Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Friday 6 July 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 13 April 2018 and of the special meetings held on 2 May 2018, 9 May 2018 and 1 June 2018 (Pages 3 - 36)
4. Declarations of Interest, if any
5. Media Issues
6. Any Items from Co-opted Members or Interested Parties
7. Review of Stroke Rehabilitation Services in County Durham - Presentation by representatives of County Durham Clinical Commissioning Groups and County Durham and Darlington NHS Foundation Trust
8. Review of Urgent Care Hubs across Durham Dales, Easington and Sedgefield CCG - Joint Report of the Director of Transformation and Partnerships, Durham County Council and Sarah Burns, Director of Commissioning, DDES CCG (Pages 37 - 68)
9. Adult and Health Services Update - Report of the Corporate Director of Health and Adult Services (Pages 69 - 84)

10. Public Health Update - Presentation by the Director of Public Health for County Durham
11. Quarter 4 2017/18 Performance Management - Report of the Director of Transformation and Partnerships (Pages 85 - 100)
12. NHS Foundation Trust 2017/18 Quality Accounts - Report of the Director of Transformation and Partnerships (Pages 101 - 108)
13. Council Plan 2016-19: Refresh of the Adults Wellbeing and Health Overview and Scrutiny Work Programme - Report of the Director of Transformation and Partnership (Pages 109 - 118)
14. 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
28 June 2018

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

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

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

Co-opted Members: Mrs R Hassoon and Mr D J Taylor Gooby

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 13 April 2018 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, A Bainbridge, R Bell, P Crathorne, M Davinson, J Grant, E Huntington, L Mavin, A Patterson, S Quinn, M Simmons, L Taylor and O Temple

Co-opted Members:
Mrs R Hassoon

1 Apologies

Apologies for absence were received from Councillors R Crute, G Darkes, C Kay, K Liddell, A Reed, A Savory, H Smith and Mrs B Carr

2 Substitute Members

There were no substitute Members.

3 Minutes

The minutes of the meeting held on 5 March 2018 were agreed and signed by the Chairman as a correct record.

The Principal Overview and Scruitny Officer advised that in relation to the item on Winter Pressures, a special meeting of the Committee had been arranged to take place on 2 May 2018 to discuss the re-procurement of the Community Services contract and the review of Community Hospitals.

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;

- NHS services explained: Where should North East patients go if you feel ill - hospital, GP, or walk-in centre? – Evening Chronicle - 10/04/18

The region's A&E departments are stretched after a tough winter.
Health bosses in the region say emergency departments are struggling to cope with high volumes of patients - including many who do not actually need emergency care.
In a bid to ease the pressure, efforts are under way to provide members of the public with information about where to go to treat different types of ailments.

- Councillors 'insulted' over response to concerns about moving hospital services from South Tyneside to Sunderland – Sunderland Echo – 11/04/18

Councillors say they were left feeling 'insulted' and 'disgusted' by the response to their concerns over proposed health reforms in Sunderland and South Tyneside. Health bosses say the plans - which involve some services being moved from South Tyneside District Hospital to Sunderland Royal Hospital - are necessary to improve care and cut costs. But members of the South Tyneside and Sunderland Joint Health Scrutiny Committee are unconvinced by the scheme, which they say could leave patients and health workers struggling to cope. They are to call on Health Secretary Jeremy Hunt to rule on the issue.

- People urged to be more open about mental health – Hartlepool Mail – 09/04/18

People in Hartlepool and East Durham are being urged to take advantage of a new national awareness campaign that encourages people to speak more openly about mental health – and to find safe, non-confrontational spaces to talk. The aim of the initiative, launched by Ford and partnered with "Time to Change", an established mental health campaign run by the mental health charities Mind and Rethink Mental Illness, aims to reduce the stigma surrounding discussions on mental health. Around one in four people in the UK experiences mental health problems, and young men in particular have been identified as vulnerable.

6 Any Items from Co-opted Members or Interested Parties - Proposed closure of Byers Green Branch Surgery

Following concerns raised to the Chairman of this Committee by local Spennymoor Councillors regarding the proposed closure of Byers Green Surgery at Spennymoor, a letter was sent to the surgery asking for the decision to be halted until consultations had been carried out and the Committee was appraised of the situation.

The Chairman welcomed the Practice Manager to the meeting. She advised that 6-8 patients used the surgery at Byers Green, which was a small surgery rented from Livin. There was no IT available at the surgery and they were unable to carry out full examinations or blood tests. Promotion was carried out to encourage people to use the surgery but to no avail. In the past year, 84 patients have been seen in the surgery, an average of 3 per week. Byers Green was a 15 minute drive from the main surgery at Spennymoor and travelling reduced the amount of time that patients could be seen at Spennymoor. The list size of patients at Byers Green had not gone up in the past year and patients over the age of 65 were 26% of the total number. The surgery in Spennymoor had recruited 4 young GPs however they were struggling with demand and not travelling to Byers Green would assist this situation. Public transport from Byers Green was once an hour with a 2 hour gap in the middle of the day. Two appointments

would be blocked each day to coincide with bus times. Spennymoor was a dispensing practice and this would not change as medication would still be delivered.

The Director of Primary Care, Partnerships and Engagement, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups informed Members that the Primary Care Committee deferred this item until they had received assurances that full conversations had happened with stakeholders and patients. From a quality and safety point of view, he felt that it was unusual for a GP to see a patient without access to clinical records as this could limit the value of the consultation. He added that he needed to ensure that money invested into premises across the whole of the area should be fit for purpose and would be looked at on a case by case basis.

The Chairman reported that the local members had attended meetings with the Practice Manager and the messages received today had been reinforced.

The Principal Overview and Scrutiny Officer said that the lines of communication between the CCGs, NHS England and the local authority, where proposals to alter GP services needed to be clearer. There were two issues to consider – the proposed closure of Byers Green and the protocols in place for engagement with the local authority via the Adults Wellbeing and Health OSC and local Councillors. On behalf of the Committee he asked that advice and guidance was issues to individual practices about their duties and responsibilities to engage, inform and consult about any proposed changes. He would pass back any comments from the meeting today.

The Chairman thanked the Practice Manager and the Director of Primary Care for coming to the meeting to give an explanation and understanding of the current situation.

The Director of Primary Care said that he supported the Committee on behalf of the CCGs.

Resolved:-

(i) That the report be received and the rationale for the proposed closure of Byers Green Branch Surgery be noted;

(ii) That NHS England and the County Durham CCGs develop a protocol which ensures that the organisation responsible for commissioning of general practice services includes the County Council's Adults Wellbeing and Health Overview and Scrutiny Committee are included within the engagement processes where changes to services are proposed.

7 NHS England Review of Specialised Vascular Services

The Committee received a report of the Director of Transformation and Partnerships that provided information in respect of proposals to reconfigure specialised and some non-specialised vascular services in the North East England in advance of a presentation to be given to members by representatives of NHS England's North Region Specialised Commissioning Team on 1 June 2018 (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer advised that concerns had been raised at the North East Regional Joint Health Scrutiny Committee regarding the proposals to reconfigure vascular services. The University Hospital North Durham was one of four

centres offering these services however, recommendations from the Northern England Strategic Clinical Network would see this option being removed. The Regional Team would be attending a special meeting of this Committee on 1 June 2018 to allow the Committee to give full consideration to the proposals.

The Chairman advised that an immediate objection had been lodged to these recommendations and that there was also a concern to the knock on effect to the Darlington Memorial Hospital and Bishop Auckland Hospitals.

Councillor Temple was concerned about the report and the clinical reasoning behind the proposed changes. In the report, he referred to Sunderland being geographically located in the centre of the region. This was particularly concerning as the STPs moved forward and there did not see to be an understanding of the geographical layout of County Durham. He added that there needed to be further understanding of the implications for the County and costs involved in making the changes. He believed that Members needed to make a case to protect the long term future of the area.

Councillor Bell agreed with those comments and asked how this fit into the plans of the STP process. He felt that County Durham would miss out everytime there were any proposal to streamline services at a regional level.

The Principal Overview and Scrutiny Officer advised that he would express these concerns to NHS England in advance of the meeting on 1 June 2018. He also advised that the Chief Executive of CDDFT would be attending the meeting with the Foundation Trusts lead vascular surgeon on 1 June 2018.

Resolved:

(i) That the report be received;

(ii) That comments on this report and the briefing paper provided by NHS England's North Region Specialised Commissioning Team in respect of the proposals to reconfigure specialised and some non-specialised vascular services in the North East and the associated communications and engagement plans be noted;

(iii) That further detailed report be brought back to the Committee following the end of the 2018 local election purdah period be agreed.

8 Improved Access to Psychological Therapies Model Development

The Committee received a report of the Director of Corporate Programmes, Delivery and Operations that provided an update 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 (for copy see file of Minutes).

The Chairman asked why no consultation was required and what the impact was for CDDFT with the change in contract. The Director of Corporate Programmes explained that this development of a new model was about enhancing the service. It was about expanding and not reducing the service and expanding the IAPT targets using the resources available. Therefore there were no changes other than improvements. TEWV were the lead provider and sub contracted this service to CDDFT and at a market

development session providers would have the opportunity to show how best to achieve the targets. He confirmed that the award of contract would depend on the outcome of the process.

Mrs Hassoon was assured that any contact would not necessarily be by telephone and any concerns raised at an assessment would be followed up.

Councillor Temple felt that there was a contradiction in the report as at paragraph 12 it was noted that the workforce were not trained to provide IAPT modalities and at paragraph 23 it stated that proposed future modelling to expand IAPT services would not present significant change. He asked why there was no need for the process of scrutiny. The Director of Corporate Programmes explained that in relation to paragraph 12 this referred to the talking changes element not meeting standards currently and this was being addressed. The practice based element contributed towards IAPT therapies and if not trained or able to deliver this would be taken out of the IAPT provision. The new model would build in capacity whilst building in lower level counselling.

The Chairman asked that the Committee be provided with a post implementation report to prove what had been carried out to improve access and the quality of the service. The Director of Corporate Programmes said that he would be happy to report back as this would be the outcome that would be hoped to achieve.

Councillor Patterson expressed concerns about patients who had to travel and she asked for assurances that they would still be able to access services locally. She was advised that IAPT outreach and delivery would be based around Teams around the Patient and a core element of that would be to provide wrap around primary care.

Resolved:

(i) That the report be received;
(ii) That the required next steps and timescales be noted;
(iii) That the proposals for developing an expanded IAPT model across a collaborative CCG footprint be noted;
(iv) That the pre-engagement already undertaken, and planned further engagement on the proposed model during Spring 2018 be noted;
(v) That the view that a formal consultation process is not considered necessary to progress the development and re-procurement of the IAPT-LTC model be noted;
(i) That the CCGs bring a post implementation update report to a future meeting of this Committee demonstrating how the service improvements expected to be delivered under the revised IAPT model are being achieved.

9 Implementation of Care Navigation

The Committee received a report and presentation from the Director of Primary Care, Partnerships and Engagement, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups regarding Primary Care Navigation (for copy see file of Minutes).

The presentation highlighted the following points:-

- Why do Care Navigation
- What is Care Navigation
- Benefits of Using Care Navigation
- What Care Navigation is not
- How Care Navigation works
- Key stages in development

The Director of Primary Care advised that this process would enhance some skills that receptionists already had and for them to be recognised and utilised. A pilot programme had been proposed, however due to the enthusiasm expressed it was going to be rolled out to all 500 GP receptionists in the County. He made of point that patients would still have the power and choice and they could refuse the option of care navigation. Some of the staff had met with GPS and practice staff in South Tees who had already implemented this system and they were very pleased with the results. AAP feedback had been very positive and had been influencial in helping to shape the product.

The Director of Primary Care introduced Feisal Jassat, a lay member on both CCGs, who had been very supportive in the implementation.

Mr Hassoon was concerned that not every member of staff had been appraised of the changes as she was still experiencing problems at her own surgery.

The Head of Service (Primary Care) DDES CCG advised that there would be online, physical and soft skills training for all staff and this would be rolled out. The Director of Primary Care said that he would be happy to take up any individual concerns.

