteers working to identify the individual needs of excluded/vulnerable people in a local area. The Area Action Partnerships working with a variety of partners including Pioneering Care Partnership, Cornforth House, East Durham Trust, Durham Community Action and local Housing Associations have piloted various schemes which either befriend, signpost or provide additional support to vulnerable older residents. All of these schemes use a mix of local knowledge and partner referrals to identify potential residents.

Social isolation indicators

15 Measuring social isolation and loneliness is important in being able to properly identify older people to participate in programmes and for agencies to be able to accurately identify those individuals who would benefit. In the past there were only a few programmes that have made use of scales/questionnaires to identify and respond to the needs of older people. However, this is beginning to change with a validated questionnaire built into the safe and wellbeing visits being undertaken by the FRS in County Durham as well as similar scales being used by the various agent based referral schemes previously highlighted.

16 There is a need to be mindful that this area is somewhat fraught by the number of related wellbeing, quality of life and social isolation scales, some of which may elicit a negative or defensive response from older people. Nevertheless, there are a few extremely valuable scales that are constructed in a sensitive and useful fashion.

Information and signposting services

17 Durham County Council has developed its own system through LOCATE, that aids with signposting around support services, care packages and local services.

18 LOCATE is being adopted by other services with GP surgeries currently piloting the use of the system closely linked to the work of the 'Wellbeing for Life' team and its volunteers. A variety of service partners have been trained to use LOCATE in 'one to one' situations to help signpost residents into relevant services to meet their needs.

19 There is still a great deal of potential with regard to improving the identification and signposting process. Work with services which have direct contact with older residents who may suffer from social isolation and/or loneliness (NHS, GPs, Social Care, Care Connect, Age UK) needs to progress further to develop a stronger referral and/or signposting process.

Networking and local connectivity

Arenas for joined up working

20 The County Durham Health and Wellbeing Board brings partners together to improve the health and wellbeing of the people of County Durham and to reduce health inequalities. Its key aim is to establish closer working between partners to enable the above to take place effectively. Social isolation and loneliness are just part of a much wider agenda for the Board but are key priorities in the Joint Health and Wellbeing Strategy.

21 As part of the Health and Wellbeing Board joint working arrangements structure, the creation of a Community Wellbeing Partnership has seen the development of a number of new programmes. The initial development of the FRS safe and wellbeing visits came through the Safe Durham Partnership; however, through cross partnership working and the ability to MECC the Community Wellbeing Partnership recognised the opportunity to look at health and wellbeing factors whilst conducting visits. Building on from this cross partnership working the Community Wellbeing Partnership have supported the development of a Health and Housing working group and again social isolation is a key part of their discussions.

Wellbeing for Life / targeted wellbeing

22 Another focus for the Community Wellbeing Partnership has been the development and monitoring of the Wellbeing for Life service. The service is operating in the 30% most deprived areas as well as providing outreach support to individuals and communities with specific needs outside of these geographical boundaries. The service is managed and delivered by a consortium of voluntary sector and public sector organisations. It provides 'one to one' support, group activities, volunteering opportunities and community development approaches. One of the main outcomes of the wellbeing for life programme is to reduce social isolation and work to enable people to connect with others in their communities.

Using links to health services

23 As previously highlighted health professionals have regular contact with older people at risk of experiencing social isolation and loneliness and systems could be established to identify and refer individuals into services and support. Initiatives that are already starting to do this include:

- Social Prescribing. Primary care services refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary/community sector.
- Home from hospital schemes. Hospital staff identify older people who may be experiencing/are at risk of loneliness because of an illness and introduce them to services. The Royal Voluntary Service's 'Hospital 2 Home', Care Connects 'Home from Hospital' and the Durham Christian Partnership's 'Homeward Bound' services support vulnerable older adults during and after hospital discharge and offer short-term support.

Social Prescribing

24 The social prescribing service began in June following on from the previous Arts on Prescription programme; *Colour Your Life*. Again the service is another programme managed and delivered by a consortium of voluntary sector organisations. It aims to provide access to social prescribing interventions for the improvement of mental health and the development of emotional resilience amongst participants. The service aims to act as a "social prescription" for the management of mental health and wellbeing. The service aims to provide access to social prescribing interventions via a hub and outreach model.

