**Adults, Wellbeing and Health Overview and Scrutiny Committee**

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| **Date** | **Monday 5 March 2018** |
| **Time** | **9.30 am** |
| **Venue** | **Committee Room 2, County Hall, Durham** |

## Business

## Part A

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

1. Apologies
2. Substitute Members
3. Minutes of the meeting held on 19 January 2018 and of the joint Children and Young People's OSC and Adults, Wellbeing & Health OSC held on 5 February 2018 (Pages 3 - 18)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. Winter Pressures - Presentation by Sue Jacques, Chief Executive of County Durham and Darlington NHS Foundation Trust and Chair of the Local A&E Delivery Board
8. North East Ambulance Service NHS Foundation Trust - Quality Account, Performance and National Ambulance Response Standards Update - Report of Director of Transformation and Partnerships, Durham County Council and Presentation by Mark Cotton, Assistant Director of Communications and Engagement, NEAS (Pages 19 - 52)

9. Improved Access to Psychological Therapies Model Development - Report by Mike Brierley, Director of Corporate Programmes, Delivery and Operations, North Durham CCG (Pages 53 - 66)

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

**Helen Lynch**
Head of Legal and Democratic Services

County Hall
Durham
23 February 2018

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

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

Councillors A Bainbridge, R Bell, P Crathorne, R Crute, G Darkes, M Davinson, J Grant, E Huntington, C Kay, K Liddell, L Mavin, A Patterson, S Quinn, A Reed, A Savory, M Simmons, H Smith, L Taylor and O Temple

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

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

**DURHAM COUNTY COUNCIL**

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Friday 19 January 2018 at 9.30 am**

**Present:**

**Councillor J Robinson (Chairman)**

**Members of the Committee:**
Councillors R Bell, G Darkes, M Davinson, J Grant, L Mavin, A Patterson, S Quinn, A Reed, A Savory, M Simmons, L Taylor and O Temple

**Co-opted Members:**
Mrs R Hassoon

## 1 Apologies

Apologies for absence were received from Councillors J Chaplow, A Bainbridge, P Crathorne, R Crute, E Huntington, C Kay, K Liddell, H Smith and Mrs B Carr

## 2 Substitute Members

There were no substitute Members.

## 3 Minutes

The Minutes of the meeting held on 9 November 2017 and of the special meeting held on 28 November 2017 were agreed and signed by the Chairman as a correct record.

With regard to minute no. 8 on page 10 regarding DDES CCG's review of Urgent Care Services, Councillor Patterson said that she had also requested that the consultation was open and transparent and that it involved the local elected members. She made reference to the request for further information on the demographical breakdown of patients accessing both the extended GP hubs and the MIU set up as part of the urgent care consultation and asked that this be progressed.

The Principal Overview and Scrutiny Officer reported that in relation to minute no. 6 on pages 8 – 9 about the car parking at Peterlee hospital, the Committee had wrote to the Foundation Trust about the removal of car parking fees. The response was received and circulated to members on 18 December 2018, and acknowledged the concerns. However, the Trust had indicated that they would not rescind the decision but would re-affirm their commitment to tackle car parking concerns with local members.

## 4 Declarations of Interest

There were no declarations of interest.

## 5 Media Issues

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

- **Campaigners prepare to take legal action in fight for South Tyneside Hospital – Evening Chronicle 12 December 2017**

Campaigners were preparing to mount a legal challenge in their fight for the future of South Tyneside Hospital. The Save South Tyneside Hospital campaign group was crowdfunding for a judicial review into proposed cuts to urgent and emergency paediatrics, stroke services and maternity and gynaecology. A spokesman for the group, said the decision to temporarily close the hospital's special care baby unit (SCBU) had made the campaign even more urgent.

- **NHS workforce 'at crunch point' – BBC Website – 19 December 2017**

The UK's medical profession was at a "crunch point", facing the prospect of too few doctors to treat rising numbers of patients, the regulator says.
The General Medical Council said that the supply of medics had failed to keep up with demand and warned against the over-reliance on overseas staff post-Brexit. The GMC's Charlie Massey called it a "crucial moment" for UK healthcare. It came despite government promises in England to increase the number of doctors in training. The annual report by the GMC highlights four areas of concern:

- Supply of new doctors into the UK has not kept up with demand
- A dependence on non-UK qualified doctors in some specialist areas
- The risk of some overseas doctors being put off working in the UK after Brexit
- An ongoing strain on doctors in training

- **GP admits to being under severe pressure to care for patients as NHS winter crisis bites – Evening Chronicle 4 January 2018**

NHS services were under immense pressure as they struggled to cope with the surge in patients, health chiefs say. The NHS was reeling as a GP admitted to being under the most intense strain to care for patients in almost two decades.
Hospitals' inability to cope with the demand for care had left tens of thousands of patients across the country having their pre-planned operations or routine outpatient appointments delayed.

- **GP referral scheme extended for further year in north Durham – Northern Echo 17 January 2018**

An NHS scheme using private companies to assess GP referrals for specialist treatment was set to be extended by a further 12 months following an assessment which found it has saved almost £1m.
North Durham Clinical Commissioning Group (CCG) had extended its pilot project following an assessment of its Rapid Specialist Opinion (RSO) scheme, which saw GP referrals assessed by a private company called About Health before patients were given further appointments for specialist treatment.
It followed a 12-month assessment of the pilot, which was due to end in March, which the CCG says did not identify any significant adverse clinical outcomes, while there had been a 13 per cent reduction in the number of inappropriate referrals.

## 6 Any Items from Co-opted Members or Interested Parties

There were no items.

## 7 South Tyneside and Sunderland NHS Partnership Path to Excellence Consultation Feedback

The Committee received a report of the Director of Transformation and Partnerships that provided information in respect of the results of the Path to Excellence consultation undertaken by South Tyneside and Sunderland Partnership (for copy see file of Minutes).

Caroline Latta and Patrick Garner of South Tyneside and Sunderland NHS Partnership gave a detailed presentation highlighting the following:-

- Consultation analysis – quantitative and qualitative
- Consultation options
- Stroke Services –
  - Overall Options Preference
  - Qualitative Analysis
- Maternity and Women's Healthcare Services –
  - Overall Options Preference
  - Qualitative Analysis
- Children and Young People's Healthcare Services –
  - Overall Options Preference
  - Qualitative Analysis
- Overall concerns – focus groups
- Staff question and answer sessions

Members were given a summary of the preferred options for each service and the alternative solutions proposed.

Councillor Darkes referred to the stroke services and asked if plans had been put in to address and mitigate the transport requirements. Patrick Garner explained that this applied to all services and conversations had taken place with NEAS and the CCGs about what they would need to mitigate extra travel. NEAS felt that they would need more capacity. With regards to the stroke services all patients from the South Tyneside area had been using Sunderland since the temporary change was introduced in 2016. This had allowed more timely interventions and quicker access to the stroke unit with good outcomes as a result of that.

Councillor Patterson asked who had decided on the three options out for consultation to the public. She believed that this led the public into choosing the option that least affected them. Caroline Latta said that there was not a 'how to' guide on how to conduct a consultation. The NHS had clear statutes and was included in the constitution. She advised that a lot of work took place on developing the options by talking to patients and staff either by a survey or face to face contacts. There was a pre-consultation report that included all of this documentation and clearly evidenced how the clinical design teams

used it. With regards to the options available Ms Latta explained that they were designed to improve quality and safety for services.

Councillor Bell commented that NEAS were having difficulties responding now and asked if they had given a formal response to the options put forward. Mr Garner confirmed that they had responded formally and assured the Committee that they had been involved in conversations since 2016. They had been provided with data to enable them to carry out their own assessments.

The Chairman added that the whole of the North of England were concerned about NEAS without the added pressure from CCGS. He asked that transport would be addressed for all areas of concern. Ms Latta advised that the Travel and Transport Working Group, as part of the delivery of the five year forward view, would address these concerns.

Referring to the consultation, Councillor Grant asked how much influence the exercise has and did feedback show if people felt they had a voice or if decisions had already been made. Ms Latta explained that was why they carried out qualitative and quantitative analysis. People were asked to weigh up the issues and put forward any solutions. For those people wanting the status quo this was an ongoing dilemma as if things did not change people could be harmed. Mr Garner added that the consultation was a good way of influencing decisions as for example, comments about the 8am-8pm service for paediatrics reported that this would not cater for all needs and it had therefore been decided to change to times to 8am-10pm.

Referring back to the stroke services, Councillor Darkes suggested that any cost savings be used to back up transport issues for this area and would therefore back up any weaknesses that the service might encounter.

Councillor Davinson asked if there was a summary document available and pointed out duplicate information on pages 134 and 135 of the report, and asked that these pages could have the same format. Ms Latta said that the Committee needed to have sight the full document. The document was published for a month from 10 December 2017 with comments received. A short video had also been produced and the report had been presented to staff.

The Chairman said that a lot of residents from the east of the County used Sunderland hospital. He asked what affect this would have on them as numbers would increase with the addition of South Tyneside residents. Mr Garner explained that there had already been a temporary change in place for stroke services and capacity would not be a problem. Paediatrics had extra physical space and extra staffing and it would fit within capacity for Obstetrics and Gynaecology.

The Chairman thanked the officers for their detailed presentation.

**Resolved:**
That the report and presentation be noted.

## 8 North Durham Clinical Commissioning Group - Rapid Specialist Opinion service

The Committee received a report of the Director of Transformation and Partnerships that provided an update in respect of a clinical audit undertaken in respect of North Durham Clinical Commissioning Group's Rapid Specialist Opinion (RSO) service (for copy see file of Minutes). The Chairman advised members that notification of consideration of this item had been passed to Roberta Blackman-Woods M.P.

Mike Brierley, Director of Corporate Programmes, Delivery and Operations, North Durham CCG shared the findings of the clinical audit undertaken of the RSO process. Members were advised that the aim of the service was to provide the most appropriate treatment for a patient's condition and only affected the following services:- dermatology, ophthalmology, ENT, gastroenterology, cardiology, gynaecology. Members were advised that Dr John Nicholls had carried out the referral of audits working with seven practices, covering all three localities. There had been a regional procurement exercise carried out and interest shown from GP federations. Option 2 was preferred which would see the RSO continue for a further year.

Referring to table 6 of the report, Councillor Temple asked what the elective admissions were and was advised that they were planned admissions booked in. Councillor Temple was concerned about the effect on the long term system and the admission of failure to train referrers. He added that if unnecessary referrals were removed the result would be the same as the amount of elective referrals. Mr Brierley explained that people on waiting lists could be pulled down but that it was the hardest part to quantify. Councillor Temple went on to add that he was concerned at the lack of analysis of elective admissions versus the people put through. He asked if people removed from the system were adversely affected. Mr Brierley advised that the way of managing referrals did have a shelf life and the audit of the cross section of people referred back. If an RSO was not in place it was harder to quantify. Councillor Temple referred to the part of the report where it stated that there was no clinical disadvantage however he believed that the clinical audit represented half the number and did not feel that the report explained why the numbers were so different. Mr Brierley explained that it reflected the difference in undertaking the audit. He added that primary care was done as a matter of course. The RSO number of referrals was not done as a matter of routine. He said that it was difficult to undertake an audit in primary care. Councillor Temple believed that the report justified the actions rather than analysis. Mr Brierley commented that the report sought to understand the impact of an RSO and the impact of deliverability, to manage demands and re-invest back into primary care.