Councillor Chaplow queried if it would be more appropriate to train the receptionists as health care assistants. The Director of Primary Care replied that some receptionists did try alternative career paths but that this programme was not designed to turn them into health care professionals. It was designed as a signposting tool however it could be a stepping stone for receptionists.

Councillor Grant expressed concerns about confidentiality as so many practices were open plan and people's conversations could easily be heard. She felt that this needed to be addressed so that it would not put people off using the system. The Head of Service (Primary Care) advised that they were working with individual practices to address that. They would be suggesting that a senior partner or GP from the practice use a voicemail to inform people about the care navigation practice when telephoning the surgery. She added that in Wakefield they used a red card system whereby a patient could point to that if they wanted to have a confidential conversation. She welcomed any suggestions from members as they were still in the development phase.

Adding to the issue of the reception areas, Councillor Grant said that the space between the receptionists and the waiting area needed to be sufficient so that people could not hear conversations as this was embarrassing to all parties. She also suggested that background noise was used to distract what was being said at the reception desk.

Councillor Crathorne asked what qualifications the care navigators would have and Councillor Patterson agreed that this was as concern as they could be directing patients

away from seeing a GP. She was shocked to see this programme being rolled out across the County as would have expected it to have been carried out on a trial basis, with lessons learnt.

The Director of Primary Care explained that this was a mandatory national piece of work, covered in NHS England's five year forward view for Gernal Practice. Money would come centrally to support care navigation. The initiative supported a pilot scheme in Wakefield two years ago and the evaluation of that model had been successful. Wakefield had been approached by a number of CCGs to help them implement the programme. All liability would rest with the GPs and they needed to ensure they felt safe with it. He added that the attitude of receptionists were dealt with by the individual practice but that it was important that they dealt with all patients in a professional manner.

Councillor Bell said that he could see this working in a big urban community but that in small rural communities there was nowhere to be able to have those private conversations required. In smaller communities most people knew each other and this could cause problems without any physical alterations to the buildings.

Referring again to the issue of confidentiality, Councillor Huntington said that a doctors reception felt like a hotel reception and people could hear most conversations. She also felt that even when complaints were made about awkward receptionists nothing was done to address them.

On a more positive note, Councillor Quinn added that she had never heard any conversations at her own surgery.

The Chairman asked how the public were going to be assured about receptionists and why would a record of you saying no to the care navigator system be recorded.

The Director of Primary Care said that they had a brilliant receptionist workforce and that there always tended to be a focus on when things didn't go well. They were often put in a difficult position by the GPs they worked for. Each practice had an obligation to ensure confidentiality and it was suggested that telephone areas were kept separate from the main reception. He added that unfortunately GPs were left with the buildings they had and these were regulated by the CQC.

Councillor Patterson asked that a consultation was carried out to ask patients for their views before implementation. The Chairman reiterated the point that this was a compulsory function imposed on the CCGs. The Director of Primary Care added that this was not seen as a substantial variation and that the choice would remain with the patient.

The Head of Service (Primary Care) explained that they were working with Healthwatch to carry out an independent evaluation to find out the public perception. Once this system was set up and running in Wakefield, the patients there preferred it. She said that they would be collecting data on how many people accepted care navigation and how many declined it so that could gain a greater understanding. The GP would not interrogate a patient if they had declined the system but may point out that they could have received treatment elsewhere.

In conclusion, the Principal Overview and Scrutiny Officer said that he would respond formally in writing to the CCG on the Committees setting out the comments and concerns raised by the Committee.

Resolved:

(i) That the report and presentation be received.

(ii) That the comments and concerns raised by the Committee be forwarded to DDES CCG.

10 Quarter Three 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 third quarter of the 2017/18 financial year (for copy of report, see file of minutes).

The Team Leader, Performance, Co-ordination and Development presented the report and highlighted that breastfeeding prevalence and mothers smoking at the time of delivery was still a challenge. She advised that Public Health had undertaken work into breastfeeding and an action plan had been produced to promote the take up, linking in with the AAPs. There had been fewer suicide rates in the 2014-16 period but the figures were still significantly higher than in England, with male suicides higher than females. A Strategic Review had taken place and prevention would be a key focus moving forward.

Councillor Davinson was concerned that the target rate for suicides was highlighted green, although the rates were still high. He was advised that this was to show that in comparison to the performance 12 months ago the number had improved. He was also concerned about the active and inactive figures for participation in sport and physical activity. He was advised that this was not comparing like with like and that there were fewer people doing larger amounts of activity but that more people were doing a little bit of activity.

Referring to suicides, Councillor Davinson commented that until people were given something to live for the rates would not improve significantly. Councillor Huntington said that it would be helpful to have this data broken down so ascertain the different types of suicide and the reasons why. The Principal Overview and Scrutiny Officer explained that this was looked at in the review undertaken, including age, profiles, deprivation and employment.

With reference to breastfeeding, Councillor Quinn asked if this was something that was encouraged. She was informed that it was about trying to change the social norm and a piece of work was taking place around that to make it more acceptable.

Mrs Hassoon referred to the roll out of Universal Credit and commented that if people did not have money their situations could not be improved. The Principal Overview and Scrutiny Officer advised that this matter impacted on the whole gambit of Overview and Scrutiny Committees and the Corporate OS Management Board were taking the lead.

Resolved:

That the report be received.

11 Adults and Health Services Quarter 3 Forecast of Revenue and Capital Outturn 2017/18

The Committee considered a report of the Head of Finance and Transactional Services, presented by the Principal Accountant 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 December 2017 (for copy of report and slides see file of Minutes).

Resolved:
That the financial forecasts, summarised in the Quarter 3 forecast of outturn report to Cabinet in March 2018, be noted.

12 Council Plan 2016-19: Refresh of the Adults Wellbeing and Health Overview and Scrutiny Committee Work Programme

The Committee considered a report of the Director of Transformation and Partnerships which provided information contained within the Council Plan 2016-2019, relevant to the work of the Adults, Wellbeing and Health Overview and Scrutiny Committee, which enabled members to refresh the Committee Work Programme to reflect the four objectives and actions within the Council Plan for the Council's 'Altogether Healthier' priority theme (for copy see file of Minutes).

The Principal Overview and Scrutiny Officer highlighted the current work programme of the Committee and the cross cutting areas covered across Children & Young People and Safe & Stronger Overview & Scrutiny Committees. Members were advised that the work programme for 2017-18 would be brought back to the Committee in July 2018. He also advised that the STP plans were still to be confirmed however, reports would come back to the committee on progress.

Councillor Temple commented that the Committee should concentrate on public health issues that the Council could investigate and report back on. He suggested that the Committee review smoking in pregnancy and breastfeeding, as these were issues highlighted in the performance report and both related to public health.

Councillor Davinson referred to a small wellbeing pilot in his area, linked to the larger Wellbeing for Life project. He suggested that this could be a topic for consideration at a future meeting and underpinned all of the factors that the Committee were looking at. He was happy to support Councillor Temple's suggestion to carry out an extended piece of work if the work programme allowed this.

Referring to the issue of Health and Social Care, Councillor Patterson asked how this could be integrated by looking at the strategic approach of the Council.

Mrs Hassoon and Councillor Davinson expressed concerns about the STPs. Councillor Davinson said that the Northern area did not seem to understand the rurality of County Durham and all reports so far were from Newcastle and Gateshead. The Chairman added that at a recent Health and Wellbeing Board it had been reported that there could

be just one STP in future and he was concerned about the future of Durham and Darlington.

The Principal Overview and Scrutiny Officer reported that there was input at the Southern STP from our own directors of Adult and Health Services and Public Health and the Director of Integration. He would look at replicating this method of input at the Northern area STP.

Resolved:

1. That the information contained in the Altogether Healthier priority theme of the Council Plan 2016-2019, be noted.

2. That the comments from the Committee be reflected within the refresh of the Adults, Wellbeing and Health Overview and Scrutiny Committee work programme for 2017-2018.

3. That at its meeting on 6 July 2018, the Adults, Wellbeing and Health Committee receives a further report detailing the Committee's work programme for 2018-2019.

DURHAM COUNTY COUNCIL

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

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, A Bainbridge, R Crute, G Darkes, M Davinson, J Grant, E Huntington, A Patterson, S Quinn, M Simmons, L Taylor and O Temple

Co-opted Members:
Mrs R Hassoon

1 Apologies for Absence

Apologies for absence were received from Councillors R Bell, P Crathorne, C Kay, K Liddell, L Mavin, A Reed, A Savory, H Smith and Mrs B Carr

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 County Durham and Darlington NHS Foundation Trust - Review of stroke rehabilitation services

The Committee received a presentation from the Chief Executive, County Durham and Darlington NHS Foundation Trust (CDDFT) that provided an update of the review of stroke rehabilitation (for copy see file of Minutes).

The Chief Executive was accompanied by the Lead Stroke Consultant, Commissioning & Development Manager, and the General Manager of CDDFT together with the Director of Commissioning for DDES CCG.

The Commissioning and Development Manager highlighted the following information from the presentation:-

- Key Facts about Stroke
- Scope of Service Review
- Current Pathway
- Current Discharge Pathways
- Drivers for Change
- Case for Change – Quality of Care
- Case for Change – Workforce
- Next Steps – doing nothing is not an option
- Engagement & our commitment
- Timescales

The Chairman thanked officers for the presentation. He asked for assurances that this was not linked to changes to the regional vascular services and The Chief Executive provided that assurance.

Councillor Crute referred to early supported discharge and asked how the service would know that people received the same level of support at home as they would in hospital. The Lead Consultant advised that early discharge was was not available at present countywide however a small team based in Easington were involved in setting this up.

The Chairman referred to the previous changes to hyper-acute stroke services moving from Darlington to Durham and he expressed concerns about these further changes in respect of the viability of services provided at University Hospital North Durham and Bishop Auckland Hospital. He requested evidence to provide the assurances about the future of these hospitals. The Chief Executive referred to the changes made to hyper-acute services and the recognised significant improvement outcomes as a result. She advised that the key aspect was to have early supported discharge as a commissioned service as this would make a big difference. She referred to opportunities around Bishop Auckland Hospital to enhance the assessment services for frail patients.

The Lead Consultant added that there had been no complaints about patients being in the wrong place following the changes to the hyper-acute services. referring to community services he said that patients did want to be in their own homes and that we needed to make best use of the facilities available. He added that it was important for patients to receive continuity of care and by putting services in place would ensure that happened. Referring to Bishop Auckland Hospital he commented that this was a great facility and was an aspiration to have this as a centre of excellence for elderly care.

The Director of Commissioning explained that there was not a direct link between stroke services and the rest of the services taking place at Bishop Auckland Services. She would share the list of services available at Bishop Auckland Hospital following the meeting with the Committee. She assured the members that Bishop Auckland Hospital was thriving.

Referring to early supported discharge Mrs Hasson expressed concerns about those people leaving hospital where a good service was not available within the community.

The General Manager advised that other services were being developed in relation to discharge to assess. The Director of Integration added that discharge to assess was only carried out when safe to do so.

Councillor Patterson welcomed the advantages of centralisation and was pleased to hear about the aspirations for Bishop Auckland Hospital however she was concerned about transport for patients and their families. She agreed that the best care for patients was to receive that locally however, it had also been noted that in the recent CQC inspection, there were a lot of areas that required improvement. She went on to ask what an acceptable sample size was for public engagement.

The Director of Commissioning assured members that this was not about the centralisation of services, that was the view expressed by the Lead Consultant.
The views of patients would also be sought together with those of clinicians. She added that it would be difficult to say what the sample size would be but said that they would be talking to people who had suffered from a stroke together with their families. They would not receive a 100% response rate but would share who they had talked to and what the response rate was at the end of the engagement exercise.

The Chairman suggested that a special meeting of the committee be arranged whereby evidence could be presented from patients. He believed that this was a significant change to the service and would like to view the evidence to back up the ideas for change. Referring to the slide on the workforce, he asked what had caused the deterioration across the board. The General Manager explained that recruitment to Bishop Auckland Hospital and UHND had been difficult. Retaining therapists had also been problematic due to not delivering the best outcomes. The Chairman asked if this would be improved and was advised that staff would be consolidated in teams and a named clinician would follow the patient into the home or community where teams around the patient would take over.