25 Social prescribing is a mechanism for linking people with non-medical sources of support from within the community. Individuals experiencing significant life changes or living a chaotic lifestyle can benefit from a constant and regular engagement which can help to stabilize their life. In addition doing something creative, learning a new skill, having time for oneself and developing friendships are all recognised to contribute significantly to mental wellbeing.

Community based approaches

26 The evidence is very clear that communities with high levels of social capital have better outcomes in health and can enjoy greater levels of social cohesion. For these reasons (among others), reducing social isolation needs to be a key priority for a range of organisations.

27 Only through engaging local communities in co-producing local solutions can the issues relating to social isolation be addressed. Work in partnership with community groups, local faith groups, the voluntary and private sectors is needed to build community cohesion and to offer the personal and integrated approach that supports those suffering from social isolation.

28 The Health and Wellbeing Board recognises the value of communities working together to reduce isolation and increase resilience and the benefits that a well-connected society can bring.

Area Action Partnerships

29 AAPs and partners are playing a major role in helping to address social isolation through engagement and community focused programmes. Many AAPs have prioritised work with older people around reducing social isolation and improving health and wellbeing.

30 The AAPs and partners have supported and/or developed numerous community based projects which tackle social isolation and loneliness whilst working with a variety of targeted groups and ages. Examples are provided below which provide support for older isolated residents:

- Flexible Emergency Packs Provision - Woodhouse Close Church (BASH)
- Flexible emergency provision and crisis intervention - Shildon Alive (BASH)
- Advice in County Durham – Chester-le-Street Advice Hub Pilot (Ch le St)
- Derwent Valley Diners – Age UK CD (D/went)
- Centre of Excellence linked to Dementia support (E Durham)
- Neighbourhood Networks – Durham Community Action (M Durham)
- Teesdale Retired Farmers Lunches/Socials – Upper Teesdale Agricultural Support Services Limited (T/dale)
- Silver Talk – Derwentside Homes (M Durham)
- Keeping in touch in Teesdale – Leap in Teesdale (T/dale)
- Wheels to Meal's – W/dale Community Transport (W/dale)
- B Network – Cornforth P/ship (Spennymoor)
- Buddies Befriending Service – Pioneering Care Trust (GAMP)
- 'Open Art' Surgery - RT Projects designs (Durham)
- The County Durham Stroke Club (Durham)
- Dementia Action Alliance Coordinator – Alzheimer's Society (M Durham)
- Various Cree Projects across several AAP areas.

31 The AAPs try to work closely with partners to address social isolation by not only developing and sustaining projects but by promoting community based projects with key statutory health and wellbeing providers in an attempt to provide low cost, preventative and supportive services. The AAPs work closely with the Wellbeing for Life service and in turn help them to recognise and use these projects too. Recent work between these two and the County Durham Partnership has seen the recognition of how the local faith community can also have a positive impact upon addressing social isolation and loneliness.

Faith and wellbeing

32 A Breakfast seminar held on the 23 September 2015 brought together elected members, officers, partners and faith communities in a roundtable conversation: "Loneliness in County Durham ....Private Problem or Public Issue?"

Some key points came from this conversation including:

- Role of the Voluntary Sector – providing innovative solutions;
- Need to recapture a culture of 'taking care of each other';
- Good Neighbour Schemes and Crees;
- Keep in mind the isolation of young people as well as old.

33 Following on from this conversation there have been three 'Faith & Wellbeing' events held during 2015/16 which have brought together churches and faith groups in three AAPs to share their experiences of the links between faith and wellbeing and reflect on what they are doing locally. A key aim was to facilitate engagement between faith groups, the Wellbeing for Life Service and AAPs and to start looking practically at some of the key points coming out of the breakfast meeting.