The Chairman agreed with Councillor Temple in that there was no evidence base and that the report did not give any assurances. Mr Brierley would speak to Dr Nicholls about providing more information.

Councillor Davinson agreed that further robust evidence was required.

Mr Chandy, DDES CCG explained that GPs could not use RSO if they felt that it would compromise the safety of a patient. If patients were wrongly denied treatment through an RSO then the practice would not sign up for it. He explained that not every referral result was an inpatient procedure and it was about balancing demand and supporting clinicians.

In noting the reduction in unnecessary referrals and the cost savings associated with this, the Committee felt that they would have expected to see more information within the audit report detailing how alternative treatment pathways had benefitted patients. It was suggested that further information be brought back to the Committee in 12 months time.

**Resolved:**
That the report be received and a further report be brought back to the Committee in 12 months time.

## 9 Decommissioning of Stroke Support Service by County Durham and Darlington CCGs - Update

The Committee received a report of the Director of Transformation and Partnerships that provided further information in respect to the proposed decommissioning of the stroke support service currently provided by the Stroke Association across County Durham and Darlington CCGs (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer informed members that this issue had been discussed as part of a media slide in April 2017 and further information was brought to committee in July 2017. An update was given in November 2017 that advised of an engagement exercise that had been undertaken.

Mr Brierley, North Durham CCG advised that this had been a positive outcome and good news story. Work with Healthwatch County Durham and their evaluation of service users and carers had been invaluable. He advised that the CCGs had looked to commission the Stroke Association to undertake six monthly reviews and assessments. One of the improvements had been to better share information with the right mechanisms and governance arrangements in place. Primary care would continue to support those patients who did not want to share their information. The service would be reviewed in 6 months and Mr Brierley agreed that an update would be provided to the committee in the next year.

Councillor Patterson pointed out that this was a good news story that was affected by the involvement of this committee. She referred to the governments select committee with regards to scrutiny and how we could make third party organisations more accountable to scrutiny. She asked that when services were commissioned that this was build in to any future contracts.

**Resolved:**
That the report be received.

## 10 Draft Pharmaceutical Needs Assessment 2018 Consultation

The Committee received a report of Director of Public Health, Durham County Council that presented the draft Pharmaceutical Needs Assessment (PNA) (for copy see file of Minutes).

The Director of Public Health advised that there was a statutory duty to produce a PNA every three years. The new PNA was out for public consultation until 26 January 2018

and would be approved by the Health and Wellbeing Board before publication on 1 April 2018.

The Public Health Pharmacist said that the PNA considered the health needs of the population and the provision of pharmaceutical services and a judgement would be made if there was sufficient services or potential gaps. The conclusion of the PNA said that there were sufficient services across County Durham. The Public Health Pharmacist thanked Healthwatch for their involvement with the survey and the number of good public responses received.

The Public Health Pharmacist added that the PNA was a live document that would be backed up by supplementary statements as and when changes in pharmacy services occurred. These changes would be kept under review by the Health and Wellbeing Board.

Councillor Bell referred to the cuts to pharmacy services and was advised that this was under the national Pharmacy contract from December 2016. On answering a further question from Councillor Bell, the Public Health Pharmacist explained that the government were responsible for the campaign about using your pharmacist for certain issues rather than your GP. She added that this campaign was welcomed from the pharmacists.

Referring to the draft PNA, Councillor Davinson informed the team that on page 74 the Middles Farm Village was in Craghead and not Stanley.
Councillor Darkes also commented that on page 74 of the PNA that the number of houses left to be built on land north of Durham Road, Middlestone Moor has increased from 300 to 336.

Councillor Temple was advised that the PNA looks at the quantity of services in an area and that NHS England were responsible for monitoring the quality and the offer of services.

The Chairman referred to the number of pharmacists that were not accessible by wheelchair and asked what was doing done by the Health and Wellbeing Board to address this. He also asked that when a pharmacy made any changes that affected a community could this be done in a more timely manner to ensure that what happened at the Weardale practice did not happen in future, as he was concerned at the short timescale that had been involved with this closure. He further asked about the STP cover from North Yorkshire and whether the strategy would fit into that.

The Public Health Pharmacist said that a recommendation would go to the Health and Wellbeing Board around wheelchair accessibility and they could take this issue up with the Local Pharmacy Committee. She also explained that generally with a closure notice would be given three months in advance but unfortunately, the Weardale practice closed very quickly to protect the safety of patients. The service were in regular contact with NHS England who would report matters of any changes as soon as they emerged.
Following on from this point, Councillor Patterson said that as two people had offered to take up the vacant posts at the Weardale practice she could not understand the reason to close was due to the lack of qualified staff. The Public Health Pharmacist explained that the GP had overall clinical responsibility for the dispensary and that it was the decision of the GP to close the service.

The Director of Public Health informed the Committee that the final STP report to Health and Wellbeing Board would invite leads from the Pharmacy Committee to advise on what could be offered. She added that colleagues from the CCGs would ensure that the offers fed into with STPs and were linked to the prevention workstream. The Health and Wellbeing Board would also feed into the appropriate workstreams.

Following a concern raised from Mrs Hassoon, the Public Health Pharmacist assured the Committee that all pharmacists should now have a confidential consultation room as this formed part of the national contract.

**Resolved:**
That comments on the draft Pharmaceutical Needs Assessment be noted.

## 11 Quarter Two 2017/18 Performance Management Report

The Committee considered a report of the Director of Transformation and Partnerships that presented progress against the Council's corporate performance framework for the Altogether Healthier priority theme for the second quarter of the 2017/18 financial year (for copy of report, see file of minutes).

The Corporate Scrutiny and Performance Manager presented the report and highlighted that smoking cessation continued to increase, adult social care and rehabilitation was improving, breastfeeding prevalence remained a challenge and mothers smoking at the time of delivery had also increased. There was no change in the figures for the delayed transfer of care, County Durham had higher than the national average number of suicides although there had been a reduction. Under 18 conceptions continued to reduce and a new provider for drug and alcohol treatment would be launched from February 2018.

**Resolved:**
That the report be received.

## 12 Adults and Health Services Quarter 2 Forecast of Revenue and Capital Outturn 2017/18

The Committee considered a report of the Head of Finance and Transactional Services, presented by the Finance Manager for Adults and Health Services, that provided details of the updated forecast outturn position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget, based on spending to the end of September 2017 (for copy of report and slides see file of Minutes).

Councillor Bell asked if there were any government plans for social care funding beyond 2020. He also asked if we were comfortable with the suppliers in relation to the increase in payments for care home providers. The Finance Manager advised that the opportunity to increase Council Tax by 6% had been implemented by DCC as 2% over three year period. The green paper was awaited and it was hoped to get further funding for social care and this would be responded to from a finance perspective. With regards to the care home providers, discussions were ongoing to ensure there was enough capacity in the market and that the offer was fair. This was still to be determined.

Mrs Hassoon commented that it was early days and she could foresee many changes. The Finance Manager added that there was an agenda to work closely with health colleagues and that they were working much more closely with the CCGs. There was also benefit in having a Director of Integration to ensure we all worked together with the same agenda.

On answering a question from Councillor Temple, the Finance Manager explained that the £13m increase for the improved better care fund was already set into the budget and that the transfer to services was due to the unitisation of the planning and performance team moving Children and Young People's Services and Transformation and Partnerships.

Members were concerned about the delay in figures being reported to scrutiny and asked if this could be speeded up. The Finance Manager explained that the quarterly reports come to scrutiny at the next appropriate meeting following Cabinet.

**Resolved:**
That the financial forecasts, summarised in the Quarter 2 forecast of outturn report to Cabinet in November 2017, be noted.

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**DURHAM COUNTY COUNCIL**

At a Joint Meeting of **Children and Young People's Overview and Scrutiny Committee and Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2, County Hall, Durham on **Monday 5 February 2018 at 9.30 am**

**Present:**

**Councillor C Potts (Chairman)**

**Members of the Children and Young People's Overview and Scrutiny Committee:**
Councillors H Smith, D Bell, P Brookes, J Charlton, J Considine, R Crute, C Hampson, I Jewell, A Reed, M Simmons and A Willis

**Members of the Adults, Wellbeing and Health Overview and Scrutiny Committee:**
Councillors J Grant and Mrs Hassoon

**Also Present:**
Councillors L Maddison and M McKeon

## 1 Apologies

Apologies for absence were received from Councillors J Blakey, G Darkes, K Hopper, L Kennedy, A Patterson, S Quinn, J Robinson, L Taylor, O Temple, M Wilson, Mrs B Carr, Mrs C Craig and Mrs C Johnston

## 2 Substitute Members

There were no substitute members.

## 3 Declarations of Interest

There were no declarations of interest.

## 4 Any items from Co-opted Members or Interested Parties

There were no items from co-opted members or interested parties.

## 5 Obesity in County Durham

The Committee received a report of the Director of Public Health that provided a contextual overview for the presentation that focused on obesity and the work of the County Durham Healthy Weight Alliance (for copy see file of Minutes).

The Chairman welcomed Karen McCabe, Kirsty Wilkinson, Jo Boyd and Liz Charles to the meeting who presented the following:-

- The aim and objectives of the Healthy Weight Alliance
    - The context of obesity and the costs and benefits of preventing it
    - The impact of the environment
    - The scale of the issue in County Durham
    - National and Local Drivers
    - The vision going forward – *'to halt the rise in obesity in County Durham by 2022 and by focusing resources upon addressing inequalities, see a sustained decline in obesity rates locally to below England national average by 2025'*

  Obesity was both a regional and a national issue, being overweight or obese in England in 2018 was the norm. The government states in their Childhood Obesity: a plan for action that the country spends more on obesity and diabetes than it does on police, fire service and judicial system combined.
  Obesity was more complex that food intake and energy used it was interlinked with many other factors such as deprivation.

- Sugar Smart campaign
    - For Durham
    - Why was sugar such a problem
    - Statistics about the amount of sugar consumed and how it affect us
    - Community Survey Findings
    - Focus – raising, reducing, challenging, supporting and working with
    - Sign up to website

  The presentation highlighted the fact that today's children were the first generation predicted to live shorter lives than their parents because of their diet and inactivity. Sugar Smart Durham was focusing on raising awareness of the sugar content in foods, reducing unhealthy food and drink offers in leisure centres, challenging the tuck shop and sweet treats culture, supporting schools and working with businesses and restaurants to do more to keep customers and staff healthy.