The Chairman asked a question on behalf of Councillor Smith relating to stroke and mortality figures and was advised by the Lead Consultant that all of the North East Stroke Units have average mortality rates but that it did vary according to postcodes. He assured members that they were not experiencing an increase in mortality rates and added that regular reviews took place whereby clinicians were presented with data.
Councillor Patterson re-iterated her point about travelling and the costs associated with transport and car parking not only for patients but for their families. The Director of Commissioning explained that this was one of the reasons why the service were supportive of discharge to home and this wold also make it easier for families. Their views would be sought.

Councillor Darkes asked if the centralisation reaction was due to staff shortages and he asked for a scheduled plan of where the staff would be recruited from and how they would be recruited. The Director of Commissioning confirmed that they were not preparing to centralise as development plans and options had not yet been proposed. She again referred to the views of the Lead Consultant.

Councillor Darkes commented on the reduction from 9 to 6 units and was advised that this was in relation to the hyper-acute unit and those changes had already taken place.

The Lead Consultant commented that a national directive, led by Professor Tony Rudd on hyper-acute treatments, was about trying to get the size of the units right. He added that in Durham a lot of consultants had been recruited and would hopefully be retained. Referring to the comments made about centralisation he said that it was not only his view but that of his team and something that the therapists would like to see happen.

On answering a question from Councillor Darkes about finding additional staff, the Director of Commissioning advised that they did have a recruitment plan and patients would still have the choice as to whether they wanted to accept the service. The General Manager added that once they had spoken to patients they would have a better understanding of who wanted to be at home receiving treatments.

The Chief Clinical Officer, DDES CCG said that there was evidence to support the restructure in one area. He said that 27 days in hospital was too long and that patients should be in their own homes. He added that investments into the service were much better and he believed that this would help to recruit staff. There had been concerns about the speed of getting patients from home to hospital but with further investments into NEAS from the CCG it was expected that they would deliver.

With reference to the hyper-acute unit Councillor Temple said that the changes had produced a much better service. However, further evidence was needed in relation to early supported discharge as he was not convinced by the arguments put forward. He did agree that to do nothing was not an option but was concerned about what the losses would be as a result of the proposed changes.

Councillor Chaplow was concerned that many patients would say that they wanted to go home and then refuse the help and support when they leave hospital. Her view was that in hospital patients would get the care they required and believed that we had a really good system in place.

Councillor Patterson agreed with Councillor Temple's point that we couldn't do nothing but she added that these changes were due to a shortage of staff as the NHS was heavily under funded.

Resolved:-

(i) That the report be noted.

(ii) That the proposed review of stroke support services across County Durham be added to the Committee's 2018/19 work programme.

(iii) That a special meeting be arranged to discuss options for future stroke rehabilitation services across County Durham and for evidence to be presented to that meeting which demonstrated the case for change and also set out the views of patients in respect of the existing stroke rehabilitation services.

6 County Durham and Darlington NHS Foundation Trust - CQC Re-inspection report and action plan

The Committee received a report from the Chief Executive, County Durham and Darlington NHS Foundation Trust regarding the CQC inspection report (for copy see file of Minutes).

The Chief Executive, CDDFT reported that the overall rating for this trust was requiring improvement. The CQC had however rated the trust well-led with the leadership team showing a range of skills and expertise, were leaders at every level and were approachable.

The Chief Executive highlighted the summary of findings and the areas for improvement. She advised that maternity services had won the service improvement award in the annual staff awards and had been shortlisted for the Royal College of Midwives annual midwifery awards. She informed the committee that the trust had requested that the CQC carry out an inspection on End of Life Services.

The Chairman congratulated Maternity Services as some areas had been outstanding.

In relation to surgery, Councillor Crute said that there were concerns raised about both sites and that there had been a deterioration in staffing levels, safeguarding and training and said that this indicated a failure at the leadership level. He asked what measures would be put in place to address this. The Chief Executive said that the board shared these concerns about all areas where improvements were required. She advised that a separate review had been undertaken on the overall leadership that gave a confidence. She referred to significant concerns around maternity services at the last inspection that had now improved to outstanding in some areas, and the same concerns were now being expressed in surgery. A number of actions had taken place specifically around self assessment and never events had reported fewer numbers. The trust were keen to see improvements and regular meetings were taking place with the medical director.

Councillor Grant said that it would be good to see comparative data and asked if most trusts required improvement. The Chief Executive confirmed that most trusts that had been assessed required some improvements, and she confirmed that comparative data was available that she could share with the committee.

Councillor Huntington asked what happened inside the trust as she was concerned that areas for improvement were not picked up by the leadership team. The Chief Executive confirmed that any issues were reported via appraisals and were linked to what was going on in the trust. She added that in relation to surgery, there were self assessments carried out in June every year and the deterioration was due to the level of never events that had occurred. An action plan was put in place and managers had picked up on those. She reminded members that the CQC were looking back whilst undertaking the inspection.

Councillor Patterson referred to the number of changes that had taken place recently, including changes to urgent care, removal of A&E at Bishop Auckland and asked how the table on page 17 of the pack compared to the last CQC report. The Chief Executive reported that only urgent and emergency services had been looked at in Durham and Darlington and had been rated slightly better than at the last inspection. She added that more people were seen now within four hours, and this was a comparison to patients waiting to be seen in other areas. There were fewer urgent care attendances coming through A&E but more people were being seen within the four hour target.

With regards to training, Councillor Temple asked for assurances that the culture around this was being addressed. The Chief Executive said that there had been concerns

following the never events and work around the culture had been taking place. The CQC had seen evidence of this work and the comprehensive approach being undertaken.

Councillor Temple asked if there were any signs that the figures were changing and was advised that data could be shared with the committee. She added that with regards to mortality there had been some positive outcomes and again said that this data could be shared with the committee.

The Chairman asked what had been put in place to address the lack of consultants available in A&E. The Chief Executive explained that it was difficult to recruit to A&E but that there was a detailed targeted plan which aimed to make the jobs more attractive. Nurse specialists had been recruited and there was now technology in place to ensure the flow of patients out was facilitated in a better way. The Chairman asked if the trust could come back to committee with a report on how this was going to be addressed.

The Chairman went on to ask about the lack of training for all board members and that staff at UHND had commented that they had not seen an executive director present at the hospital. The Chief Executive explained that executive directors spend half their time in Durham and half in Darlington. The CQC did not challenge this at interview however, the team were now publishing where they would be for team and board meetings. She reminded members that th CQC had described the leadership team as approachable.

Referencing the recently published re-inspection report for North Tees and Hartlepool NHS Foundation Trust which had improved from “requires improvement” to “good”, the Chairman asked if good practice could be learnt and shared from that trust. He reminded the trust that they had said they would be outstanding after the last inspection and asked what actions would be put in place to achieve this result. The Chief Executive said that it was their aspiration to be outstanding in the next two years however as the inspections regimes change there was no guarantee that this would happen. She reported that their own inspections for end of life care were good but they could not force the CQC to carry out on inspection in this area. With regards to North Tees and Hartlepool Trust, the Chief Executive said that they were part of a Learning from Others programme and this had helped them access the move to a good outcome. She advised that CDDFT had also applied to be part of this process.

Councillor Darkes referred to sepsis and was concerned that following a personal loss, nothing appeared to have changed or improved within the last nine years. The Chief Executive confirmed that they did look at all key signs including pathology systems and prompt clinicians. She added that this was an audited system and included a bespoke system whereby the Head of NHS Improvement viewed important steps forward.

The Chairman asked what the Boards opinion was and what action the CCG would take following the outcome. The Chief Clinical Officer, DDES CCG said that they shared the disappointment that there no improvement to the overall score had been shown. He assured members that there was a huge amount of quality work being carried out and meetings and discussions were taking place regularly to discuss the quality. The CCG acted as a critical friend and it had been recognised that a lot of changes were cultural. He believed this was a unique opportunity to allow working together to improve the quality of the services.

Resolved:-

(i) That the report be noted.

(ii) That the CQC re-inspection report for County Durham and Darlington NHS Foundation Trust and the associated Improvement Action plan be added to the Committee's 2018/19 programme.

7 Teams around the practice, Community Services contract and review of Community Hospitals in County Durham

The Committee received a presentation from the Director of Integration that gave an update on teams around the patient, community services contract and community hospitals in County Durham (for copy see file of Minutes).

The presentation highlighted the following:-

- The Integrated Model
- Teams around patients
- Our ambition
- Progress to date
- Proposed governance structure for the Integrated Care System
- Next steps – including community contract, integrated senior management arrangements, mobilisation work and community hospitals

In relation to Community Hospitals, the Director of Integration advised that this was an important part of the community services offer and the role and function needed to be addressed. A reduced bed base had in Weardale, Sedgefield and Richardson Hospitals had been implemented as the had been a significant drop in occupancy and was inefficient. Activity had now levelled off and the hospitals were seeing 95% occupancy levels.

Sedgefield and Richardson Hospitals had been developed under PFI arrangements and a 14 year lease ran in both hospitals. As the rental costs have to be paid, space would be utilised and it would be recommended to strengthen the use by working with local groups. There were no plans however to increase the number of beds. This was the same for Weardale where occupancy had been around 75% but was now at 95% with the potential to flex the number of beds in winter to accommodate demand.

Referring to Shotley Bridge Hospital, the Director of Integration said that concerns had been raised a number of years ago and the CCGs agreed to undertake a review and work was still ongoing. A reference group had been set up with senior members and officers of the Council that was open and transparent in terms of the planning and proposed changes. The group were now at the stage of receiving recommendations that would be debated at length.

Councillor Temple pointed out that not all community hospitals had been mentioned and asked for an update on Peterlee and Chester-le-Street. The Director of Integration explained that these were outside of the scope that she had been asked to look into. However, she did explain that these hospitals were funded differently.

The Chief Executive CDDFT explained that Chester-le-Street had many additional services available that were all being utilised. The Director of Commissioning said that Peterlee was owned by North Tees and Hartlepool Trust and a large number of services were delivered there including out of hours and community clinics, and there were no issues around void space.

The Director of Integration added that the CCG had plans to utilise some of the space at Sedgefield for office use so would become less of an issue going forward.

The Chairman referenced the recent establishment of the County Durham Integrated Care Partnership and asked where Scrutiny would sit within the governance arrangements. The Director of Integration said that they would illustrate reporting arrangements and she confirmed that they would report to scrutiny with any updates. The Chairman said that this was viewed as a major change and therefore would be added to the work programme to be monitored closely by this committee. Councillor Crute suggested that the structure be revised to show that scrutiny would be involved.

Resolved:-

(i) That the report be noted;

(ii) That a more detailed update in respect of the Community Hospitals review be brought to a future meeting of the Committee;

(iii) That the governance arrangements for the County Durham Integrated Care Partnership be amended to show where Scrutiny sits within the process;

(iv) That consideration of the County Durham Integrated Care Partnership be added to the 2018/19 work programme for the Committee.

DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Council Chamber - County Hall, Durham on **Wednesday 9 May 2018 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors A Bainbridge, R Crute, G Darkes, M Davinson, J Grant, E Huntington, S Quinn, A Savory, H Smith and L Taylor

1 Apologies

Apologies for absence were received from Councillors J Chaplow, R Bell, P Crathorne, C Kay, K Liddell, L Mavin, A Patterson, A Reed, M Simmons, O Temple, Mrs B Carr and Mrs R Hassoon.

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 NHS Foundation Trust 2017/18 Quality Accounts

The Committee noted a report of the Director of Transformation and Partnerships which provided information on the proposed process for preparation of the 2017/18 Quality Accounts for:

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

(for copy see file of Minutes).

The Principal Overview and Scrutiny Officer informed the Committee that the draft Quality Accounts had been circulated to members for the statutory 30 day consultation period. Deadlines for comments were 13 May 2018 for TEWV and 21 May 2018 for CDDFT and

NEAS. The responses would then be drafted and signed off in conjunction with the Chairman and reported back to committee on 6 July 2018.