34 A key outcome from these 3 events has been the funding secured for community projects run by faith groups, many of which will assist in helping to reduce social isolation e.g;

- St Elizabeth's Woodham Community Hall – to encourage social activity
- St Claire's Newton Aycliffe Community Hall – to encourage social activity
- St Elizabeth's Newton Aycliffe - 'Knit & natter'
- St Catherine's Church New Brancepeth – Luncheon and coffee morning sessions
- St John's Church Hall Meadowfield - rebuild the church hall for social purposes

Key to the delivery of a lot of the services mentioned in the last few sections is the access to local community buildings.

Community Buildings

35 The County Council has supported many community buildings in the county, through the asset transfer programme over the past four years. Most of these buildings have been able to strengthen the level of activity that they provide as a result of a greater level of control, better finances, improved volunteer numbers and stronger management committees.

36 Services and activities provided by community buildings are often aimed at more isolated members of the community such as the elderly, young mums, older men or those with health issues (both mental and physical). Examples of activities provided include:

- Activities aimed at those who are isolated and those with dementia who can reminisce by looking at pictures and listening to music such as the 'forget me not' friends group at Citizens House in Consett and dementia clubs at Shotton (who include residents from the local care home nearby)
- Men's Crees projects in Trimdon Station Shotton, Wheatley Hill and Annfield Plain
- Tea dances, coffee mornings, art clubs and bridge clubs, sewing clubs and 'knit and natter' in various locations
- Disability Parliament group at Newton Hall and Disabled Club at Wheatley House.

37 Durham Community Action and East Durham Trust are supporting our community venues to keep open and thrive through advice, support and guidance. They are developing building networks and consortia to deliver health and wellbeing activity and with the AAP's and county councillors helping to contribute funding and advice too it is hoped that we can sustain most, if not all of these local physical assets.

Transport and access to services

38 Gaining access to the previously mentioned community based provision as well as health services has been seen as an issue for many residents with transportation cited as the main problem. Statutory services and AAPs have recognised this and there have been, and are, several commissioned and funded transport schemes across the county which are trying to address this:

- There are several CCG/NHS and public health commissioned transport services which focus upon getting residents to and from their healthcare appointments.
- There are three volunteer car driver schemes supported through their associated AAPs (4 Together, Stanley and Mid Durham) which enable people and their carers to access healthcare appointments in hospitals as well as local social activities.
- Weardale AAP have used their public health grant to support a 'Meals to Wheels' project that enables older people to access other services in particular a meal.

39 This section has highlighted numerous examples of community led provision which will help to address social isolation across our county. The need to connect the community led services with those of our statutory health and wellbeing providers has begun, but there is still a great deal more to do. There is a need for all partners to examine this further, so that a connected, quality care/support package can be offered to all our older residents in the future.

Policy and Training

Strategy and Policy

40 The County Durham Joint Health and Wellbeing Strategy has identified and put in place targets and actions to start to identify and support people at a local level who are, or could be affected from social isolation and loneliness. Alongside this they will be seeking to build resilience and social capital in local communities to further address these needs.

41 The Clinical Commissioning Groups' Frail Elderly model incorporates a whole system review that cuts across health, housing, social care and the third sector providing safe, high quality seven day integrated services; delivering person centred care, and places early identification, timely intervention and prevention at its core.

42 The Better Care Fund has tackling social isolation as one of its work programmes with increasing community capacity and resilience to provide local low level services as one of its actions.

43 Durham Community Action has put in place policies, procedures and accreditation to support the recognition and delivery of volunteer led services across County Durham. They, along with other community based providers of befriending, support and signposting services have developed policies and procedures alongside specific training packages to enable volunteers to identify, support and signpost people suffering from social isolation.

Training

44 As previously highlighted there are a number of services delivering a wide variety of training that will enable front line staff and volunteers to identify, support and signpost older residents. Programmes that offer befriending, mentoring, buddying or navigating have seen a great investment of both time and resources into training programmes for their volunteers.

Commissioning

45 A number of councils are recognising the importance of addressing loneliness and building small but important steps into contracts.