- Early Years
    - Delivery, supporting children
    - The plan and where we are now

  Members were advised of an early years tooth brushing scheme that was being targeted in Bishop Auckland and Peterlee areas which has support from dentists.

- Children and Young people
    - Working with schools to embed healthy eating, physical activity
    - Growing Healthy
    - Slow for 20 safer streets
    - Beat the streets
    - Active 30
    - FISCH
    - Childhood obesity pathway review

- HYPER – hearing young people's views on energy drinks
    - What we know about energy drinks
    - Resources available – leaflets and short films

It was highlighted that whilst carrying out research on energy drinks it was found that there was no information to educate young people and families on the dangers of energy drinks so work was undertaken to produce a leaflet.

- Adults and Workplaces –
    - catering & vending,
    - Better Health at Work award,
    - stepjockey
    - Sport England Bid,
    - Business Durham
    - Adults and the wider environment

- County Durham Community Foundation
    - Background
    - DCC Healthy Communities Fund 2018
    - Going Forward – long term goals

The Chairman thanked the officers for the detailed and informative presentation.

Councillor Brookes referred to the links with alcohol and the contributory factor of the calorie intake associated with it. He added that the problem with obesity was that people were too inactive and did not account for the amount calories they consumed. Karen McCabe agreed that a lot of alcoholic drinks were calorie laden and people did not think about the calories they contained.

With regards to the dental problem Councillor Charlton asked if there would be a programme whereby school children where shown and encouraged how to brush their teeth. Kirsty Wilkinson confirmed that this would be carried out.

Councillor McKeon was concerned that mental health had only been mentioned once and queried if there was enough focus on mental health and obesity. She referred to the anti-smoking campaign that had been really successful and suggested that there could be any lessons learnt from that. Ms McCabe said that they were looking at this and she agreed that when people were suffering with low mental health they could comfort eat and become addicted to food.

Councillor Crute referred to the prevalence of deprivation and the socio economic factor and asked if funding was a problem as it was based less on need. He was advised that Public Health would never have enough funding to take forward what needed to be done. The generalised funding pot would help tackle obesity in County Durham with a focus on delivering targeted work. Ms McCabe added that it was important to work together, across the years, in schools, with oral health, to connect everything and make a difference.

With reference to smoking and tobacco health problems, Councillor Jewell asked if legislation could also be used in this context to combat the problem of obesity. He was also concerned that potentially solving the problem of obesity could have a knock on effect. Ms McCabe said that legislation was a driving force to combat tobacco and took years to put into place. It was also directed at a certain group of people whereas there could be no direct legislation for obesity as everyone was affected by food. Instead, there was a childhood obesity plan and products targeted at children and young people had to

reduce sugar. By 2020 the government wanted products to be re-formulated to contain less sugar. Ms McCabe went on to say that there were a number of complex factors about obesity, such as the environmental factors and the range of choices people had to make. People generally know about whether the choices they made were healthy and it was about putting that into practice. Councillor Jewell went on to say that there could become a problem with eating disorders if people took advice about obesity to another level. Ms McCabe that that this issue was being discussed at a regional level as it had been reported that some young people went on to have eating disorders. Further clinical information had been requested as a number of factors could have been responsible that made the young person vulnerable.

Mrs Hassoon asked if there would be hubs to support people in a detox environment who craved sugar, as it was an addiction. Jo Boyd confirmed that there was work ongoing to support people.

Councillor Maddison asked what was being done to tackle to food and drinks offered at cinemas, concerts and the fact that there were no warning signs up at these places to make people think about what they were consuming. Ms McCabe said that this was a very valid point and she advised that Sugar Smart were talking to these venues and retailers about looking at different options. The driver from government was to tackle this in public buildings and there was an opportunity to take this forward into the business sector. The Alliance were working with Business Durham and smaller businesses and it was about nudging what was available and what was acceptable. She added that businesses were becoming smarter and were looking at healthy options but that these changes would not happen overnight. Ms McCabe went on to add that a piece of joint work with the Planning Team was taking place looking at take aways and supporting policies in the County Durham Plan.

Referring to the Children and Young People's work, the Chairman commented that the Beat the Streets project had worked really well with positive feedback, with older people joining in.

Councillor Jewell suggested that this presentation be shared with other departments as he found it difficult when dealing with assets and planning teams at times. Recently he had been trying to organise exercise facilities within a local park and felt that departments would benefit from the knowledge gained today.

Councillor Smith said that the initiative to train staff offering childcare facilities was excellent but was concerned about training for parents and carers. She often found that parents could be defensive when help was offered about their child. Ms Wilkinson explained that nurseries work directly with families and developed menus with them, which could be used at nursery and at home. Family taster days were also arranged and work also took place directly with health visitors.
Ms McCabe added that Wellbeing for Life through the Public Health team were keen to promote trying new things and had arranged discussion and focus groups with parents. Alcohol would often be discussed at these events and the empty calories that it contains. Families were encouraged to participate in a range of activities. She did agree with Councillor Smith's point about parents often feeling defensive as they thought their parental skills were being questioned.

With regards to physical education, Councillor McKeon commented that there were many competitive activities taking place in schools and she asked what was being done to encourage schools to bring in non competitive elements. She was concerned that any interventions by the teachers and professionals in a school environment were carried out at the right time and in the right way. Ms McCabe explained that they were going into schools to develop healthy eating and physical activity at a level where everyone could take part. She agreed that there needed to be a shift in the culture and how we perceived things. She said that there also activities such as Beat the Streets that encouraged people to walk that could be carried out at all levels of fitness. The team were conscious that they should be taking activities rather than a sports programme forward.

Councillor Brookes said that the real cause of the problem was in the level of inactivity and that we should all be encouraging parents to walk to school and let our children be active. Ms McCabe added that it was about changing the social norms and did understand that often parents had to deal with a time factor if travelling to work and dropping the children off en route. She agreed that we all need to look at food, drink, exercise and whether streets were safe in terms of traffic and crime, and therefore a whole systems approach was required.

Councillor Charlton commented that a lot of parents would not let their children play on open space because the amount of dog waste. She went on to ask if the team would help local councillors to deliver a message in schools about the importance of dental health in their areas, with councillors funding being made available to help support this. Ms McCabe said that it was a three year programme that would be delivered to all children.

Further to a question from Councillor Jewell about sandwich shops and the dressings used being a contributory factor to obesity, Ms McCabe explained that it was a problem together with options for meal deals that some shops offer. Discussions were taking place with businesses about nudging at the norm and offering water and fruit as part of a deal rather than just the usual crisps and fizzy pop.

Councillor Reed asked what was required from local members in order to promote this piece of work. Ms McCabe said that she would like everyone to help raise the profile, let people know what work was going on, lobby, support us, help open doors for us and keep obesity as a topic for discussion.

**Resolved:**

(i) That the report and presentation be received.

(ii) That the Committee continue to provide commitment and support to the ongoing work to address obesity.

(iii) That an update would be brought back to Committee in the next year.

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**Adults Wellbeing and Health Overview and Scrutiny**

**5 March 2018**

# NEAS Ambulance Response Standards and Quality Account progress update

## Report of Lorraine O'Donnell, Director of Transformation and Partnerships

### Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with supporting information to accompany a presentation by North East Ambulance Service NHS Foundation Trust setting out the new Ambulance Response Standards and progress made against their Quality Accounts' priorities for 2017/18.

### Background

2 At its meeting held on 7 July 2017, the Adults, Wellbeing and Health Overview and Scrutiny Committee endorsed responses to Draft Quality Accounts for 2016/17 from:-

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

3 As part of each response, the Adults Wellbeing and Health Overview and Scrutiny Committee requested that a six monthly progress report be given by each NHS Trust in respect of delivery of 2017/18 priorities and performance targets.

4 At a special meeting of the Adults Wellbeing and Health Overview and Scrutiny Committee held on 28 November 2017, updates were provided by County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust. North East Ambulance Service tendered apologies for the meeting but gave a commitment to report progress at a future meeting.

5 The Committee also considered a post implementation update report by DDES CCG in respect of their Accident and Emergency Ambulance Service Review. As part of the presentation made at that meeting, members were provided with the latest ambulance response performance information by North East Ambulance Service NHS Foundation Trust together with information in respect of the National Ambulance Response Programme.

6 At that time, NEAS advised members of the new ambulance response performance standards which were to be implemented on 30 October 2017 and which set out a new set of standards to be applied to every 999 patient.

7 Members were informed that the new standards would require NEAS to undertake some modelling work to enable it to better understand what changes to requirements may need to be considered to working practices, staffing, estates and fleet arising from the new standards.

8 It was also highlighted that formal performance monitoring by regulators was expected to commence from April 2018.

**Ambulance Response Standards**

9 As indicated, North East Ambulance Service has been operating under the new ambulance response standards from 30 October 2017 and representatives from NEAS will provide a presentation which will set out the latest position across November 2017 – January 2018 in respect of these new standards.

**NHS Quality Accounts 2016/17 – Updates against 2017/18 priorities**

10 Set against the context of ongoing engagement between NHS Foundation Trust partners and the Adults Wellbeing and Health Overview and Scrutiny Committee in respect of Quality Accounts, the presentation by North East Ambulance NHS Foundation Trust will also set out progress made against their Quality Accounts' priorities for 2017/18.

11 During consideration of the presentations members may wish to give consideration to:-

- How NHS Trust partners are delivering against the Quality Accounts priorities for 2017/18?
- How do those Quality Accounts priorities for 2017/18 meet the Commissioning priorities of the Clinical Commissioning Groups and are services being provided which address those CCG priorities?
- The views of County Durham Healthwatch and any other sources of independent information regarding service provision.

**Recommendation**

12 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are asked to receive the report and provide comment on the presentation given by North East Ambulance Service NHS Foundation Trust.