The Committee received detailed presentations from each trust (for copy see file of Minutes).

Tees, Esk and Wear Valley NHS FT
The Head of Planning and Business Development and Deputy Director of Nursing highlighted the following:

- Purpose of the presentation
- Section 1 Chief Executive's introduction
- Section 2 Quality Priorities
- How did we do on 17/18 improvement priorities – 5 priorities with 37 actions, 2 of which were no completed by 31 March
- Preventable Deaths
- Transitions
- Statements of Assurance
- Performance against Quality Metrics
- Red Quality Metrics
- Forward Looking priorities for 18/19
- Care Planning
- Dual Diagnosis
- Other QA Information
- Next Steps

The Chairman commented that this was the tenth year for care planning and preventable deaths as priorities and asked why they were not right and asked if anything else had been identified. The Deputy Director of Nursing explained that there had been longstanding issues around care planning and although IT systems had been improved the bar kept being raised in terms of standards as the personalisation agenda and recovery had changed its focus. Overall the standards continued to rise each year.

Councillor Darkes was concerned that there were no deadlines related to any improvement plans and felt that they were absent of detail. The Head of Planning and Business Development explained that they did have plans and they would be open and honest when they came back to committee, however, in the meantime he could provide details to the committee.

The Chairman referred to suicide prevention and training and was advised that this was linked to lessons learnt from overall deaths.

The Chairman asked if there had been any improvements to the Crisis Centre further to previous concerns raised. He was advised that events had been held six months previously and aimed to help and improve the situation. The plans for next year would include discussions around this and stakeholders and carers would be asked if they had seen any improvements. If not then this would feature within the plan. It was recognised that Crisis Services should be good and members were encouraged to feedback any concerns they still had.

With reference to the governance arrangements, the Chairman said that there seemed to be a lack of children's mental health services and as the transitions service required further work he felt that it was important to address this.

The Head of Planning and Business Development explained that County Durham were fortunate that the CCG had invested well as services were under a lot of stress. With regards to transitions, there had been some cultural changes with staff listening to young people's stories and not being complacent. The panels were set up and there was a need to ensure that they were working well.

The Chairman asked if the take up on offers for out of pocket expenses with regards to the reconfiguration of dementia wards had been successful. This information would be sought and fed back to the committee.

Comparing the low level of safety experienced by patients to those having had a good experience, the Chairman was advised that safety was at the centre of all patients on a ward and a lot of work was ongoing to understand the reasons behind this. One of the reasons people did not feel safe was due to other patients on the ward that may be distressed and suffering from some mental health issues.

The Chairman referred to the reconfiguration of inpatient care at Roseberry Park and the effect on Lanchester Road, Sandwell Park and Auckland Park and asked how County Durham patients were getting access. The Head of Planning and Business Development explained that the issues at Roseberry Park had been very complex and some decisions were subject to impending court decisions. The building required significant works and the best was being done to manage the situation. There was an understanding the patients from East Durham did go there and the effect on these patients was being minimised. The Chairman referred to assurances given to the Committee by Sharon Pickering saying that she would supply out of Durham figures.

County Durham and Darlington NHS FT
The Associate Director of Nursing (Patient Safety & Governance) highlighted the following:-

- Safety Domain
  - Falls – patient falls and focus
  - Care of patients with Dementia
  - Healthcare Associated Infections – MRSA & CD
  - Pressure Ulcers – assessment
  - Incidents
  - Management of patients with Sepsis
  - Local Safety Standards
- Patient Experience Domain
  - Nutrition and Hydration
  - End of Life Care
  - Responding to Patients' Personal Needs – responsiveness
  - Staff Experience
- Clinical Effectiveness
  - Risk Adjusted Mortality

- Re-admission to hospital and timelines of assessment and treatment in Emergency Departments
- Maternity Standards
- Paediatric Care

The Chairman passed on the congratulations of the Committee for the outstanding rating for maternity services.

Councillor Darkes, referring to sepsis, said that he would like to see more details on the effectiveness and training aspect. The Associate Director of Nursing said that this information could be pulled together and forwarded to members of the committee. She informed him that a regional framework was used and if a patient hit trigger five they would be assessed and staff were trained to always think sepsis. Councillor Darkes commented that not all issues were being addressed by waiting until the fifth indicator to assess. The Associate Director of Nursing said that they used an aggregate score of 5 and if one trigger showed temperature, pulse, blood pressure abnormalities then this would be built into the nerve centre. This could be demonstrated and information would be circulated to the committee to that effect.

Referring to falls, Councillor Darkes went on to ask if there was any correlation between the figures and the staff availability. The Associate Director of Nursing assured him that this was not the case and they carried out a deep dive into all falls that resulted in significant harm. She added that when patients were on wards with multiple beds, a fall might occur when one patient tried to help another. Where this was a risk one to one supervision was discussed.

In regards to staff shortages, the Chairman asked if people were being employed and if staff were being transferred from other wards. The Associate Director of Nursing explained that there were first responders in a hospital setting that would make themselves available at times of real pressure. This was built into the nerve centre and helped to focus on patient flows and delayed transfers of care.

The Chairman asked if there were any plans for nurses to go out in ambulances and would they only respond in the hospital environment. He was informed that there were no plans for nurses to go out with ambulance crews.

Councillor Smith referred to paediatric care and the plans to establish consultant paediatric clinics in GP surgeries and commented that this used to be done 20 years ago when she was in the profession. She asked if there were sufficient staff available and if there was room in the job plans and the demand from GPs. The Associate Director of Nursing explained that this would be an advisory service so that GPs could seek the service of a paediatrician and where they could buddy up when a child had been in hospital.

The Chairman sought assurance about A&E performance due to the impact of performance targets. The Associate Director of Nursing said that the plans to increase staff would continue but she would gather further information tom circulate to the Committee.

The Chairman asked how many days of planned surgery had been cancelled due to the recent winter pressures. The Associate Director of Nursing said that this had impacted on all organisations but she would send the answers to the Committee following the meeting. The Principal Overview and Scrutiny Officer added that the question sought assurances in the delays to elective surgery did not then go on to become emergency admissions. He said that local members had expressed concerns around planned elective care and the knock on effect of the impact of delays. The Associate Director of Nursing said that the cancellations would be carried out on a risk basis and those patients needing surgery would have had it and some of the delays would have been to accommodate emergency patients.

Referring to the CQC rating of requiring improvement, the Chairman asked when the committee would receive assurances that the next time the trust were inspected they would not receive this rating, and was advised that there was an action plan included in the quality accounts.

North East Ambulance Service NHS FT
The Deputy Director of Quality and Safety highlighted the following:-

- Priority 1: Early recognition of sepsis
  - Why, on track to achieve, we want to do more and why this
- Priority 2: Cardiac Arrest
  - What we are doing, partially achieved, we want to do more
- Priority 3: Long waits
  - Why this, partially achieved, we want to do more
- Priority 4: Safeguarding referrals
  - Why this, what we are doing, partially achieved, we want to do more
- Quality Strategy 2017-2020
- Quality Priorities 2018/19
- Improving the care of patients with mental health needs

In addition, Mark Cotton, Assistant Director of Communications and Engagement, NEAS referred to a previous question posed by the committee in March asking for a trend on job cycle times over the last two decades. Information was shown as far back as 2006 and the average monthly job cycle time by incident was highlighted on a chart showing the times across the NEAS area and County Durham. The job cycle time by incident in 2006 was 52 minutes which had doubled to 1 hour and 43 minutes in 2018. He explained that there were a number of reasons for the increase including the complexity of patients with more than one condition and that the skills of the ambulance crews had changed. There was also an increase in journey times as crews had to travel to specialist centres when there were changes to A&E, for example to closure of Hartlepool A&E.

The Chairman asked if the 40% target for sepsis could be made more stretching and was advised that this would be implemented.

The Chairman thanked Mr Cotton for information on the last slide of the presentation and said that this would be used in future arguments when service propose changes regarding transport.

Mr Cotton responded that this was a long standing issue and they needed to work closely with the commissioners about having the right resources. They were thinking about how to work better with other trusts, for example, mental health and how the ambulance service could play a key role without letting pressures build up.

Councillors Darkes asked where the plans were to reduce the job cycle times and was informed that there was not necessary to reduce this as it was reflective of how the service had changed. Mr Cotton added that this should not be confused with the response times as this was about ensuring the right resources were available to meet demand. Not all patients needed to go to hospital and could be referred to alternative pathways or treat on scene.

The Chairman referred to the increase in the staff compliment in our area by 121 however as there was only funding for 84 he asked how the additional funds would be found. Mr Cotton said that this was part of ongoing discussions with the commissioners. He added that they had invested additional funds over the last 12 months and that the vacancy rate had come down. As new standards were introduced as part of the Spring review the service were assessing what they required going forward.

Referring to the many services changing in the region the Chairman expressed concerns that NEAS were not involved in all discussions. Mr Cotton said that this had been raised to ensure that they were involved but assured the committee that they were involved in any big geographical projects. He commented that the small changes did impact on the service. The relocation of services or reconfiguration of services over a period of time did have an impact on the service.

The Principal Overview and Scrutiny Officer advised that formal responses would be signed off in conjunction with the Chairman and reported back to committee on 6 July 2018. He would include the comments made at this meeting about performance and service issues and the priorities moving forward.

Resolved:

(i) That the report be received and noted;

(ii) That comments on the information provided within the presentations made by Tees Esk and Wear Valleys NHS Foundation Trust; County Durham and Darlington NHS Foundation Trust and North East Ambulance Service NHS Foundation Trust as well as their respective Quality Account documents be noted;

(iii) That the submission of the Committee's formal response to the Quality Accounts be delegated to the Chair and Vice Chair of the Adults Wellbeing and Health Committee in view of the short timescales within which the Committee has to respond;

(iv) That a further report detailing the formal responses to the Quality Accounts be submitted to the Committee's meeting scheduled for 6 July 2018.

DURHAM COUNTY COUNCIL

ADULTS, WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in **Committee Room 2 - County Hall, Durham** on **Friday 1 June 2018** at **9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors P Crathorne, G Darkes, A Hopgood, E Huntington, A Patterson, S Quinn, M Simmons and H Smith

Co-opted Members:
Mrs R Hassoon and Mr D J Taylor Gooby

Also Present:
Councillors L Hovvels and L Maddison

1 Apologies

Apologies for absence were received from Councillors J Chaplow, R Bell, R Crute, J Grant, A Reed, A Savory, L Taylor and O Temple.

2 Substitute Members

No notification of Substitute Members had been received.

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 NHS England Review of Specialised Vascular Services

The Chairman thanked the officers and colleagues from the Council and the various branches of the National Health Service (NHS) for their attendance.

The Chairman noted there would be a presentation from NHS colleagues (for copy see file of minutes) and asked the Principal Overview and Scrutiny Officer, Stephen Gwillym to explain the background in relation to the Special Meeting.

The Principal Overview and Scrutiny Officer noted that at a meeting of the North East Joint Health Scrutiny Committee held on 15 February 2018, representatives of NHS England's North East Region Specialised Commissioning Team presented a report and gave a presentation in respect of proposals to review specialised and some non-vascular services across the North East. Members were referred to the "North East Vascular Services Case for Change" as set out in the agenda papers. The Committee were reminded that it considered a briefing paper at its meeting on 13 April 2018 on the proposed delivery of vascular services in the North East from 3 locations, reduced from 4. It was noted current delivery from: South Tees Hospital NHS Foundation Trust (James Cook University Hospital); County Durham and Darlington NHS Foundation Trust (University Hospital of North Durham - UHND); City Hospitals Sunderland NHS Foundation Trust (Sunderland Royal Hospital - CHS); and Newcastle Hospitals NHS Foundation Trust (Freeman Hospital).

The Principal Overview and Scrutiny Officer noted that Members had raised concerns in terms of Durham being chosen as the location to cease providing specialised vascular services, in terms of reference to Sunderland as being at the "centre of the region" and also in terms of clinical evidence of selecting Sunderland over Durham. It was added that accordingly, the Committee had requested a Special Meeting to consider the proposals in more detail.

The Principal Overview and Scrutiny Officer asked the Assistant Director - Specialised Commissioning, NHS England, Penny Gray to give an introduction.