46 As a result Birmingham Council is now requiring the voluntary organisations it commissions to provide preventative services that reduce social isolation, to use the following measures:

- Percentage of individuals using the service reporting that they feel they have adequate social contact
- Training of staff to ask, advise and assist and use local signposting for those who may be lonely
- Percentage of individuals using the service reporting that they feel less lonely and depressed

- Percentage of service users reporting that their lifestyle has improved for the better

Way forward

47 Clearly there is a considerable amount of work from numerous partners taking place across the county that is starting to address the recommendations made in the *'All the Lonely People'* report. As our population continues to grow and resident's lifespans increase, it is highly probable that the number of older residents who are affected by social isolation and loneliness will continue to grow unless we sustain and develop services to address these issues.

48 There is a need to examine and measure the impacts these existing services are making on our older residents so that we are sure that the services are making positive differences. There is a need to provide health and wellbeing practitioners and volunteers with clear 'pathways' of services which could support those identified that are affected by social isolation and loneliness. As indicated this has already started with an emphasis on 'local' pathways, but there is still a need to draw this together so that all practitioners, volunteers and residents across the county have access to good quality service provision to meet their needs.

49 As previously highlighted in this report the Community Wellbeing Partnership have sought to discuss, develop and monitor a number of programmes which impact upon social isolation and loneliness; however, this has not been carried out with a wider view on addressing social isolation as a whole. The Partnership has discussed recently the idea of having a 12 to 18 month key area of focus, with social isolation being one of those possible areas.

Recommendations

50 The Health and Wellbeing Board is asked to note the contents of the report and support the specific recommendations that:

- Organisations and partners who prioritise reducing social isolation and loneliness should develop interventions that are based on the current evidence of what works: befriending services, community navigator programmes and group activities;
- That commissions, where relevant should continue to consider 'building in' indicators which will tackle social isolation and loneliness;
- That a basic common training package on how to engage and identify social isolated individuals and groups should be developed;
- The Community Wellbeing Partnership will design and develop an evaluation framework to support organisations to be able to capture a range of outcome measures to demonstrate value and contribute to learning;
- Given the numbers of older people in County Durham with one or more long term conditions, work to reduce social isolation and loneliness, will need to integrate with the proposed CCG integrated community hubs model;

- On the back of recommendation that contact schemes should train individuals in using making every contact count (MECC) and undertake some brief and sensitive questionnaires to identify and appropriately refer people to local programmes using Locate;
- The Community Wellbeing Partnership should consider placing social isolation and loneliness as a key focus of work for the foreseeable future to support, steer and enable the above recommendations to take place.

Contact: Graeme Greig, Public Health Specialist
Tel: 03000 267682
Andy Coulthard, Area Action Partnerships Coordinator
01205 529085

Appendix 1: Implications

Finance – There are financial implications of the ageing population with long term conditions.

Staffing – There are workforce issues relating to the training and development of staff including using MECC and screening tools.

Risk – The are risks to the physical and psychological health of lonely and isolated people.

Equality and Diversity / Public Sector Equality Duty – This relates to reducing health inequalities and narrowing the gap in health outcomes

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues – Considerable numbers of older socially isolated people will have a long term condition

Legal Implications – None

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Health and Wellbeing Board

31 January 2017

Healthwatch County Durham Work Plan 2016/17

Report of Brian Jackson, Lay Chair of Healthwatch County Durham

Purpose of the Report

1 The purpose of the report is to provide the Health and Wellbeing Board with the Healthwatch Work Plan 2016/17, attached as Appendix 2, for comment.

Background

2 A consortium of three local voluntary sector organisations (Pioneering Care Partnership, Citizen's Advice County Durham and Durham Community Action) recently took over responsibility for delivery of Healthwatch County Durham (HWCD).

3 Following a smooth transition of staff and volunteers recruitment of the HWCD Board commenced late August 2016.

4 A transparent recruitment process has taken place and eight members were recruited to the HWCD Board by December 2016 to meet the target set by providers.

5 Careful consideration has been given to the membership of the Board to ensure that it is representative of the people of County Durham in relation to geography, protected characteristics, skills and interests (i.e. Health and Social Care).

6 A Work Plan has been created through liaison with colleagues in Health, Public Health, and Social Care, ensuring alignment with the Joint Health and Wellbeing Strategy, Clinical Commissioning Group (CCG) Commissioning Plans and priority areas.