**Background Papers**

NHS Quality Accounts Report to Adults Wellbeing and Health Overview and Scrutiny Committee – 7 July 2017

North East Ambulance Service Draft Quality Account 2016/17

**Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer Tel: 03000 268140**
**E-mail : stephen.gwillym@durham.gov.uk**

## Appendix 1: Implications

**Finance –** None.

**Staffing -** None

**Equality and Diversity -** None

**Accommodation –** None.

**Crime and Disorder –** None.

**Human Rights –** None

**Consultation –** None.

**Procurement –** None

**Disability Discrimination Act –** None

**Legal Implications –** None.

North East Ambulance Service NHS
NHS Foundation Trust

# Ambulance Response Standards

**Mark Cotton**

**Assistant Director of Communications**

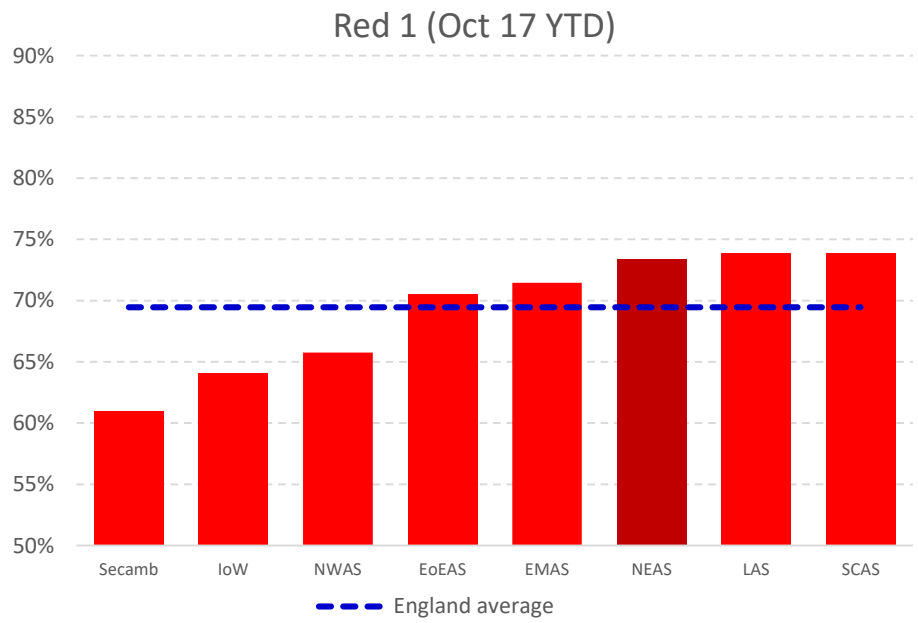
# Response time standards up to 30th October 2017

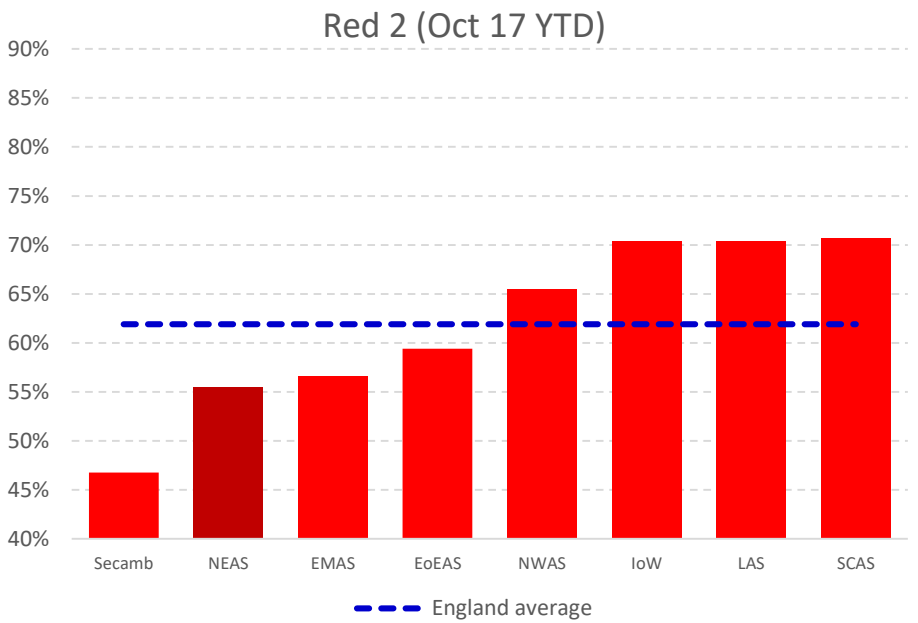


| Call Type | Call definition | Response time | |
|---|---|---|---|
| Red 1 | Time-critical life-threatening call | 8 minutes in 75% of cases | 19 minutes in 95% of cases |
| Red 2 | Time-critical life-threatening call | 8 minutes in 75% of cases | 19 minutes in 95% of cases |
| Green 1 | Serious clinical need | No standard | Aim to respond in 20 mins to any case |
| Green 2 | Less serious clinical need | No standard | Aim to respond in 30 mins to any case |
| Green 3 | Not an emergency | No standard | Aim to respond in 60 mins to any case |
| Green 4 | Not an emergency | No standard | Telephone assessment and referral |

# National Benchmarking – Pre ARP

## October 2017 Year to Date Red Performance



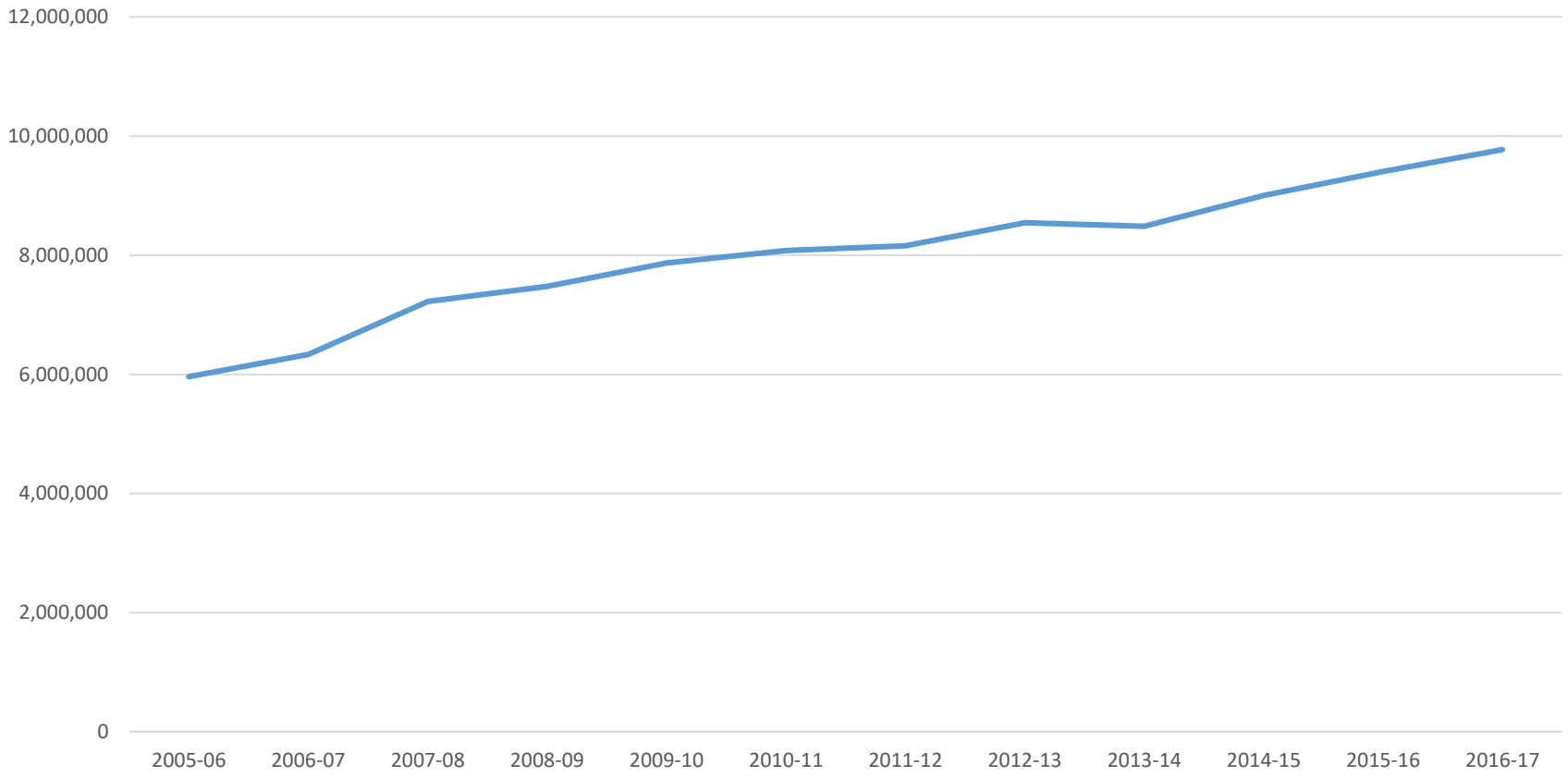




Data Source: NHS England, Ambulance Quality Indicators
National submissions exclude data from South West Ambulance Service, West Midlands Ambulance Service and Yorkshire Ambulance Service for the full year and East Midlands Ambulance Service and North West Ambulance Service as of August 2017 following implementation of ARP

# Ambulance call volumes

## 2005/06 to 2016/17





# Ambulance performance standards

*Professor Keith Willett, NHS England's Medical Director for Acute Care*

"Paramedics are rightly frustrated that under the current 'stop the clock' system they are frequently dispatched to simply hit targets.

"This has led to the inefficient use of ambulances, with the knock-on effect of 'hidden waits'.

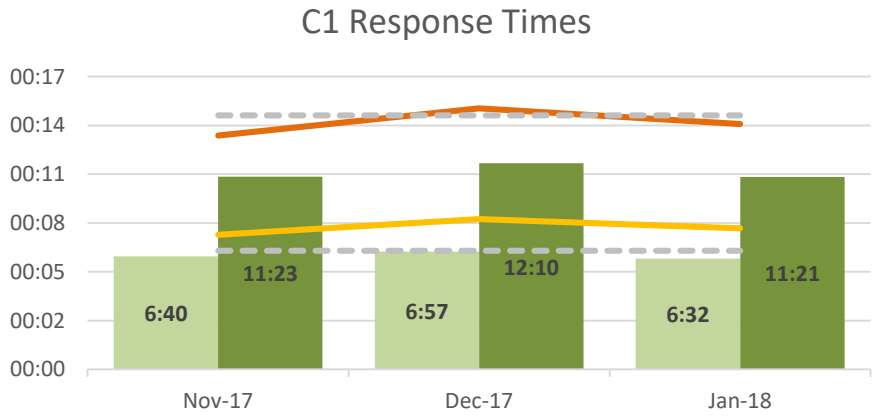
"This is about ***updating a decade old system*** to respond to modern needs. In most 999 calls we know the best clinical outcome for patients is ***most appropriate response,*** not the fastest response