P Gray noted that purpose of the review was to support the delivery of the patient benefits and outcomes for vascular service in the North East in general and Durham/Darlington specifically. She added that support was sought for the recommendation of the review, for a "three centre service" configuration and noted it was recognised that the choice between CHS and UHND was marginal. P Gray noted that agreement was also sought in terms of the rationale for the choice of CHS rather than UHND, and for support of the implementation of the review as set out in the presentation, including the plans that the commissioners have for communicating with patients and public to explain the changes.

P Gray asked the Consultant Vascular Surgeons for both UHND and CHS, Phil Davey and Paul Dunlop respectively, to explain the case for change and the recommendation for services to be delivered from CHS rather than UHND.

P Davey explained that while he was the lead for Durham, he cared very much for Sunderland, and explained that he and his colleagues giving the presentation were all local people and cared greatly about the delivery of vascular services in our area.
P Davey noted that it had been recognised around 20 years ago as regards the need to centralise delivery of specialised services, though more recently the pace of change had gathered such momentum that historic delivery methods had not kept up.

He noted that use of x-ray technology, with 60% of procedures involving minimally invasive techniques required highly specialised staff and it was not possible to deliver at all district hospitals nationally. He added that Vascular Surgeons were not General Surgeons, it was a separate and very specialised/niche area.

P Davey explained that also over the last 10 years, there had been concern nationally as regards vascular procedures and the UK versus Europe versus the rest of the world in terms of inferior outcomes for the UK and how to address this. He added that both Darlington and Gateshead had previous ceased to provide specialised vascular services, leaving the 4 delivery centres as previously noted. However, P Davey explained that all clinicians agreed that there was a need to rationalise further to three vascular centres and this was set out within the "North East Vascular Services Case for Change 2014".

The Committee were informed that key clinical drivers for change included the strong evidence of a link between surgical volumes and improved patient outcomes from complex arterial surgery, especially abdominal aortic aneurysms (AAA). P Davey reiterated that advances in technology and the shift towards non-invasive treatments methods for vascular patients (endovascular) had an associated increased reliance upon specialised interventional radiology support. Members were informed that the advances in treatment that had greatly improved patient outcomes require 24/7 availability of endovascular practitioners, interventional radiologists or dual-trained surgeons, who have highly expert and specialised skills.

P Davey explained that an ageing population presented a general increasing pressure on services and there was also the AAA screening programme which in order to give low mortality rate required a high volume. He added that a centralised service would also improve overall sustainability and aid recruitment. It was noted that it would also fit with the national service specification in terms of a hub and spoke network model.

Members were informed that benefits to a centralised service included: improved infrastructure, for example imaging services; enable compliant vascular surgical / interventional radiology on-call rotas; appropriate vascular anaesthesia / nursing and allied professional support / expertise; provide adequate critical care support; facilitate essential interactions with other services; and improved post-graduate training and research opportunities.

P Davey explained that the Freeman and James Cook were major vascular trauma centres and therefore the two models that had been considered were a "two centre model", with only those two hospitals, or a "three centre model" that would include either CHS or UHND. He explained that an independent clinical review was accepted to consider the clinical requirements of a third centre. It was explained that The Vascular Society were asked to recommend the most effective and safe configuration of Specialised Vascular Surgery Services within the North East of England and to consider the clinical requirements of a third centre. It was added that the review was supported by the Clinical Advisory Group, both Trusts and endorsed by NHS England.

P Davey explained that both UHND and CHS had made very strong cases to become the third arterial centre with both having: strong clinical relationships and excellent management support.

He noted the final recommendation had been based upon: ability to meet capacity requirements; geography and population density; and existing allied service site profiles.

The Vascular Society Recommendations were to “reconfigure services onto three Arterial Centres with networked Non-Arterial sites:
1. Newcastle, networking with Gateshead
2. Sunderland, networking with South Tyneside and Durham
3. Middlesbrough, networking with Darlington in addition to current networked sites”.

P Davey noted that the decision of CHS over UHND had been a marginal decision, non-critical of either service, and had been based upon: capacity/infrastructure; staffing; theatres/imaging/ICCU; geography and population; travel times (<1 hr); current networking arrangements; co-located services; renal services; and interventional cardiology.

It was explained that the proposed service model would be patient centred with access preserved and enhanced across Durham. It was noted that Durham would continue to provide: out-patient clinics; diagnostics and day case surgery, with Sunderland providing all vascular in-patient activity.

P Davey explained that in terms of patient impact, there would be no change in the number of out-patient clinics, approximately 3,600 episodes per annum. He added that there would also be no change in terms of non-invasive imaging and that day case surgery would to remain in Durham, approximately 200 cases per annum. Members noted that all primary in-patient vascular care delivered exclusively at CHS or James Cook University Hospital (JCUH) and this would affect approximately 650 patients per annum, with 12 cases per week transferring to CHS and 2 cases per week to JCUH. P Davey added that other speciality in-patient vascular support would not change and be provided at UHND and Bishop Auckland General Hospital (BAGH). It was noted that there would be an expected reduction at the tertiary centre, the Freeman Hospital, referrals needing to be centralised.

P Davey noted in conclusion that clinical consensus had now been reached, with a single clinical option to provide a sustainable local vascular service at CHS as the arterial hub with UHND/BAGH/JCUH as spoke sites. He added the proposals were: endorsed by NHS England; supported by the CCG; reinforced by the Clinical Advisory Group; and both Trusts were fully supportive and engaged.

The Head of Communications and Engagement, NHS North of England Commissioning Support Unit, Caroline Latta explained that consultation and engagement would include: and external project partnership board being established; an equality impact assessment; a travel impact assessment; a detailed communications and engagement plan developed in partnership with NHSE, CCGs and Trusts. It was added that this plan would include: patient engagement events facilitated by Health Watch; focus groups; patient reference groups; stakeholder communications and engagement; variety of ways patients and stakeholders can feedback; internal communications; engagement with NEAS.

P Gray noted summarised that there was a need for centralisation, a three centre model; the clinical outcomes and patient benefits had been set out.

She explained that the next steps would be for the Committee to be asked to support the presented plans to enable commissioners and providers to move ahead with the recommended reconfiguration. Members noted that Officers would continue to develop the full business case and there would be a Stage 2 assurance process within NHS England. P Gray concluded by noting the implement communications and engagement activity, continued engagement with Joint Overview and Scrutiny Committees and the ongoing internal communications and to begin the staff consultation process.

The Chairman thanked the speakers and noted a number of questions had been raised, including: had the case been made in terms of CHS; engagement, why was there no formal consultation under the Act; why NHS England was not managing the process; why 2014/15 figures were used why not newer data; what the opinions of CCGs were; viability of UHND going forward; why the sustainability and transformation partnership (STP) was being ignored; all options should be within 60 minutes, only UHND meeting this; there were travel risk regarding the A19, with the local MP, Grahame Morris looking at this issue; it was noted that the consultation stated to serve a 600,000 population, with Durham having 685,000 and Sunderland having 480,000; the case for change noting 33 referrals, with UHND having approximately 60; and as regards whether people from Stanhope and Weardale would look to "migrate" if they found travelling to Cumbria / Carlisle easier.

R Hassoon noted increased waiting times to have surgery and lack of vascular intensive care beds, only general intensive care beds and a lack of skills. P Dunlop noted that the proposals were that if more concentrated to 3 centres, there would be an associated concentration of expertise that should lead to better services. P Davey noted this would help to address and shortfall in services.

Councillor A Hopgood noted as regards proposed communication and engagement and asked if there was a possibility of the proposals being changed on the basis of any feedback. C Latta noted there would be stakeholder events and genuine alternatives and ideas would be considered, with formal consultation if required. Councillor A Hopgood noted that if there was a feeling that the case was fixed, then there would not be meaningful engagement. She added she was not anti-Sunderland, the issues was the large geographical area to the west of County Durham. Councillor A Hopgood noted that the travel times as stated in the document seemed incorrect, with it not realistic and the proposals catered more towards the south and built up areas, not the rural west of the County. The Chairman added that residents of areas such as Stanhope may vote with their feet, and choose Carlisle for example.

C Latta noted she was from a rural community and understood the concerns and that it would be through the engagement process that issues would be rooted out, and that the evidence and issues such as rurality and travel times could be tested. She added that a number of patients that had experienced the service had been contacted directly as regards their experience, with this to be then reported back.

Councillor P Crathorne noted that in the past there had been consultations as regards services at Bishop Auckland and she felt that this had not changed the proposed model in that case, and asked whether in this case it had been decided.

Councillor H Smith noted that the clinical case had been well made in terms of CHS over UHND, for example issues relating to theatre time / experience, numbers of radiologists and specific intensive care beds. She added that however the geography of County Durham was huge and her Division was in rural Teesdale and that there was a long travel time to Durham, with the time to Sunderland being even longer.

Councillor G Darkes noted that Sunderland had 40% less population than Durham and also asked as regards any discussions that had taken place with the North East Ambulance Service (NEAS) in respect of the proposals, noting the current ambulance times.

Councillor S Quinn noted that it seemed that the older centres seemed to be favoured over the newer centres and asked if there was any rationale as regards this.

Councillor L Maddison thanked the Chairman and noted that one of her concerns related to staffing, with the proposals noting they were sufficient at Sunderland and that this suggested they may be overstaffed in the future. She asked if this was not the case and the extra staff was building extra capacity, what was the lead-in time in terms of providing training to enable them to provided services. P Dunlop noted that Consultant Surgeons would transfer via TUPE, some nursing staff would TUPE and there would be more recruitment in terms of intensive care unit staff and theatre staff, adding it was not extra training.

The Chairman asked why the new hospital at Sunderland was not being used, with Members having been told renal patients would have services delivered at Durham. The Associate Director of Operations for the County Durham and Darlington Foundation Trust, Shane Longden explained that Durham was state of the art, however, did not have in-patient / overnight facility. He added there was dialysis services and intensive treatment units at UHND. Mr D Taylor-Gooby observed that the impression had been given that if UHND had been chosen it would require significant investment and therefore the decision appeared to be made. P Dunlop noted that more renal services would have to move to Durham if required.

The Chairman asked whether formal consultation under the Act would be carried out and highlight options regarding CHS or UHND. C Latta noted that stakeholder events would lead to information for critical partners to take away and consider, it was added there was a duty to be honest as regards options that would be achievable and that there would be engagement with previous vascular patients and there was a genuine opportunity to influence mobility plans, helping commissioners regarding services, looking at quality of care and clinical outcomes too.

Councillor A Hopgood noted that in terms of consultation, she felt it was a little disingenuous to use “communication”, as this was a two-way street and engagement was not the correct word as there was no doubt in terms of the clinical case, however, there was an issue in terms of the geography of the County, with those living at Stanhope not being able to get to Sunderland within an hour. The Chairman noted NHS England had not responded to the question of the west of the County.

P Gray reiterated that the Consultant Vascular Surgeons were local people and passionate and would not leave out the west of County Durham, the recommendation from the review was a marginal decision, however, the clinical outcomes for patients were the main factors in proposing the Sunderland centre. P Dunlop added that the proposals were the best in terms of reducing deaths, stokes and amputations. Councillor H Smith noted that that was correct, once you got to Sunderland, however, it was a very long time from the Durham Dales to Sunderland. The Chairman noted as a former nurse he agreed with the clinical case, however he felt the proposal was wrong geographically.

Councillor A Patterson felt that the report was flawed in that it focused on a region, and that it was more of an issue between Durham and Sunderland, and there should be a formal consultation. She added that in terms of canvassing vascular patients, she asked how you would predict those that may become such patients, and suggested it would be better to consult with all residents. Councillor A Patterson added that Durham was not at the geographic centre of the county, however, if Durham was felt to be the best location, would it not be best to relocate services accordingly. She added that from her Division, Crook, to Durham would require two buses and that in terms of the East Durham Corridor, there was easy access along the A19 and to the Metro. Councillor A Patterson noted she felt location was key and that the staff and equipment should be transferred to that location. She continued noting that there should be consultation with residents and the report should include information regarding location. Councillor A Patterson asked as regards other consultation and engagement events and who advertised them, where there were advertised and how to get involved.