7 HWCD is the independent consumer champion, therefore whilst themes and topics are considered with statutory partners, specific areas are subject to review and actions are determined by the Board.

8 Intelligence gathered through HWCD Information and Signposting Service and through general engagement also informs the development of the HWCD Work Plan. Furthermore the HWCD Board interprets local and regional data to support Work Plan development.

9 The development and approval of the HWCD Work Plan is the responsibility of the HWCD Board.

Development of the Work Plan

10 The HWCD Work Plan sets out an ambitious programme to promote the rights of patients, service users and carers which importantly are linked to commissioning intentions and cycles.

11 In addition to providing direction and steer for HWCD activities locally, the aim of the Work Plan is to galvanise consumer interest in topics and gather intelligence. This will enable HWCD to consider trends and feed insights into commissioners and providers to ultimately improve service delivery in the County.

12 In developing the Work Plan, the priorities identified in the Joint Health and Wellbeing Strategy and CCG commissioning intentions have been considered and incorporated.

13 The Work Plan identifies key areas of work until summer 2017 and was approved by the HWCD Board in November 2016.

Recruitment, induction and training of Board and volunteers

14 Although the target for the number of HWCD Board members is eight, the Board have agreed to increase this to 10 members to allow for the recruitment of young people to the HWCD Board to represent the voice of young people.

15 Work is currently taking place to identify young people who may be interested in becoming HWCD Board members. A presentation has been given to the Investing in Children Health group to outline the role and expectation for HWCD Board members and to answer questions.

16 Questions related to accessibility for meetings, for example in relation to times and location. The HWCD Board has agreed to plan meetings for 2017 to consider the inclusion of young people.

17 Work is taking place to map the current volunteer base of HWCD. There are currently 39 volunteers. Role descriptions have been produced and individual meetings are taking place with all volunteers to discuss roles and identify any training needs.

18 This work also considers ensuring that we have volunteers who will be actively involved in engagement and research as well as Registered Enter and View Representatives. Current volunteers who are unable to take on an active role will become “Healthwatchers” as part of the wider HWCD network.

Marketing, communication and engagement plan

19 A young person was recruited as a Media and Communications Apprentice in December 2016 who will also study for an NVQ as part of their role.

20 This role will increase the reach of HWCD by growing newsletter distribution and social media following.

Planned engagement activities

21 A number of engagement activities are planned for the coming year. A summary is provided below with further details highlighted in the HWCD Work Plan at Appendix 2.

Learning Disabilities

22 A Learning Disability Residential Care review is currently taking place and HWCD will support service users to be included as part of the consultation through a number of visits and 1:1 interviews in January 2017.

23 It is recognised that there is a poor uptake of Healthchecks by people with learning disabilities (LD). To identify the reasons for this HWCD has worked with people with LD understand their issues. This included engagement with people with LD at the Fulfilling Lives event, partnership working with organisations supporting people with LD and both face to face and online surveys.

24 Work is also planned for early 2017 to target GPs to share examples of good practice in encouraging people to attend LD Healthchecks to consider roll out to increase uptake.

Care Packages

25 A pilot is in place to ensure new recipients of care packages receive a card which will raise an awareness of Healthwatch and provide an easy way to send feedback in relation to their care as this card is also a prepaid feedback form. Estimates show this will reach 1800 people throughout the six month pilot.

Uptake of oral health education, support and services

26 Initial research has taken place identifying inequalities within the County in children's oral health. HWCD plan to deliver engagement activities that complement worked planned by Public Health following the Oral Health Strategy Refresh in 2017.

Barriers to health screening programmes

27 Work is planned with partners including GPs to identify the areas within the County who have the poorest uptake of health screening programmes to further understand the barriers to inform future work.

Safeguarding Adults

28 Work is taking place with the Safeguarding Adults Board to further develop the relationship with HWCD. The Chair of HWCD is a member of the Safeguarding Adults Board.

Areas of work for future consideration

29 HWCD are keen to be involved in further areas of work in the future and a number of subject areas area identified below in response to data and engagement feedback.