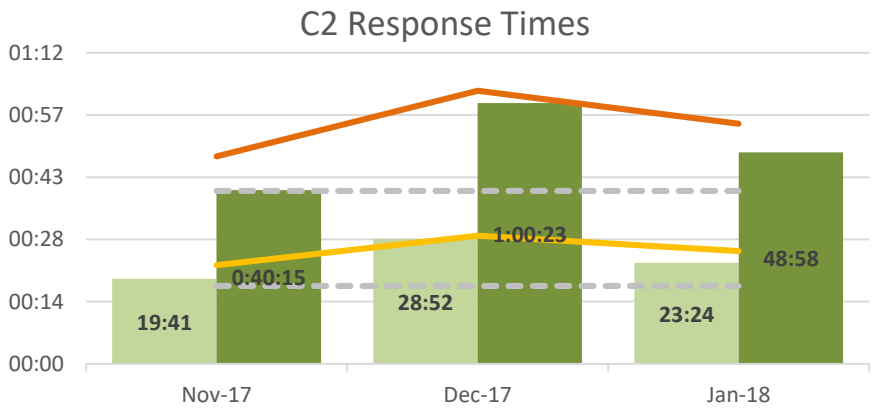
# Ambulance Standards

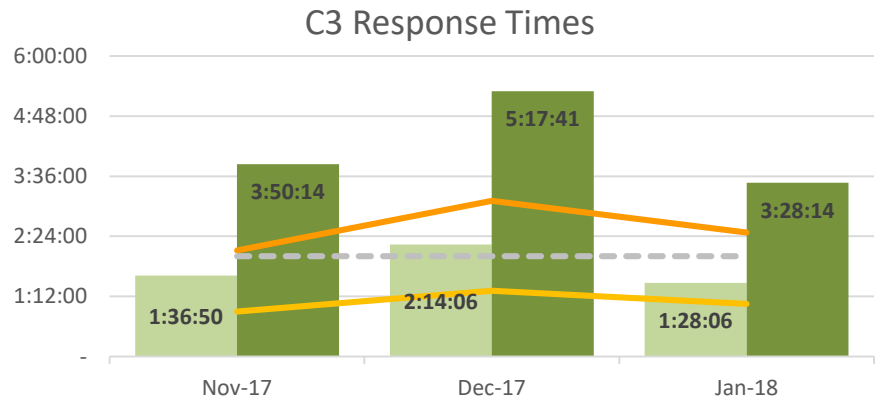


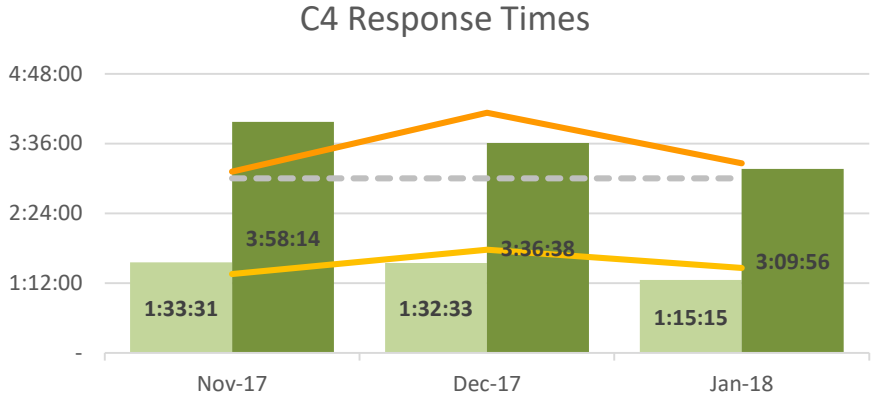
| Call type | Call definition | Average response time (100% of all cases) | 90% response time |
|---|---|---|---|
| Category 1 | Time-critical life-threatening event | 7 minutes | 15 minutes |
| Category 2 | Potentially serious conditions | 18 minutes | 40 minutes |
| Category 3 | Urgent problems not immediately life-threatening | | 120 minutes |
| Category 4 | Non-urgent; needs telephone or face-to-face assessment | | 180 minutes |
| Specialist response | Hazardous area, specialist rescue, mass casualty. | | |

# Ambulance Response Programme



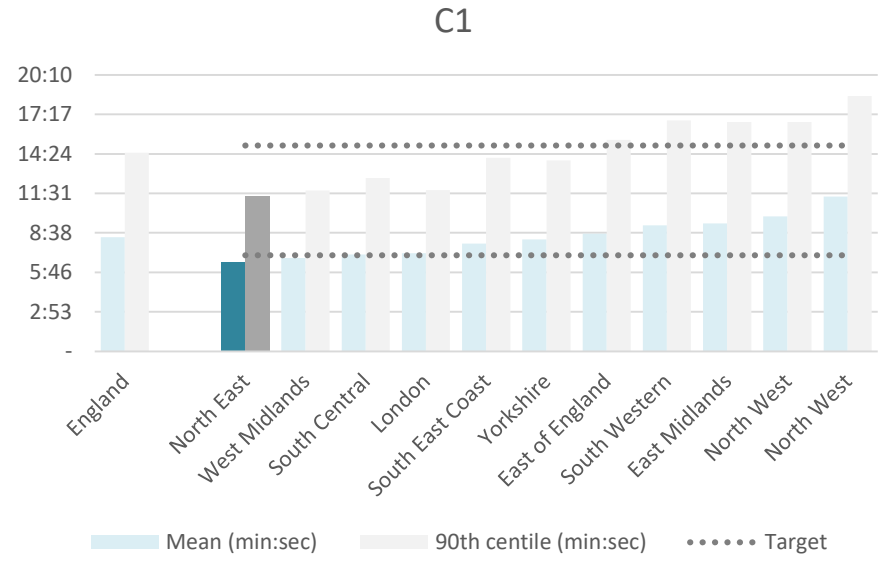



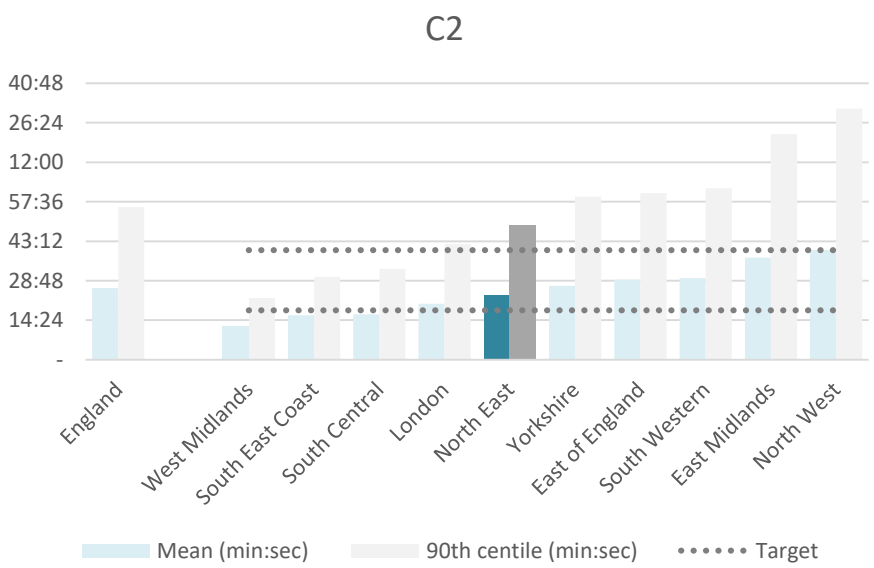

NEAS Mean | NEAS 90th Centile | England Average Mean | England Average 90th Centile | National Standard

# ARP Categories 1 and 2



## January 2018 Benchmark



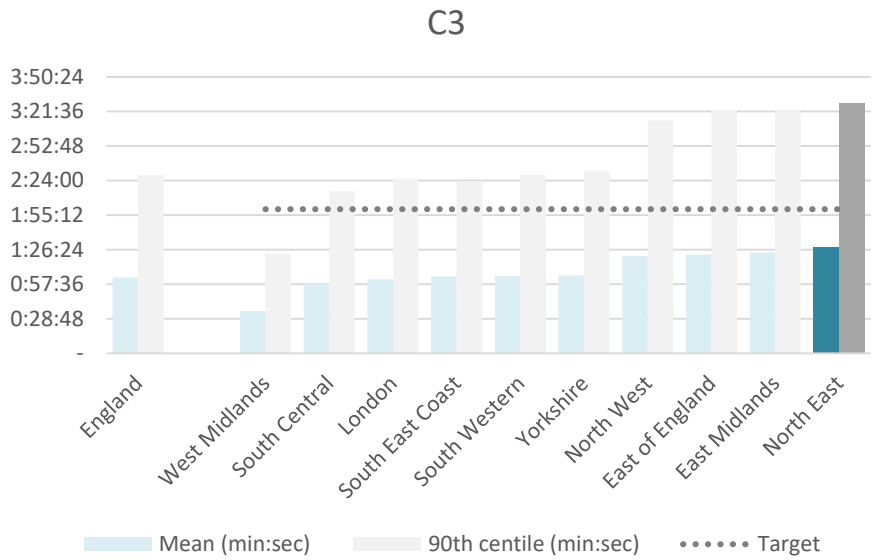



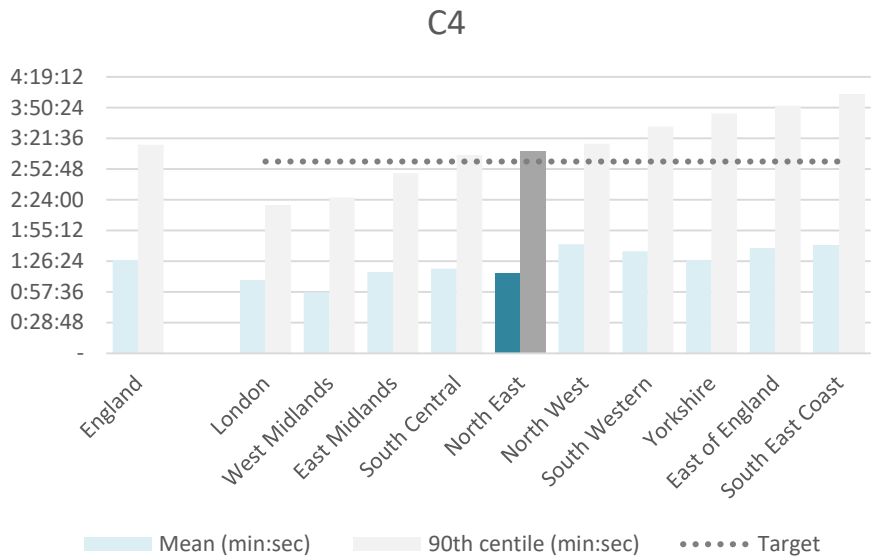

NEAS has been the best performing Ambulance Trust for Category 1 incidents since we implemented the new system, consistently achieving both mean and 90th centile targets.

Category 2 targets have not been achieved, however our performance is better than the national average, with only 3 Trusts nationally achieving the standard.

# ARP Categories 3 and 4

## January 2018 Benchmark




Category 3 incidents remains our biggest challenge, with all but one Trust nationally not meeting the standard.

Category 4 performance continues to improve month on month, only narrowly missing the target for January 2018. NEAS performance continues to perform better than the national average.

North East Ambulance Service NHS
NHS Foundation Trust

ForLife

# Quality Priorities 2017/18

**Debra Stephen,**
**Deputy Director of Quality & Safety**

# Quality Priorities

## Current position

- We have 4 quality priorities identified with the aim of improving patient safety, patient experience and clinical effectiveness
- We are required to report on progress of each quality priority in the Quality Report 17/18, which is included in the Quality Accounts
- We welcome feedback on quality priorities for 18/19

# Priority 1: Early recognition of sepsis



## Why sepsis?

- Sepsis is a life-threatening condition which can occur as part of the body's response to infection. It was estimated in 2016 that there are around 150,000 cases of sepsis every year resulting in 44,000 deaths, claiming more lives than bowel, breast and prostate cancer combined. The ambulance service can play a key role in improving outcomes for patients with sepsis through accurate, early identification and appropriate treatment.