The Chairman asked whether Clinical Commissioning Groups (CCGs) and STPs had been circumnavigated in terms of this issue. The Chief Clinical Officer, Durham Dales Easington and Sedgefield CCG, Stewart Findlay noted that both Durham CCGs tried to protect services in County Durham, Darlington and Bishop Auckland, noting the securing of a 3 year contract in terms of acute services, and 5-10 years in terms of community services. He added that in reference to this issue specifically he could not argue in terms of the clinical reasons for colocation of other services. He added that travel time from Stanhope to Sunderland was approximately 1 hour 30 minutes, and was similar to Carlisle, those areas being equidistant from those centres. S Findlay added that tackling transport issues in rural areas was hard, and there had been work with NEAS, though it was noted that despite investment, times had not improved. He asked what discussions had taken place with NEAS in terms of investment and added that it was known that if patients were to get to specialist units then outcome were better. S Findlay asked what the time limit was in terms of reaching a unit where outcomes would be better. P Dunlop noted it was within 1 hour, however there was evidence that even within 2 hours to main specialised centre had better outcomes.

Councillor A Patterson agreed with specialist units, providing better outcomes, even with longer travel times, however, she suggested that if Durham could be used as the location for services then this could serve more people and people and equipment should be moved to the location that was best.

The Chairman noted there had been some argument in the past regarding stroke services, having been provided in Durham, with Darlington losing out and asked why the arguments were different this time. P Gray noted that previous arguments related to strokes services specifically.

P Davey noted stroke services ran alongside vascular services, just they were supported from different locations, with assessment, imaging and stroke care being available at Durham. The Chairman noted that 3 years ago Members were told Durham was the best location for stoke services, why not the best location now. P Davey noted that what made good stroke services was not necessarily the same for vascular services and that the discussions as regards vascular services did not impact upon the previous decisions on stroke services. P Davey reiterated that he had fought for UHND, and added that if Durham had the theatre capacity, equipment, intensive care capacity / staff, and physical space, then it would solely be a geography issue.

He added that it was not possible to deliver world class service at both sites and that he accepted the clinical case for CHS.

Councillor A Hopgood asked what services would be left at UHND and the Chairman asked how this would impact upon the viability of UHND. Councillor G Darkes referred to page 46 of agenda pack, with the Vascular Society noting the decision was difficult and all travel times between units being less than 1 hour, he suggested that this was not correct.

The Executive Director of Operations, County Durham and Darlington NHS Foundation Trust, Carol Langrick noted that in terms of the future viability of UHND, it was a very busy hospital, with very busy services and in some respect for that reason alone it had a vibrant future. She added that in terms of general district hospital services, vascular services was not a typical service and that an absence of such service was not a sign of a hospital without a future. She continued noting that when the proposal had come forward, UHND was disappointed and challenged the proposals, raising questions. C Langrick explained that in the end UHND had been assured in terms of the clinical case for the proposals for CHS to deliver vascular services. She reiterated UHND had a number of services and was committed to the site in Durham, noting the improvement to the Emergency Department and front of house improvements.

Councillor J Robinson noted Councillors were representatives of the people of County Durham and this was why they fought passionately for services for County Durham. S Findlay noted that the geography of the Wear Valley was different to Weardale and added that it was not practical to move resources to UHND in order to make vascular services at this location viable. He noted that this did not mean UHND was not viable without vascular services, as outlined by C Langrick.

A Patterson noted the report set out that UHND was very good at delivering vascular services and felt that perhaps the proposals could put lives at risk in the west. The Chairman noted that all Members could support the move from 4 centres to 3, the concern was whether the location proposed was correct.

P Gray noted that as C Latta had explained, stakeholder events would explore those issues in more detail, including resources and travel. Councillor A Patterson reiterated that such events should be open to all County Durham residents. C Latta noted the events would involve interested parties, including Councillors, charities, Health Watch and patients that had directly experienced vascular services in the last 3 years would be invited to share their experiences. She added this pre-engagement would take place and then there would be an opportunity to take stock before taking the next steps.

Councillor P Crathorne noted it did not seem like proper consultation, and that most people's opinions would not be taken on board. The Chairman noted that he felt the Committee agreed with the clinical case for 3 centres, reduced from 4, however, they were not convinced as regards the geographical argument for CHS over UHND. He added that the Committee had powers of referral to the Secretary of State for Health and Social Care and that Members would fight for their local areas.

The Principal Overview and Scrutiny Officer noted that the North East Regional Joint Health Overview and Scrutiny Committee would consider the proposals at its meeting 21 June 2018. He added that the recommendations of the Committee today would be fed into that body. The Principal Overview and Scrutiny Officer noted that the Committee accepted the clinical rationale as regards the reduction from 4 centre to 3 centres. He added that the Committee was not convinced in terms of the proposal for CHS to deliver vascular services rather than UHND, geographically it had not been fully justified. The Principal Overview and Scrutiny Officer noted that Members had debated the type of engagement proposed against statutory consultation, with the Committee suggesting that the proposals constituted a significant development/substantial variation in specialised vascular health services and therefore require formal consultation particularly in respect of the location of the third regional centre being either Sunderland Royal Hospital or UHND, Durham. He added that in terms of pre-engagement across the County, Members had wanted to see the information gathered from these sessions brought back to this Committee and at the regional level, and to have the consultation widened out to include all County Durham residents.

Resolved:

(i) the Committee receive the report and note the content of the presentation in respect of the proposals to reconfigure specialised and some non-specialised vascular services in the North East and the associated communications and engagement plans;

(ii) the Committee agree to recommend to the North East Regional Joint Health Overview and Scrutiny Committee that:

1. The clinical case for the reduction from 4 to 3 specialised vascular services centres in the North East is accepted by Durham County Council's Adults Wellbeing and Health Overview and Scrutiny Committee;

2. The rationale for the selection of Sunderland Royal Hospital as the third regional specialised vascular services centre is disputed from a geographical perspective as this would leave almost half of County Durham more than an hour's travel away from specialised vascular services;

3. The County Council's Adults Wellbeing and Health OSC believes that the proposals constitute a substantial development and significant variation in health services and that statutory consultation is required under Section 244 of the NHS Act 2006, particularly in respect of the decision of the location of the third regional centre for specialised vascular services between University Hospital North Durham and Sunderland Royal Hospital;

4. The proposed communication and engagement activity in respect of the proposed review needs to be widened to ensure that the whole population of County Durham have the opportunity to provide their views on the proposals given the significant impact upon Durham of the preferred option.

Adults Wellbeing and Health Overview & Scrutiny Committee

6 July 2018

Durham Dales, Easington and Sedgefield CCG Review of Urgent Care Services – Proposed review of Urgent Care Hub provision

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

Purpose

1. To provide the Adults Wellbeing and Health Overview and Scrutiny Committee with details of proposals to review the provision of Urgent Care Hubs as part of the extended and enhanced primary care service provision by Durham Dales, Easington and Sedgefield CCG which commenced on 1 April 2017.

Background

2. At a special meeting of the Adults Wellbeing and Health OSC held on 1 September 2016, the Committee received a detailed report and presentations updating members regarding the results of the consultation feedback in respect of proposals by DDES CCG to review urgent care services in its locality.

3. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee had previously considered reports and presentations from DDES CCG setting out the consultation and engagement plans and the proposed options for future urgent care service provision being consulted upon.

4. Following consideration of the report and presentations, the Adults Wellbeing and Health Overview and Scrutiny Committee in supporting option 3 the Committee remained of the view that:-

   (i) the CCG must take steps to ensure that GP capacity is available to provide assurance that the new model of Urgent Care services provision can be delivered;

   (ii) the preferred new Urgent Care service model will place a continued reliance on the NHS 111 service. In view of this, the CCG needs to ensure that current concerns of members and their constituents in respect of their experiences with the 111 service concerning the patient assessment process; the use of the default triage algorithm and the need for clinical expertise to be available during the assessment process are addressed.

(iii) the CCG should consider how it will market and publicise the new Urgent Care service, ensuring that the public know exactly which part of the Health service to access in which circumstances.

(iv) given the increase in usage of GP practices for Urgent Care under the new model, GP practices must take all reasonable steps to ensure that their reception areas allow for patient privacy and confidentiality.

Latest Position

5. The new Urgent Care service model was introduced on 1 April 2017.

6. Representatives of Durham Dales, Easington and Sedgefield CCG attended the Committee's meeting on 9 November 2017 and gave a presentation to members detailing post implementation monitoring of the new services and also how the Committee's concerns outlined on paragraph 4 above had been addressed.

7. The new Urgent Care service model has been operating for over a year and following an analysis of usage by DDES CCG during that period, a report has been drafted which proposes some revisions to the current provision of urgent care hubs across the CCG are and also sets out plans for consultation to be undertaken in respect of the proposed changes. A copy of this report is attached at Appendix 2.

8. Representatives of Durham Dales, Easington and Sedgefield CCG will give a presentation to members detailing the proposed revision of urgent care hub provision across DDES CCG, the stakeholder engagement undertaken to date and the proposals for consultation on the revisions.

Recommendation

9. Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are requested to receive this report and consider and comment on the presentation and the information contained therein.

Background Papers

Report and Minutes of the Adults Wellbeing and Health Overview and Scrutiny Committee on 9 October 2015, 1 March 2016, 24 May 2016 and 1 September 2016 and 9 November 2018.

Contact and Author: Stephen Gwillym, Principal Overview and Scrutiny Officer Tel: 03000 268140

Appendix 1: Implications

Finance – None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues – None

Legal Implications – None

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Business Case for Extended Primary Care Access Improvements May 2018

Authors :
Clair White, Head of Commissioning
Lindsay Fox, Commissioning Support Officer
Sarah Burns, Director of Commissioning

Contents

CCG	Durham Dales, Easington & Sedgefield (DDES)
Programme / Workstream:	Adults - Primary Care Services
Project Title:	Extended Primary Care Access
Project Leads:	Clair White, Head of Commissioning Sarah Burns, Director of Commissioning
Project Sponsor (s)	Sarah Burns, Director of Commissioning, DDES CCG
Expected implementation	July 2018

Background

In spring 2016, DDES CCG undertook a public consultation in relation to urgent care services. There were previously four urgent care services that operated within the DDES geography as follows:

Site	Type of Service	Staffing	Hours of Opening	Accessed via
Peterlee Community Hospital	Urgent Care Centre and MIU with x-ray facilities	GP led	24/7 (x-ray open during day time hours only)	Walk in and Telephone
Bishop Auckland Hospital Community Hospital	Urgent Care Centre and MIU with x-ray facilities	GP led	24/7 (x-ray open during day time hours only)	Walk in and Telephone
Seaham Primary Care Centre	Urgent Care Centre	Nurse led	8am-6pm Monday to Friday	Walk in and Telephone
Easington Healthworks	Urgent Care Centre	GP led	8am-8pm 7 days	Walk in and Telephone

Three options were considered as part of the public consultation as set out below:

	Minor Injury Units	Urgent Care	Out-of-hours services	Existing GP services	Enhanced GP services
Option 1	MI units available 12 hours per day (instead of 24 hours per day)	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	
Option 2	MI units available 12 hours per day (instead of 24 hours per day)	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	**Option 1 PLUS** Enhanced GP Service - Urgent care provided from your GP practice or in a hub arrangement 8am–8pm
Option 3	**Option 1 + 2 PLUS** MI units available 24 hours per day	No Urgent Care Centre in hours	OOH services (out of hours urgent care) remain local 8pm-8am weekdays and 24/7 weekends	GP practices open longer, 8am-8pm weekdays and 8am-1pm Saturday and Sunday (or provided in a hub arrangement)	**Option 1 PLUS** Enhanced GP Service - Urgent care provided from your GP practice or in a hub arrangement 8am–8pm

Option three received the most public support and was also supported by the CCG executive and the Governing Body. As a result the new service model was implemented in April 2017.

During the consultation, the CCG also engaged with the public on the locations of the extended and enhanced GP opening times. As a result nine hubs were developed in the following locations, with each providing appointments up to 8pm on week nights and 8am - 1pm on Saturday and Sunday.