30 Potential subjects areas are identified as follows which align to the Joint Health and Wellbeing Strategy:

- Initial contacts have been made within CCGs to offer support for engagement in relation to Maternity services;
- Use of positive Enter and View visits linked to GP surgeries who have received outstanding Care Quality Commission inspections, as a way of promoting and sharing good practice. A pilot is being considered by CCGs for this area of work;
- Support partners with health and social care integration and be engaged in the development of the Community Hub model.

31 A report detailing actions, findings and recommendations will be produced for each topic and this will be reported to the Health and Wellbeing Board.

Recommendations

32 The Health and Wellbeing Board is recommended to:

- Provide comments on the HWCD Work Plan and suggest any further areas of work for the future to be considered by the HWCD Board.

Contact: Carol Gaskarth, Chief Executive, Pioneering Care Partnership
Tel: 01325 321234

Healthwatch County Durham Work Plan 2016 – 2017

Key:

BJ – Brian Jackson – HWCD Board Chair
MM – Mary Mitchell – HWCD Board Member
BH – Burnard Hume – HWCD Board Member
JW – Jim Welch – HWCD Board Member
LM - Lakkur Murthy – HWCD Board Member
JE – Judi Evans – HWCD Board Member

MP – Marianne Patterson – HWCD Programme Manager
CC – Claire Cowell – HWCD Volunteer Support
DA – Denise Alexander – HWCD Engagement & Signposting Lead
DR – Denise Rudkin – HWCD Research & Intelligence Officer
EB - Ethan Burnett – HWCD Media & Comms Apprentice
GA - Gail Anderson – HWCD Office Manager
JC – Julia Catherall – HWCD Engagement & Signposting Lead

Topic	Intelligence/Need	Key Actions	By whom	Board Member	By when
Recruitment, induction and training of Board and volunteers (including Enter and View)	Healthwatch County Durham (HWCD) requires an independent Board, trained, authorised Enter & View representatives and trained engagement and research volunteers to deliver the contract	• Recruitment, induction, training and ongoing support of Board members (target of 10) • Audit of existing volunteer base and appropriate roles (target of 12) • Work towards Co Durham Volunteering Kitemark • Skills audit and training plan for existing volunteers • Ensure appropriate number of active, authorised Enter & View Representatives (target of 8 with geographic representation) • Programme of quarterly team meetings and twice yearly 1-2-1's • Increase in volunteering activity by 10% each quarter (14.5 hours in Quarter 2 2016)	MP CC CC & MP CC CC CC CC	BJ	December 2016 December 2016 March 2017 Ongoing Ongoing Ongoing Ongoing
Marketing, Communications and Engagement	To raise awareness of HWCD and increase membership and use of signposting service	• Recruitment and induction of Marketing & Communications Apprentice • Produce monthly e-newsletter and increase distribution by 10% (from 1288 Q2 2016) • Increase social media profile – 10% increase in Twitter followers	MP & GA GA & EB GA & EB	JW	December 2016 Ongoing Ongoing

		(1717 Q2 2016) & Webpage visits (1830 Q2 2016) • Refresh existing and produce new marketing materials • Identify new opportunities to raise awareness of HWCD • Up to date leaflets in every GP surgery and community pharmacy • Annual report	GA & EB EB CC / volunteers All		December 2016 Ongoing January 2017 May2017
Learning Disability Residential Care review	Durham County Council are reviewing Learning Disability residential care homes but only meeting staff and reviewing files. HWCD want to meet with service users to give them the opportunity to feedback on their care and share this with commissioners to improve services	• Meet with DCC commissioners to agree appropriate action plan, selection of homes and focus group topics • Produce standard questions to prompt conversations • Run focus groups and carry out 1-2-1 interviews with service users and family members at 8 care homes with the highest number of residents to increase reach (20% sample and 26 service users) • Report findings and recommendations to DCC • Review impact in 12 months	MP & DR DR DR & engagement leads DR DR	BH	October 2016 October 2016 January 2017 January 2017 January 2018