# Priority 1 – Early Recognition of Sepsis

## On Track to achieve ☑

| | Latest reported position | Target |
|---|---|---|
| % eligible staff trained (Dec 17) | 81.6% | 95% |
| % compliance with Sepsis Care Bundle (Dec 17) | 61% | 40% |

- Additional communication with crews has been undertaken
- Continued engagement through regional network

# Priority 1 – Early Recognition of Sepsis



We want to do more…!

- Develop a paediatric sepsis recognition tool
- Develop a maternity sepsis recognition tool
- Determine the sensitivity and specificity of the adult sepsis recognition tool
- Look at how well we use the national early warning score
- Take part in the national sepsis audit

# Priority 2: Cardiac arrest

## Why this?

- It is well known that survival for patients experiencing a cardiac arrest is dependent on their receiving treatment within a very short time frame. Early recognition and access to treatment, early cardiopulmonary resuscitation (CPR) and early defibrillation are all key to survival. The ambulance service plays a key part in the chain of survival through the timeliness and quality of interventions provided.

# Priority 2: Cardiac arrest



## What are we doing?

- Review the Resuscitation Academy's '10 steps' and develop an action plan to improve outcomes for patients.
- Embed the use of new technology which provides live feedback on the quality of CPR delivered.
- Further develop cardiac arrest data set to identify training needs.
- Develop and implement resuscitation checklists to support clinicians when managing cardiac arrest.

# Priority 2 – Cardiac Arrest

## Partially On Track to achieve

- Dec 2015 – November 2016 (baseline) there were 304 successful Return of Spontaneous Circulation (ROSC)
- Dec 2016 – August 2017 there were 394 successful ROSC
- On average an additional 10 successful ROSC's every month has been achieved

The volume of successful ROSC/ROSC Utstein has increased significantly, however the volume of attempted ROSC/ROSC Utstein has also increased leading to challenges in meeting the proportional target.

# Priority 2: Cardiac arrest



We want to do more….

- Implement a cardiac arrest strategy
- Audit the resuscitation checklists in place
- Roll out Zoll defibrillators further – with real time feedback on effective cardiac compressions
- Evaluate the ‘10 steps’ action plan
- Strengthen the mortality review process for cardiac arrest deaths whilst the patient is under our care

# Priority 3: Long waits

## Why this?

- Over the last 18 months all ambulance services have seen a deterioration in national response times resulting from increasing demand, staffing pressures, increased travel times and waits resulting from increased pressure across the health system. While we are working hard to recover our performance targets we also know that there are patients who are waiting an unacceptable length of time for an ambulance response.

# Priority 3: Long waits



## What are we doing?

- Develop an escalation plan which highlights those patients experiencing waits and ensure these are passed to the clinical hub for review - **completed**
- A pilot will be carried out to improve clinician input into the allocation of vehicles to support the efficient use of resources available and further enhance our Integrated Care and Transport delivery – **completed**
- Regular audit of ambulance waits to determine whether the patient came to any harm as a result – **clinical reviews undertaken**
- Develop and implement improvement actions based on the audit findings - **ongoing**

# Priority 3 – Long Waits

## Partially On Track to achieve

| | Review of Harm | Latest reported position (YTD 29 Oct 17) | 2016/17 Baseline |
|---|---|---|---|
| Red waits over an hour | 10 Near Misses | 151 | 50 |
| Green waits over 8 hours | 1 Near Miss | 94 | 105 |
| Urgent waits over 12 hours | | 78 | 166 |

# Priority 3: Long waits



We want to do more….

- Enhance the use of real time performance feedback in EOC through use of a dashboard, pulling a range of information together
- Review the process for managing patients who fall and experience long delays
- Implement the CARE platform to provide feedback to paramedics regarding their contribution to providing timely responses for patients
- Refine our process to review delays in order to maintain patient safety / improve patient experience, through triangulation with complaint & incident / SI reporting

# Priority 4: Safeguarding referrals

## Why this?

- Submitting appropriate and complete safeguarding referrals is key to ensuring that vulnerable individuals receive the care and support that is needed in an effective and efficient manner.
- Improving the quality of our safeguarding referrals will ensure that the right information is shared to deliver improved outcomes for our patients.

# Priority 4: Safeguarding referrals



## What are we doing?

- Regularly review sample of cases to identify improvements that can be made to the referrals submitted, and feedback shared with individuals – **partially achieved**
- Develop and implement safeguarding tool to support clinicians' decision making – **delayed**
- Develop and implement improvement actions based on the referral review findings - **ongoing**

# Priority 4 – Safeguarding Referrals

## Partially on track to achieve

| Safeguarding Audit Results | Latest reported position | Target Improvement against baseline |
|---|---|---|
| Appropriateness of referral | 100% | 100% |
| Accuracy of referral<br>Q3 accuracy (short audit) | 55%<br>85% | 60% |

Audit shows improvement in quality of referrals, with learning being fed back in to Statutory and Mandatory Training.
The CWILTED tool is soon to be included to ePCR to aid staff when completing referrals.

# Priority 4: Safeguarding Referrals



We want to do more….

- Enhance the audit process for Safeguarding Referrals, and act on findings
- Develop and deliver, in partnership with the Training school sessions on Mental Capacity Act and Mental Health Act and how it is applied in practice
- Develop a pool of safeguarding champions across the organisation
- Develop and implement a model of safeguarding supervision for the safeguarding champions

# Quality Strategy 2017 - 2020

To care, to see, to learn, to improve

| Patient Safety | Experience | Effectiveness |
|---|---|---|
| Sign up to Safety | Learning from complaints | Clinical Ambulance Quality Indicators |
| Improving recognition of sepsis | Longest waits | Cardiac arrest |
| Keeping vulnerable children, young people & adults safe | End of life care | Learning from deaths |
| Frailty | | National Audits & Confidential Enquiries |
| Infection prevention & control | | NICE Guidance & Quality Standards |
| Pressure ulcer prevention | | Research & Development |
| Medicines governance | | |

# Quality Priorities 2018/19



## Building on what we've achieved

- Continuing with the work on sepsis, cardiac arrest and delays, with a focus on patient who fall have received some initial support

- Other opportunities such as:
  - improving mental health pathways
  - improving end of life care
  - the frailty agenda i.e. falls, dementia & Emergency Health Care Plans

# Stakeholder feedback

## We welcome your views

- We are developing an online survey to gain feedback from internal and external stakeholders to assist in determining our 4 quality priorities for 2018/19
- We will circulate this on 23rd February – 19th March 2018.
- Please respond, thank you!


# www.neas.nhs.uk

/North East Ambulance Service

@NEAmbulance

**Adults Wellbeing and Health Overview & Scrutiny Committee**

**05 March 2018**

# Improving Access to Psychological Therapies Model Development

## Report of Mike Brierley, Director of Corporate Programmes, Delivery and Operations

### Purpose

1. The purpose of the report is to provide an update to the Adults Wellbeing and Health Overview and Scrutiny Committee on the current developments in relation to the proposed expansion of the Improving Access to Psychological Therapies Model, the national strategic direction of travel and planned engagement on the proposed expanded model.

### Background

2. The Improving Access to Psychological Therapies (IAPT) programme began nationally in 2008 to transform the treatment of adult anxiety disorders and depression in England. Over 900,000 people now access IAPT services each year.

3. In 2016, key developments were set out in the NHS England Five Year Forward View for Mental Health to expand and improve quality in IAPT services. The priorities were:

    - Expand IAPT from seeing a year to date average as at December 2017 of 15.5% of people with anxiety and depression each year across County Durham and Darlington and an average of 20% across Hartlepool, Stockton and South Tees to 25% overall and address the significant variation in access across the collaborative;
    - Integrate IAPT services with physical health services to provide better support to people with long term conditions (IAPT-LTC); and
    - Improve the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups.

4. The national guidance for implementing an IAPT-LTC service makes specific reference to the inclusion of people with Persistent Physical Symptoms (PPS - also known as Medically Unexplained Physical Symptoms – MUPS). It notes that two thirds of people with a long-term condition will also have a mental health problem, mostly depression and anxiety disorders. A further 70% of people with PPS will experience depression or an anxiety disorder.

5. PPS refers to a cohort of patient presentations that manifest as persistent physical symptoms but that do not have a readily identifiable medical cause, or are out of proportion to any underlying medical illness. The symptoms are nonetheless real to the patient and cause disability and distress (HM Government, 2011).There is also a strong association between medically unexplained symptoms and psychiatric disorder. Over 40% of patients with medically unexplained symptoms have anxiety and depression (Royal College of Psychiatrists & Academy of Medical Royal Colleges, 2009).

6. In April 2017, Hartlepool and Stockton-on-Tees (HaST) and Darlington Clinical Commissioning Groups established an IAPT Project Group to re-design, expand and re-procure an IAPT service across HaST and Darlington Clinical Commissioning Groups, in line with the Mental Health Five Year Forward View. In September 2017, North Durham and DDES Clinical Commissioning Groups' joined the IAPT Project Group to promote collaborative working across the region and reduce duplication in developing and implementing a new IAPT model.

7. Since September 2017, South Tees Clinical Commissioning Group has also been part of the IAPT Project Group and discussions. This Clinical Commissioning Group (CCG) agreed to join the collaborative re-procurement in November 2017, making a total of five CCG's.

8. A period of pre-engagement with service users has taken place across all five CCG's. Across North Durham, DDES and Darlington, this took place within a review of the existing IAPT service between 10th February 2017 to 10th March 2017. It is included service users and GP's. The CCG's Engagement Team Lead has confirmed that the pre-engagement undertaken was sufficient.

9. Pre-engagement within HaST and further engagement in Darlington took place from 24th July to 8th September 2017 and South Tees engaged from early September 2017 through to the end of October 2017.

10. There were a number of identifiable themes arising from the pre-engagement undertaken across the collaborative including suggested improvements to referral processes and timely access, flexibility and choice around support and treatment options, reduced waiting times, improved communication to support attendance at appointments and more responsive step up and step down processes between primary and secondary care, to flexibly manage complex needs.

11. During the commissioner review of IAPT across North Durham, DDES and Darlington, NHS England's Intensive Support Team (IST) offered to undertake their own review of the current IAPT Service and locally provided Practice Based Counselling Services. This was facilitated locally and in May 2017, the IST published their findings.

12. The IST advised Commissioners that workforce for the provision of counselling services are not trained to provide IAPT modalities and are not delivering evidence based treatments for anxiety and depression in line with national guidance.

13. In May 2017, several steps were taken, including the immediate ceasing of reporting counselling activity within the IAPT dataset and communications both to GP Practices and all Practice Based Counsellors (and Insight who provide Counselling in Darlington), to advise that with immediate effect all patients with a diagnosis of depression and/or anxiety must be referred, with their consent, for an IAPT Assessment and not referred directly to counselling services.