Sedgefield - 6pm - 8pm weekdays and 8am-1pm weekends
Newton Aycliffe – Jubilee Practice
Spennymoor – Spennymoor Health Centre
Sedgefield – Skerne Medical Practice

Dales - 6pm - 8pm weekdays and 8am-1pm weekends
Bishop Auckland – Bishop Auckland Hospital
Upper Dales – Weardale Practice
Lower Dales – Richardson Community Hospital

Easington - *8am - 8pm weekdays* and 8am-1pm weekends
Seaham – Seaham Primary Care Centre
Peterlee – Peterlee Health Centre
Easington - Healthworks

In Sedgefield and Dales, demand for patients that previously attended urgent care centres during weekdays (8am-6pm) would be seen by their GP practice. In Easington, GPs did not feel that they could cope with this additional demand, as services in Easington saw an average of 11 patients per practice per day. As a result, three hubs were opened during weekdays from 8am to 8pm to meet the historic demand seen in this area.

A key change was that in future services would be accessible via appointment and rather than 'walk in' services.

Finance

Historically urgent care services were delivered jointly with minor injury units and GP out of hours services. Services had not been reviewed for a number of years and the costs of services were high in comparison to benchmarked services. A contact in the services cost £76 which compared to £76.51 which GPs receive to deliver a service for each patient per year in 2016/17. The national average cost of an urgent care attendance at the same time was c£35.

As a result of the service re-design QIPP savings of £1.14m were achieved which were then reinvested into other health services for the DDES population.

Transport

The new service model meant that patients would be able to receive urgent care at their own GP practice or at a GP hub. Urgent care services have a dedicated transport service which was available to patients requiring transport an appointment at one of the former urgent care centres. It was believed that use of this service would decrease as patients were able to access services closer to home. Availability of comparable data has been difficult to access, but work is ongoing to understand the impact of the service changes on use of transport.

Impact of Service Changes

Prior to implementation, an assessment was made at a geographical level based on the number of patients that may attend type 1 A&E services instead following the changes. A type 1 A&E department is a consultant led 24 hour service with full resuscitation facilities. Data for April to February 2018 has been compared with the same period in the previous year and type 1 A&E attendances have generally stayed the same with a slight increase of 0.6% (363). This compares to national growth in A&E attendances of 2.5% (forecast for 2017/18 using M11 data).

The impact on type 3 attendances (MIU/Urgent Care Centres designed to treat illness/minor injury) has varied across the local sites. In Bishop Auckland type 3 attendances have decreased by 52% (n. 14,818) and in Peterlee they have decreased by 77.5% or 21,528. This is in line with the expected decrease given that sites would no longer see walk in attendances for minor illness. Minor injuries and GP out of hours services continue to be delivered from these sites. During the same period there have been over 25,700 attendances in the extended and enhanced primary care hubs.

Since implementation attendances at Darlington urgent care centre have increased by 32% or 536 attendances compared to the same period last year. Of this increase, c10% is during the day when practices are open and comes in the majority from the three Bishop Auckland town centre practices. An audit of these attendances has been carried out and work continue to ensure this is minimised.

The remainder of the increase at the Darlington urgent care centre is in the out of hours period. There have been difficulties in staffing GP shifts in the out of hours service and patients have had to be referred to Darlington if there is not a GP on site in the Bishop Auckland service. Work has been done to ensure that the 111 Directory of Service (DoS) sets out the conditions that can still be treated at Bishop Auckland on such occasions and the impact of this change is expected to be known imminently.

It is now a national imperative that GP shifts are filled in out of hours services and local providers are being monitored by NHSE on this. Dedicated work has taken place to encourage more GPs to undertake shifts in the Out of Hours service with CDDFT (GP OoH provider) improving the process to sign up to working in the service. Despite these measures it has continued to be difficult to fully staff services under the existing staffing model.

It should be noted that other areas in the North East have started to implement a new staffing/skill mix to deliver GP Out of Hours services. This is also being considered across County Durham. This requires detailed work to understand clinical pathways and is being led by clinicians from primary care and the Out of Hours service (both GP and practitioners).

National extended access requirements

There is a national requirement for CCGs to commission extended GP access for the population. This requirement is an additional 45 minutes of access per 1,000 population. This is set out by locality in the table below:

Locality	Raw List Size - 1 April 2018	Hours Per Week
Dales	91,857	68.89
Easington	102,650	76.99
Sedgefield	97,525	73.14
Total	**292,032**	**219.02**

Extended access should offer a mix of both planned and unplanned appointments whereas the current PCS service offers only unplanned appointments although it is known that some of the hubs will offer a small number of planned appointments at their discretion.

The CCG need to ensure that any changes to service delivered do not negatively impact on these requirements. The current capacity commissioned via the PCS service far exceeds the requirements set out in the national extended access scheme and this is detailed in the locality sections later in this report.

UTC requirements

In July 2017 NHS England published "Urgent Treatment Centres –Principles and Standards" sets out the 27 standards to be implemented to meet the goals of the Five Year Forward View.

A wide variety of Minor Injuries Units, Urgent Care Centres and Walk in Centres currently exist with a confusing variation in opening times, in types of staff present and what diagnostics may be available. These standards establish as much commonality as possible to reduce the variation in the offer to the public as well as reducing attendance at and conveyance to A&E.

The CCG identified implementing these standards as a priority and have been working with CDDFT since January to implement. The CCG need to ensure that this Primary Care Service – GP Access continues to compliment and provide day time GP leadership to the full population.

During this process we will also be exploring opportunities to co locate any service where it would be better for the patient and offer best value for money.

Case for change

It was agreed that the CCG would report back to the Health Overview and Scrutiny Committee (OSC) six months post implementation to feedback on the impact of the service changes, any highlight any issues that have arisen and how the CCG was responding to any issues.

At the six month review stage it was identified that despite a few minor issues relating to signposting from the NHS 111 service in the first weekend, the changes had been made successfully with minimal disruption to the 'system'.

It was also agreed as part of the changes to service made in April 2017 that a review would be carried out once services were embedded. The feedback at the six month point was useful, but it was considered too early at this point to make any changes to services, particularly as the services had not operated during the winter period where demand for urgent appointments can be higher.

It was clear at the six month point that the available capacity was not being fully utilised although the issues were slightly different in each locality. Service providers were highlighting at this point the impact of this in retaining staff, as staff wanted to feel that they were being fully utilised. The low utilisation rates have raised concerns about value for money of the PCS services.

At the time that the initial service changes were made there was limited information (other than clinical audit) to enable a split between attendances for minor injury and illness. As services are delivered differently now, much more detailed information is available on the true demand for appointments for minor illness during core GP opening hours.

As part of the service changes practices were required to carry out an audit to understand how they were matching capacity to demand and act upon the impact of these findings. A number of practices have changed how they offer access to patients as a result which may also be impacting on demand for PCS.

There have been changes in demand for out of area services. There were changes to services in Hartlepool and Stockton that took place at the same time as the changes in DDES with UTCs opening at North Tees and Hartlepool Hospitals. Sunderland CCG is currently consulting on changes to the urgent care service they commission that border the DDES area, such as Houghton. Sunderland CCG are proposing to reduce urgent care centres, increase primary care access and to change access arrangements so they are appointment based as opposed to walk in services.

The CCG confirmed its intention to OSC to carry out further engagement with patients to gain insight into the new services to help to identify why services were not being utilised as expected. Feedback has been gathered from patients using PCS and also patients using out of area services. Additional targeted work was carried out with identified patient groups such as the GRT community. The engagement report can be found at appendix 1 with summarised information in the locality summaries later in this business case.

The following sections of the business case set out a case for change. This is specific to each locality as the issues are different in each area. This takes into account:

- Patient views
- Activity
- Capacity
- Potential impact on other services
- GP extended access requirements
- Value for money
- Transport
- Pharmacy provision

What we did and how we have engaged?

The engagement activity took place over a nine week period from the middle of December 2017 to the end of February 2018.

The aim of the engagement work was to gather the views from patients and carers who accessed the primary care services in the Durham Dales, Easington and Sedgefield CCG area and those who went out of the DDES area into Urgent Care Centres or A&E Departments.

There was a requirement to do some further data analysis and patient engagement to understand whether the way the service is current set up is giving patients the best service.

We engaged with patients and stakeholders to find out about their experiences of using the Primary Care Services but also to aim to reach those who have not. If they are not using the PCS, then where are they going? What services are they using?

Stakeholders were also engaged to give them the chance to feed into this process and give them the opportunity to aid in the development of and decisions about new options for service delivery. We wanted to find out what else patients think we should be offering, whether this is, for example: home visits, telephone calls so they can be seen on the same day if they have an urgent need.

The stakeholders we engaged included many of those who were involved in the Urgent Care consultation. We worked with our Patient Reference Groups (PRGs), Health networks and other partners who could help us to reach as many potential service users as possible. We also worked with harder to reach groups such as Gypsy Romany Traveller groups (please see feedback detailed in appendix one), Investing in Children eXtreme Group and also the young people's health group.

All of the engagement activity has been recorded and is shown in the evidence log – see engagement report.

The engagement team supported by the CCG commissioning team attended each Primary Care Service (the nine hubs), spoke to patients about their experiences of the services and completed questionnaires.

This team worked with staff within the centres to distribute questionnaires over the next four to six weeks to capture a good range of feedback. All questionnaires were put into a sealed envelope by the patient and stored in a confidential box.

The CCG commissioning team collected these periodically and a member of the corporate admin team entered the responses onto survey monkey to remain impartial.

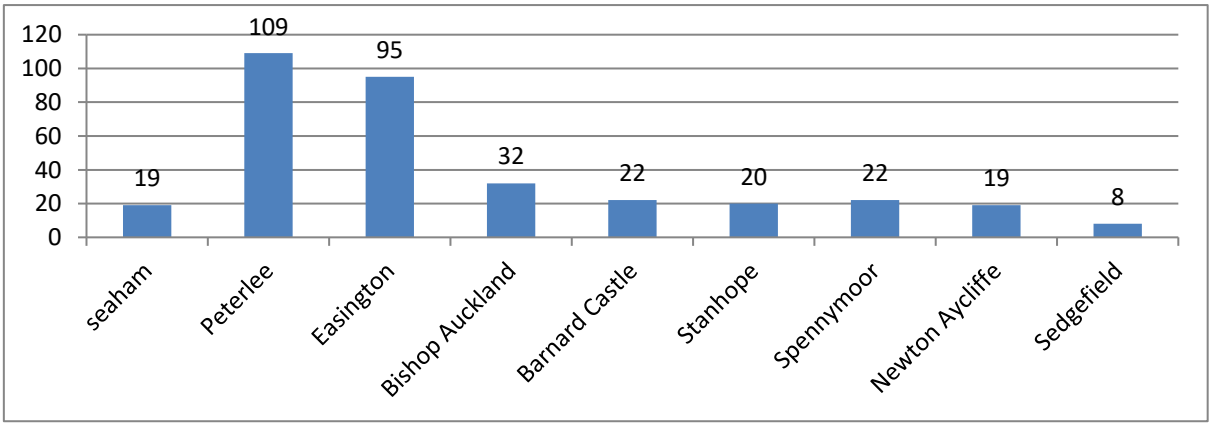
All of the engagement activity has been recorded and is shown in the evidence log, which can be found at appendix three.

Summary of key findings from the survey results around the service model

Summary of key findings from the survey results around the service model. Over 346 patients from across the Durham Dales, Easington and Sedgefield (DDES) CCG were engaged over the period; the responses were recorded through an on line survey.

The sites which received the most patient feedback were Peterlee with 32% and Easington with 27% of the 346 patients who completed a survey.

Actual number of surveys returned from each hub site are below



Current Services in Dales Locality

In the Durham Dales locality, the Primary Care Services are offered from 6-8pm Monday to Friday and 8am -1pm on a Saturday and Sunday. Services are delivered from:

- Bishop Auckland Hospital
- Richardson Hospital
- Weardale Practice

All day time same day access is provided in practices, however, the practices have worked together to set up an overflow clinic in Bishop Auckland to ensure that all patients can access a local day time same day appointment if their practice is full.