Uptake of health checks by people with Learning Disabilities	Refreshed Primary Care Strategy	• Standard questions to be produced and complement LD Residential Care review questions • Face to face consultation at Fulfilling Lives Events, drops in and focus groups (target of 100 service users to be engaged with via all media) • Online survey to be produced and promoted via social media, newsletter and partners • Young people to be engaged with via Investing in Children • Report findings and trends to CCGs and publish report	JC JC & DA JC & GA DA JC	BH	October 2016 October & November 2016 November & December 2016 November & December 2016 January 2017
Supporting STP consultations (including Better Health Programme)	Sustainability Transformation Plans	• Attend regional Healthwatch meetings about possible joint approach to Sustainability Transformation Plans (STPs) • Attend Better Health Programme Consultation Events and gather themes, trends and observations plus number and range of attendees • Report independent observations to BHP team on each event attended • Work with Clinical Commissioning Groups (CCGs) Engagement leads	MP All DA MP	ALL	Ongoing

		to support specific consultations e.g. Community Hubs as they develop			
Provision of professional signposting service	Patients, services users and their family members or carers need access to independent support, information and signposting	• Listen, advise and signpost everyone who contacts HWCD by phone, e-mail, post, social media and drop ins • Promote the service to increase uptake, aiming to increase number of service users by 10% (41 Q2 2016) • Record all queries and outcomes • Analyse data for trends and research possible need for Enter & View or further consultation • Produce reports	JR & DA GA & EB JC DR JC	JE	Ongoing Ongoing Quarterly Quarterly Quarterly
Supporting independent safeguarding client feedback process development	Safeguarding Adults Board (SAB) want HWCD's independent input into development of a client feedback process	• Chairs of Adult Safeguarding Board and HWCD to meet to discuss partnership working • HWCD to take part in partners planning day • HWCD involvement to be agreed	BJ MP & BJ BJ & MP	BJ	December 2016 November 2016 January 2017
Access to appropriate interpreting support for hearing impaired patients	Feedback from signposting callers and complaints to Independent Complaints Advocacy (ICA) has suggested that	• Work with partner organisations e.g. Durham Deafened Support (DDS) and Royal National Institute for the Deaf (RNID) to plan engagement activities such as focus groups	JC	JW	January 2017

	some hearing impaired patients are not receiving appropriate interpreting support at hospital appointments	• Produce standard questions for focus groups & survey • Produce online survey and promote via newsletter, social media and targeted approach to support groups (target to engage with 60 service users) • Deliver engagement activities • Produce report for NHS trusts	JC JC & EB JC JC		January 2017 January – March 2017 Jan – March 2017 April 2017
Consult with new recipients of care packages to get feedback on their care	Adult Social Care: opportunity to offer 300 new recipients of care packages per month the chance to give feedback on the quality of the care they receive	• Produce freepost feedback card with information about HWCD, ways to get in touch and standard questions • Distribute via inclusion in care packs for six month pilot • Collate responses and carry out follow up calls where indicated • Produce report for ASC • Evaluate effectiveness and decide whether to continue	DR DR DA & JC DR Board	MM	November 2016 Dec 2016 – May 2017 Ongoing May 2017
Uptake of oral health education, support and services by children and young people, their parents and carers	Public Health: Oral Health Strategy detailing wards in County Durham with some of the poorest oral health among children and young people in the country	• Meet with strategy lead for public health to ensure no duplication • Research provision in the county and areas of poorest oral health • Engage with partners e.g. Investing in Children (IiC) and Woodhouse Close youth teams to plan engagement activities	DR DR DA	MM	December 2016 December 2016 December 2016

		• Produce standard questions for online survey and focus groups • Promote survey via HWCD and partner networks • Deliver engagement activities (target to engage with 100 children, young people, parents / carers) • Collate evidence and produce report and recommendations	DA DA & EB DA & JC DA		 December 2016 January – March 2017 Jan – March 2017 April 2017
Barriers to health screening programmes	Refreshed Primary Care Strategy	• Research screening programmes which have poorest uptake in county • Plan appropriate engagement activities with partners in conjunction with survey • Collate data and produce report	DR JC & DA JC & DA	LM	April 2017 April 2017 April 2017

Future areas to consider:

Maternity services					

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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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