14. In addition to the pre-engagement activities outlined above with service users across the collaborative and GP's in North Durham, DDES and Darlington, the IAPT Project Group has also engaged with IAPT providers across all localities to understand what does/does not work well in the current IAPT service and what a future model should look like. Provider feedback promotes service improvement rather than a significant change for service users, and this feedback is also being used in development of the new model. Their feedback can be grouped into the same themes as for GP's and service user feedback.

15. Throughout November 2017, sessions took place across all collaborating CCG's which provided an opportunity to engage with GP's to set out the rationale for the development and expansion of the current IAPT service to include people with long-term conditions, and facilitate GP's to provide feedback on issues they would like considered within the model development at an early stage. Views are also being sought on the new IAPT-Long Term Conditions (IAPT-LTC) model, including proposed pathways, additional pathways that should be included within this model and the priority for order of introduction.

16. In addition to the fortnightly IAPT Project Group meetings, weekly sub-groups have been arranged to focus on developing the service model and the finance and contracting element of the project. The service model sub-group is made up of representatives from all CCG's to ensure feedback from all localities is considered when developing the model.

17. The five collaborative commissioners have considered whether any proposed changes to expand the current IAPT model would constitute a significant variation, and if so, to whether a public consultation would be required on those proposed changes. Although the future model for IAPT services is still in development, the IAPT Project Group/Collaborating CCG's do not foresee any significant change for service users in relation to being able to access the provision in a local setting. The expanded model will actively facilitate increased and improved access to IAPT services. Therefore formal consultation is not anticipated to be required.

18. The Tees Valley Overview and Scrutiny Committee were originally notified in November 2017 and received and update on project progress January 2018.

They were advised that formal consultation was not planned for this piece of work, and this recommendation was upheld.

## Current Provision

19. IAPT services in County Durham and Darlington are currently provided by the 'Talking Changes' Consortium, made up of three providers currently Tees, Esk and Wear Valley NHS FT (TEWV) (Lead Provider), County Durham and Darlington NHS FT (CDDFT) and Mental Health Matters (MHM). The aim of the service is to provide a comprehensive, patient centred Psychological Therapies Service in line with NICE guideline and clinical best practice for adults living within the County Durham and Darlington area.

20. Referrals come from GPs, TEWV mental health secondary care services and other health and social care sources as well as self-referrals.

21. The service is community based and offers a range of evidence-based psychological interventions at Step 2 (Low Intensity) and Step 3 (High Intensity), in line with NICE guidance, delivering approved/recommended psychological therapies that are associated with improved service user outcomes and recovery rates. Any person living in the County Durham and Darlington area aged 16 onwards can be referred. Under 16 years, adults with current psychosis, complex and severe mental health problems that present with risk and/or in need of care co-ordination are not suitable for the service.

22. The current Talking Changes Service Contract for NHS North Durham and NHS Durham Dales, Easington and Sedgefield is due to end on 31 March 2019. A small Medically Unexplained Symptoms service is currently commissioned as part of the Acute Psychiatry Liaison Service, provided by TEWV and provides for patients in Darlington, DDES and North Durham CCG's.

## Latest Position

23. The five collaborating CCG's across Durham and Tees have agreed that proposed future modelling to expand IAPT services will not present significant change, particularly for service users who will not see any change to their ongoing treatment. In the case of a new provider delivering the expanded service, patients in existing treatment at the time of transfer will not be asked to move providers and will be enabled to complete their programme of treatment.

24. The expanded IAPT model is proposed to include improvements to access for patients who do not meet IAPT criteria with a view to proactive management of prevention of escalation of symptoms. It is proposed that a wellbeing service offer is integrated within the IAPT-LTC model within Darlington, Hartlepool, Stockton and South Tees. At this stage, in North Durham and DDES CCG's the wellbeing offer will primarily ensure that appropriate links and timely referral pathways from the IAPT service are in place with existing commissioned services.

25. It is proposed that one Single Point of Access for managing referrals into IAPT is established across the collaborative. The model will include improved access to IAPT service for people with long-term conditions. The proposed model can be viewed on Page 12 of this report and is contained within a Stakeholder Briefing **(Appendix 2**).

26. The wellbeing offer will deliver interventions that are not IAPT specific (whether integrated or through timely onward referral). Access to these interventions through a referral into IAPT will still take place through an IAPT screening process to ensure that only appropriate referrals are progressed for wellbeing support and anyone who needs evidence based IAPT psychological interventions are provided with IAPT specific assessment and treatment options.

27. In North Durham and DDES, there will be potential opportunity to consolidate services in the future. In the meantime, the proposed approach will maintain stability while the IAPT-LTC service is mobilised and embedded. In the meantime, proposed variations to existing service specifications will facilitate smooth and timely access into existing wellbeing services and provide opportunity to develop and evidence base in relation to IAPT related wellbeing interventions to inform any future commissioning decisions.

28. The rationale for considering the above services within the whole IAPT offer is not to remove access to a specific intervention, but to ensure that people gain access to the most evidenced based and effective intervention at the earliest possible point.

**Project Timescales**

29. The Project Group is currently refining the proposed model, with both market and wider model engagement planned during March/April 2018. It is anticipated that the new model will be in place during February 2019.

**Engagement**

30. Within Darlington, Hartlepool, Stockton and South Tees, further engagement is currently being progressed with a view to seeking feedback on the proposed consolidation of wellbeing services within the future IAPT-LTC model. A Stakeholder Briefing including Proposed Model has been developed to facilitate a consistent message across the collaborative and engagement discussions **(Appendix 2)**.

31. Across the collaborative, proposed model engagement is planned during Spring 2018 with service users, the public, health and social care professionals including GP's and the voluntary and independent sector to invite their views on the proposed expanded model. Market engagement is also taking place to test out the proposed model and the ability and willingness of the market to deliver it. All engagement feedback will be considered and the proposed model revised as considered appropriate following receipt of this feedback. A

summary of the key themes of feedback received during pre-engagement can be found in **Appendix 3**.

32. The Overview and Scrutiny Committees will be kept informed on progress and feedback. Local Authority representatives including Public Health will be engaged in discussions in relation to the model and how the wellbeing offer will be appropriately provided.

**Equality and Diversity**

33. Any project undertaken on behalf of the CCGs is subject to compliance with S.149 of the Equality Act 2010 and measures are in place to ensure the public sector equality duty is met. An Equality Impact Assessment has been commenced and will be updated on receipt of further engagement feedback.

**Risks and Implications**

34. The IAPT Project Group will be responsible for the identification and mitigation of risk and maintain and manage an appropriate Risk Log.

35. There are risks associated with moving to an expanded model in respect of re-commissioning, mobilisation, recruitment and training of additional staff, maintenance of Core IAPT service whilst progressing the expansion of the model and overall ability of any successful provider to deliver. These risks are being mitigated through appropriate engagement both in terms of market and overall model development engagement.

**Recommendations**

36. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to:
    a. receive this report;
    b. note the required next steps and timescales;
    c. note the proposals for developing an expanded IAPT model across a collaborative CCG footprint;
    d. note the pre-engagement already undertaken, and planned further engagement on the proposed model during Spring 2018;
    e. uphold the view that a formal consultation process is not considered necessary to progress the development and re-procurement of the IAPT-LTC model;
    f. Provide any appropriate advice or guidance to support the continued work of the IAPT Project Group.

**Background Papers**

Appendix 2 - IAPT Model Development Stakeholder Briefing (Including Proposed Model)
Appendix 3 - Summary of Pre-Engagement Feedback

**Contact and Author: Anita Porter, Commissioning Delivery Manager, North of England Commissioning Support Unit, on behalf of North Durham, Darlington and DDES Clinical Commissioning Groups. Tel: 0191 374 2751**

## Appendix 1: Implications

**Finance –** The IAPT-LTC model will need to be delivered through re-configuration of existing resources. No new money is available.

**Staffing –** see Risks below.

**Risk –** There are risks of moving to an expanded model in respect of re-commissioning, mobilisation, recruitment and training of additional staff, maintenance of Core IAPT service whilst progressing the expansion of the model and overall ability of any successful provider to deliver. These risks are being mitigated through appropriate engagement both in terms of market and overall model development engagement.

**Equality and Diversity / Public Sector Equality Duty –** An Equality Impact Assessment has been commenced and will be updated on receipt of further engagement feedback.

**Accommodation -** None

**Crime and Disorder –** None

**Human Rights -** None

**Consultation –** The IAPT Project Group have advised that formal consultation is not considered to be necessary, however, proactive engagement has taken place and continues to take place in respect of the development of the expanded model.

**Procurement –** See risks above.

**Disability Issues** – An Equality Impact Assessment has been commenced and will be updated on receipt of further engagement feedback.

**Legal Implications** – None

**Appendix 2 – IAPT Model Development Stakeholder Briefing (Including Proposed Model)**

Clinical Commissioning Groups in
County Durham, Darlington and Tees

# Stakeholder Briefing:
# Improving Access to Psychological Therapies

## National Direction

Five health commissioners across Durham and Teesside are working together to re-commission an expanded Improving Access to Psychological Therapies (IAPT) across the region that is safe, equitable and supports people with long-term conditions to maintain good mental wellbeing. The expanded service will be in place by March 2019.

The Improving Access to Psychological Therapies (IAPT) programme began nationally in 2008 to transform the treatment of adult anxiety disorders and depression in England. Talking therapies are a proven, effective way of helping people with emotional and mental health problems like depression, anxiety and stress. They help work out how to deal with negative thoughts and feelings and make positive changes. The programme now aims to increase the number of people seen and treated from 900,000 in 2015 t0 1.5 million in 2021. An increase of 66% nationally. Two thirds of the expansion will focus on people with long-term conditions including medically unexplained symptoms.

IAPT services are required to provide evidence based psychological therapies that are approved by the National Institute for Health and Care Excellence (NICE). Note that this does not include general counselling.

## Current Services

The current service for Hartlepool and Stockton-on-Tees and South Tees is provided through an Any Qualified Provider (AQP) model. This means that individuals have a choice about who delivers their IAPT care. Referrals into the service are made by GPs, Tees Esk and Wear Valleys NHS Foundation Trust, secondary healthcare services and through other health and social care sources. However, the majority of people using the services choose to self-refer and are being encouraged to do so through their GP.

In County Durham and Darlington, IAPT is currently provided by Talking Changes, a joint venture consortium. Separately commissioned general counselling services are also currently available within GP Practices but they do not provide IAPT interventions. A small Medically Unexplained Symptoms service is also available.

## What Needs to Change and Why

IAPT services need to change because the Five Year Forward View for Mental Health, by 20/21, expects health commissioners to:

- Expand IAPT from seeing a year to date average as at December 2017 of 15.5% of people with anxiety and depression each year across County Durham and

Darlington and an average of 20% across Hartlepool, Stockton and South Tees to 25% overall and address the significant variation in access across the collaborative;
- Integrate IAPT services with physical health services to provide better support to people with long term conditions and distressing and persistent medically unexplained symptoms
- Improve the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups

People with depression and/or anxiety disorders who also have a long-term condition, for example, a respiratory condition, diabetes, chronic pain or medically unexplained symptoms, already access IAPT services but are under-represented.

Treating mental health needs reduces physical health care costs by around 20%[1] and the best outcomes for patients are achieved with adapted treatments that take into account long-term conditions and are embedded into care pathways[2]

Commissioners also need to take into account The GP Five Year Forward View with investment in an extra 3,000 mental health therapists to work in primary care by 2020, which is an average of a full time therapist for every 2-3 typical sized GP practices. It is anticipated that these therapists will come from existing IAPT services.

No additional funding is available to expand the current IAPT model to meet the requirements set out in the Five Year Forward View for Mental Health therefore CCG's need to look at what they can commission differently.

Commissioning differently means using funding from some services that do not provide IAPT evidence based psychological therapies and re-investing this money into an expanded IAPT service to ensure that local IAPT services in the future will be able to meet the Mental Health Five Year Forward View requirements by 20/21.

Non IAPT approved counselling can still be provided to support people who do not meet the criteria for IAPT, for example stress, anger management and relationship support, but not for people who meet IAPT access criteria.

## Local Progress to Date

In April 2017, Hartlepool and Stockton-on-Tees (HaST) and Darlington Clinical Commissioning Groups established an IAPT Project Group to re-design, expand and re-procure an IAPT service across HaST and Darlington Clinical Commissioning Groups, in line with the Mental Health Five Year Forward View. In September 2017, North Durham and DDES Clinical Commissioning Groups' joined the IAPT Project Group to promote collaborative working across the region and reduce duplication in developing and implementing a new IAPT model.

[1] Layard & Clark, 2014

[2] Long-Term Conditions Pathfinder Results

Since September 2017, South Tees Clinical Commissioning Group has also been part of the IAPT Project Group and discussions. This Clinical Commissioning Group (CCG) agreed to join the collaborative re-procurement in November 2017, making a total of five CCG's.

The group are currently in the process of developing a proposed expanded IAPT model in line with national guidance and local needs. A draft proposed model can be seen in **Appendix 1**.

In 2017 the five collaborating health commissioners reviewed current services which included engaging with members of the public, service users, GP's, stakeholders and providers to capture their views about what the issues were, if any, and how we could improve IAPT services to meet national requirements set out in the Five Year Forward View.

There were a number of themes from the pre-engagement undertaken across the five Clinical Commissioning Groups including suggested improvements to referral processes and timely access, flexibility and choice around support and treatment options, reduced waiting times, improved communication to support attendance at appointments and more responsive step up and step down processes between primary and secondary care, to flexibly manage complex needs.

This feedback has been used to help develop a proposed expanded IAPT model which people will be able to influence further by participating in local focus groups for feedback which are due to be held during Spring 2018.
Based on the feedback we want to:

- Ensure that systems and processes within the expanded IAPT model support patient choice and flexible options for service access and assessment
- Ensure that the full range of evidenced-based therapies that fall under IAPT provision are available
- Ensure that people are getting access to evidenced-based psychological treatment/interventions at the earliest opportunity
- Ensure that treatment/interventions are identified based upon the assessed need of the individual
- Ensure that screening and assessment processes are standardised and that all assessments are carried out by an appropriately trained clinician
- Provide an IAPT service that proactively supports people with long-term conditions with their mental wellbeing

## The Expanded IAPT Service

There are some key elements to the expanded IAPT model. It is proposed that it will:

- provide a single point of access into IAPT across five health commissioners, with a standardised screening and assessment
- offer co-located physical and mental healthcare as part of an integrated approach to supporting people with long-term conditions providing parity of esteem and a holistic approach to an individual's physical and mental health needs

- provide an expanded range of NICE approved psychological therapies, appropriately adapted to core IAPT and people with long-term conditions
- Provide trained IAPT Therapists who have undertaken continued professional development training in supporting people with Long-Term Conditions
- offer clear streamlined pathways for step up into secondary care from IAPT and vice versa to help stop patients re-presenting
- provide employment support through trained advisors
- provide clear identified pathways to ensure individuals are accessing the most appropriate treatment to meet their needs in a timely manner

The new model aims to meet the requirements of the Mental Health Five Year Forward View, offer an enhanced model including people with long-term conditions, a more equitable service across the collaborative and evidence based IAPT interventions that are NICE approved. It will offer the quality of care recommended in the Five Year Forward View and deliver timely evidence based treatment via a Single Point of Access across the collaborative.

## Next steps

In Spring 2018 we will carry out a series of focus groups to gather people's views about the draft model for the new service. This is to ensure that all views are s into the proposed expanded IAPT model and we deliver the best IAPT service for local people we can.

If you would like to register to take part in a focus group, please telephone: 0191 3742795 or email: necsu.engagement@nhs.net. Further details will be available as to dates, times and locations upon registering.

## Contact

If you have any queries please contact:

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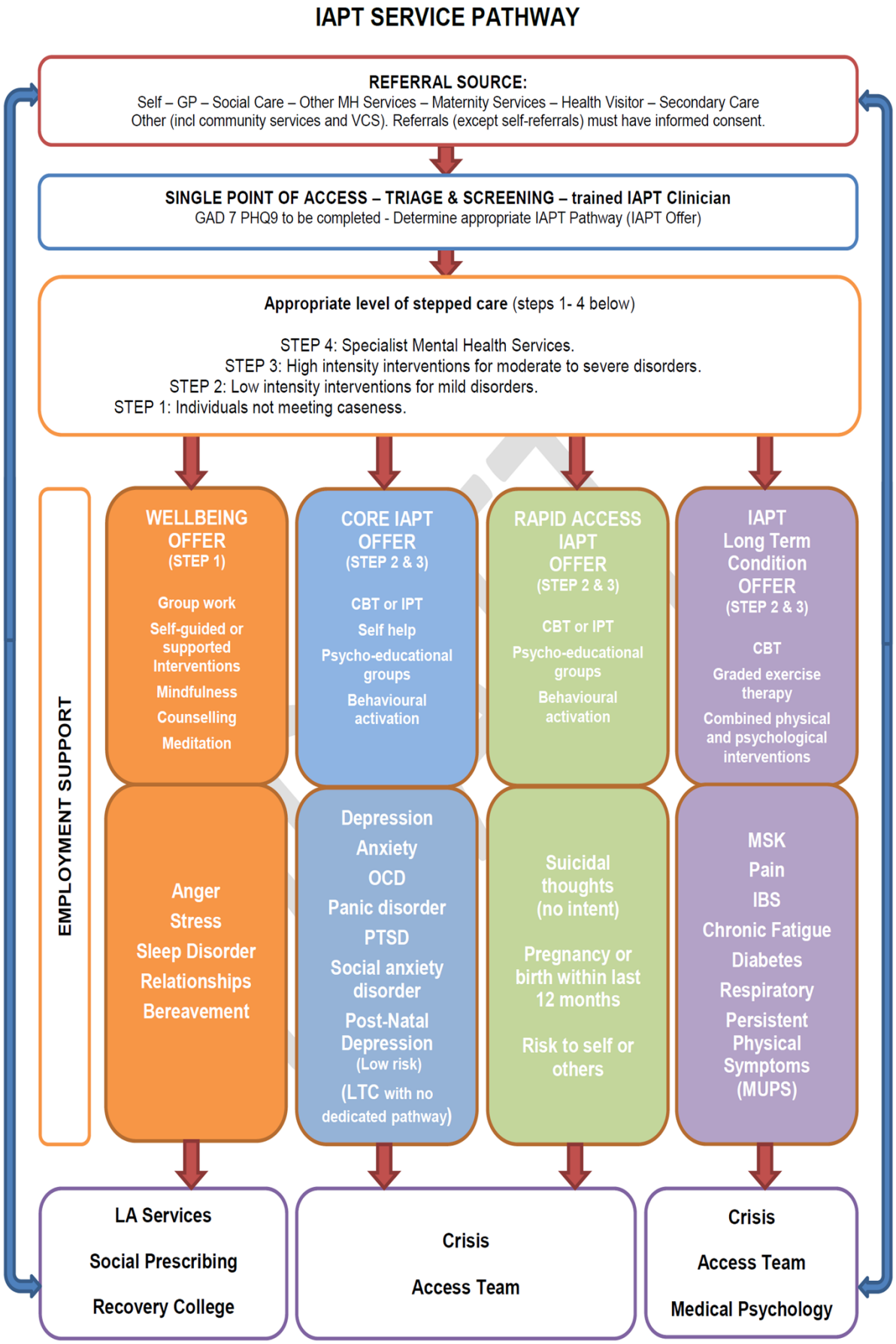
## Stakeholder Briefing Appendix 1 – Proposed IAPT Expanded Model



## Appendix 3 – Summary of Pre-Engagement Feedback

| | Patients | GP's | Providers |
|---|---|---|---|
| **Referral and Access** | • More information about the service at the point of referral - treatment options available, length of wait for treatment etc.<br>• Easier access – including online, text, letter, telephone, group and face to face referral, assessment and treatment options<br>• One referral – not to be passed between services | • Option for a more formal, electronic referral pathway from GP practice<br>• Prioritisation for assessment and / or access to treatment based on severity of initial presenting symptoms – reducing need for prescribing, input from crisis teams etc | • There needs to be patient choice in relation to location, appointment times and therapies<br>• There is disparity in the services available across different locations<br>• There is issues with people being assessed by different providers<br>• There is long waiting lists once choice of provider has been made<br>• Clearer referral pathways with options<br>• A single point of access into IAPT is needed |
| **Support/ Treatment** | • Flexibility of appointments – options for appointments outside of normal working hours<br>• Support to access other services relevant to presenting problem - housing, debt advice, weight and wellbeing, substance misuse services<br>• Continued dialogue about therapy choices and what works/doesn't work for the patient<br>• Increased support while waiting for treatment – i.e. practice nurse, group therapy<br>• Reduced waiting times | • Reduction in waiting times – particularly for high intensity therapy | • All therapies being evidence based makes the service work well<br>• A stepped care / progression model so everyone is offered step 2 interventions first<br>• Specialist clinical pathways - Long term conditions, perinatal, older adults |
| **Communication** | • Support to attend appointments – telephone/text reminders, follow up re DNA appointments | • More information about what the service provides - treatment options available, length of wait for treatment etc.<br>• Improved communication on outcome of assessment, progress and discharge – should be consistent across all therapists | • IAPT services receive inappropriate referrals |
| **Better Integration** | • More responsive escalation/de-escalation between services | • Strengthened links between primary and secondary care services<br>• Improved signposting and support while waiting for treatment – reducing practice contacts for quasi-counselling<br>• More responsive escalation/de-escalation between services | • There needs to be a standardised template across providers for stepping up/down into secondary care<br>• Flexibility is required to manage more complex presentations |