Use of primary care extended access services

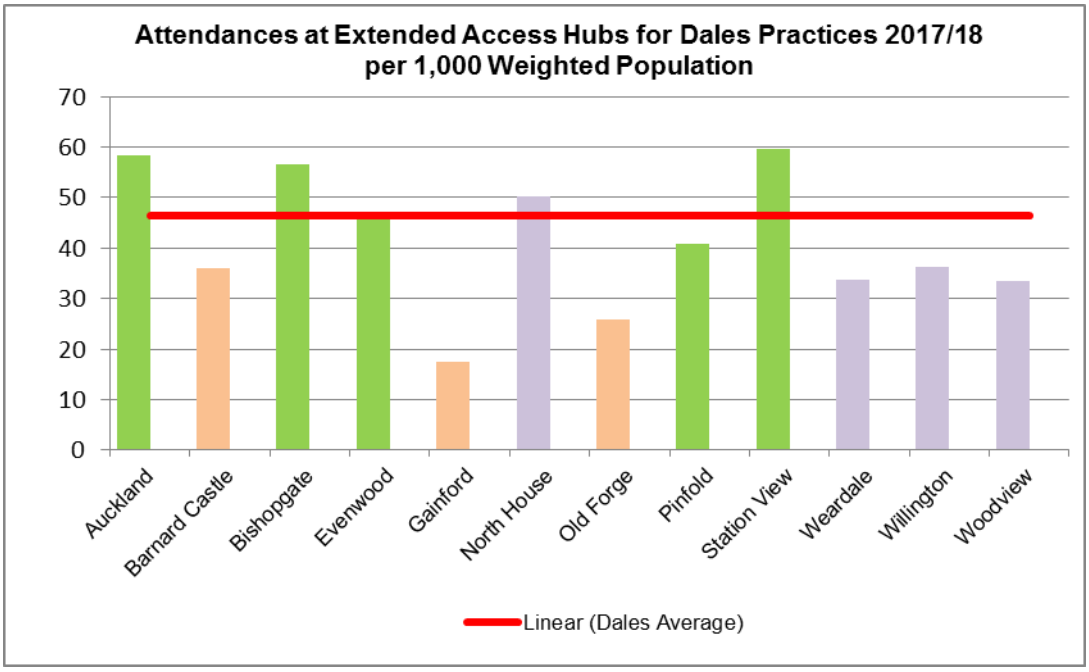
The table below shows the number of patients accessing services throughout 2017/18. There were data quality issues in the first quarter which meant that time of attendance wasn't recorded completely. The data suggests that activity has been fairly steady throughout the year with a small increase at evenings and weekends in the October to December 2017 period.

Number of contacts to GP extended hours services, by locality of the site of the service:

Locality of site	Quarter	Weekday 8am-6pm	Weekday evenings 6pm-8pm	Weekend/Bank hol 8am-1pm	Contact outside of service hours	No date/time provided	Total
Durham Dales	Q1 2017/18	15	256	508	47	304	1,130
	Q2 2017/18	31	407	713	71		1,222
	Q3 2017/18	21	437	809	103		1,370
	Q4 2017/18	28	400	759	115		1,302
Durham Dales Total		**95**	**1,500**	**2,789**	**336**	**304**	**5,024**

*Practices in the Dales set up an overflow clinic to ensure that patients could be offered a local appointment if their practice was full that day. The data above shows that this is used by c1 patient per day. This does not capture additional activity seen in individual practices.

Attendance levels vary by practice as shown in the chart below:



There are higher attendance rates from the Bishop Auckland and Crook practices and lower attendance rates from the rural practices. This is despite the fact that there are hubs in both the upper and lower Dales areas.

Patients from Crook and Willington tend to access the Bishop Auckland hub, but the level of activity differs significantly between the two practices despite the distance to the hub being relatively equal.

Hub activity

Activity data has shown that in the Dales area average attendances are as follows:

Weekday evenings 6pm-8pm	6.4 per evening
Weekends 8am-1pm including bank holidays	57 per weekend

This includes data for all three hubs.

Capacity provided

When the service changes were made in April 2017, work was undertaken to ensure that sufficient capacity was available. The additional capacity that was commissioned in the Dales which includes additional core primary care activity during weekdays plus the additional evening and weekend capacity is set out below:

Additional hours service per week -

Hours	No of appointments	Total hours
8am – 6pm	320	80 hours
6pm – 8pm	120	30 hours
Weekend	120	30 hours
Total		**140 hours per week**

Appointment time used is 15 mins however please note many appointments take much longer than the 15 minutes allocated.

** GP Access standards set are required to provide 45 minutes by 1000 population – this equates to 69 hours required in additional capacity to meet the target

Locality	Raw List Size - 1 April 2018	Hours Per Week
Dales	91,857	68.89

Utilisation of this capacity varies by hub as follows:-

Practice	Utilisation rate Q1	Utilisation rate Q2	Utilisation rate Q3	Utilisation rate Q4	Utilisation rate Total
Bishop Auckland	75%	79%	101%	87%	86%
Stanhope	19%	23%	17%	24%	21%
Barnard Castle	21%	23%	16%	25%	21%

The figures include telephone calls as well as face to face appointments.

Cost per attendance

The table below shows the cost per attendance at each of the hubs:

Locality	Hub	Funding Weekday Service 6 pm to 8pm	Funding Sat and Sun Service 8am to 1pm	Total Funding	Activity	Cost per case
Dales	Barnard Castle	62,237	93,162	155,399	578	£ 268.86
	Bishop Auckland	84,548	93,162	177,710	2,988	£ 59.47
	Stanhope	62,237	93,162	155,399	439	£ 353.98
	Telephone contacts				1,019	
	Total	209,022	279,486	488,508	5024	£ 97.23

Funding was always higher for the Bishop Auckland hub as it was expected that there would be more staff working in that hub. It should be noted that this was the budget given to the provider as opposed to actual delivery costs and is used to provide the overall service. The data does suggest that the low utilisation rates of the rural hubs result in a very high cost per attendance which could not be considered value for money.

Impact of the changes on other services

Prior to implementation, an assessment was made at a geographical level based on the number of patients that may attend type 1 A&E services instead following the changes. A type 1 A&E department is a consultant led 24 hour service with full resuscitation facilities. Data for April 2017 to February 2018 has been compared with the same period in the previous year and type 1 A&E attendances have increased by 3.1% (505).

The impact on type 3 attendances (MIU/Urgent Care Centres designed to treat illness/minor injury) has varied across the local sites. Type 3 attendances by Durham Dales locality patients have decreased by 44.7% (n. 9646). This is in line with the expected decrease given that sites would no longer see walk in attendances for minor illness. Minor injuries and GP out of hours services continue to be delivered from these sites. During the same period there have been over 4,500 attendances in the extended and enhanced primary care hubs.

Since implementation attendances at Darlington urgent care centre have increased by 32% or 536 attendances compared to the same period last year. Of this increase, c10% is during the day when practices are open and comes in the majority from the three Bishop Auckland town centre practices. An audit of these attendances was carried out and any issues addressed.

The majority of the growth in attendances in Darlington was in the out of hours period and are as a result of staffing issues in the GP out of hours service. The actions being undertaken to address this have been stated previously in this paper.

Patient engagement feedback

From the information gathered via the surveys, Bishop Auckland is the busiest site with the majority of people attending on a weekend.

The main reasons people attended was they felt they got a better service/it was easier to get an appointment, they couldn't get a GP appointment or the practice was closed. This was

not unexpected as the additional service covered the period when their practice is usually closed.

The majority of patients got an appointment via NHS 111 and had a positive experience of the service. When asked about their opinion on the sites, very few people chose to answer and therefore it is difficult to be able to gain a strong view from the remaining responses.
Most people would be prepared to travel around 10-15 miles to a PCS service. The majority found that the current opening times are convenient and didn't think the service could be improved.

Views from practices

A summary of service activity data and patient feedback was shared with the practices in the monthly commissioning meeting. A survey was also issued to practices to capture any views that practices wanted to be considered. Due to conflicts of interest (as providers of the current services) practices are not able to make a decision on service configuration. However their views based on population needs and the information provided was sought and is shown below.

During the week practices have requested that all patients are seen in their own practices with an overflow service provided to support practices. This could include pre booked appointments and support in times of surge.

During weekday evenings and at weekends, practices felt that patient need would be best met with one central hub in the Bishop Auckland area. This matched local pharmacy provision and demand.

Practices considered the patient feedback on distance that patients would be prepared to travel and felt that one central hub would not necessarily cause access issues as patients were previously used to having one central hub in that area.

However, practices felt that there needed to be an outreach service including home visits for the rural areas, with a particular focus on housebound patients where ability to travel may be a barrier to access for some.

Transport and access for patients

The distances between hubs are shown in the table below.

Dales locality distance between hubs	
Richardson Hospital to Bishop Auckland Hospital	13.4 miles
Weardale Practice to Bishop Auckland Hospital	10.9 miles
Richardson Hospital to Weardale Practice	16.3 miles

As well as public transport, the CCG commissions the Durham Urgent Care Transport Service (DUCT). The DUCT service provides transport for any patients that are unable to attend an urgent appointment. All patients that are booked to attend services via NHS111 will be asked if they have access to transport to attend an appointment and if necessary transport will be booked. Those booked to attend via the hubs or the practices also have access to transport booking.

Other known issues to be considered

Pharmacy provision is limited at evenings and weekends in the rural areas.

Access to planned appointments for shift workers or those working away was highlighted during the previous public consultation

The current service provides additional access for unplanned appointments whereas the national extended access requirements include the ability to pre book appointments.

The patient reference groups for the Dales have expressed support for service changes following discussions in their practice and locality groups.

Options appraisal

Option	Advantages	Disadvantages
1. No changes to current service delivery	Maintains status quo Provides access equally across the area Public support for services in rural areas	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding Public perception of value for money of services
2. Reduce to two sites (Bishop Auckland and one rural site)	Provides more access in the rural areas Public support for services in rural areas	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding Public perception of value for money of services Difficulty identifying the rural site due to geography
3. Reduce to one site (Bishop Auckland)	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services Easier for NHS111 to signpost patients Close to MIU and out of hours service Provides value for money	Distance to travel for rural patients Difficulties with access for frail/house bound patients Patient perception of loss of services in rural areas
4. Reduce to one site (Bishop Auckland), but change/extend weekend opening hours	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services Easier for NHS111 to signpost patients Close to MIU and out of hours service Offers more patient choice	Distance to travel for rural patients Difficulties with access for frail/house bound patients Patient perception of loss of services in rural areas Duplication of service with the Urgent Treatment Centre/Out of Hours service
5. Reduce to one site (Bishop Auckland) with outreach services for frail/housebound patients	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Improves access for housebound patients, but is more value for money Easier for patients to understand available services Easier for NHS111 to signpost patients Close to MIU and out of hours service Provides value for money	Distance to travel for non- house bound rural patients Patient perception of loss of services in rural areas

Dales Recommendations

Based on the current utilisation data and patient feedback it is proposed that changes are made to service delivery.

Of the options considered above, option 5 is the recommended option as it will deliver a service meeting a range of needs including frail and housebound patients in the rural areas, but also be better value for money. In addition to this it is proposed that engagement is carried out with local patients on the inclusion of planned appointments in the service and any other services that patients feel could be delivered from the Bishop Auckland hub.

It is recommended that the outcome of the review and the preferred alternative service model is presented to the OSC committee. Following this an outline consultation approach will be developed to support the development of final service configuration and seek patient views on the potential changes. The consultation plan be developed will be shared with the OSC for review, comment and input.

Current Service in Sedgefield

In the Sedgefield locality, the Primary Care Services are offered from 6-8pm Monday to Friday and 8am -1pm on a Saturday and Sunday.
Service are delivered from ;

- Skerne Medical Centre – Sedgefield
- Jubilee Medical Centre – Newton Aycliffe
- Spennymoor Healthcentre – Spennymoor

When the service changed from 1st April 2017, there was a significant increase in capacity in Sedgefield with the opening of three hubs at evening and weekends.

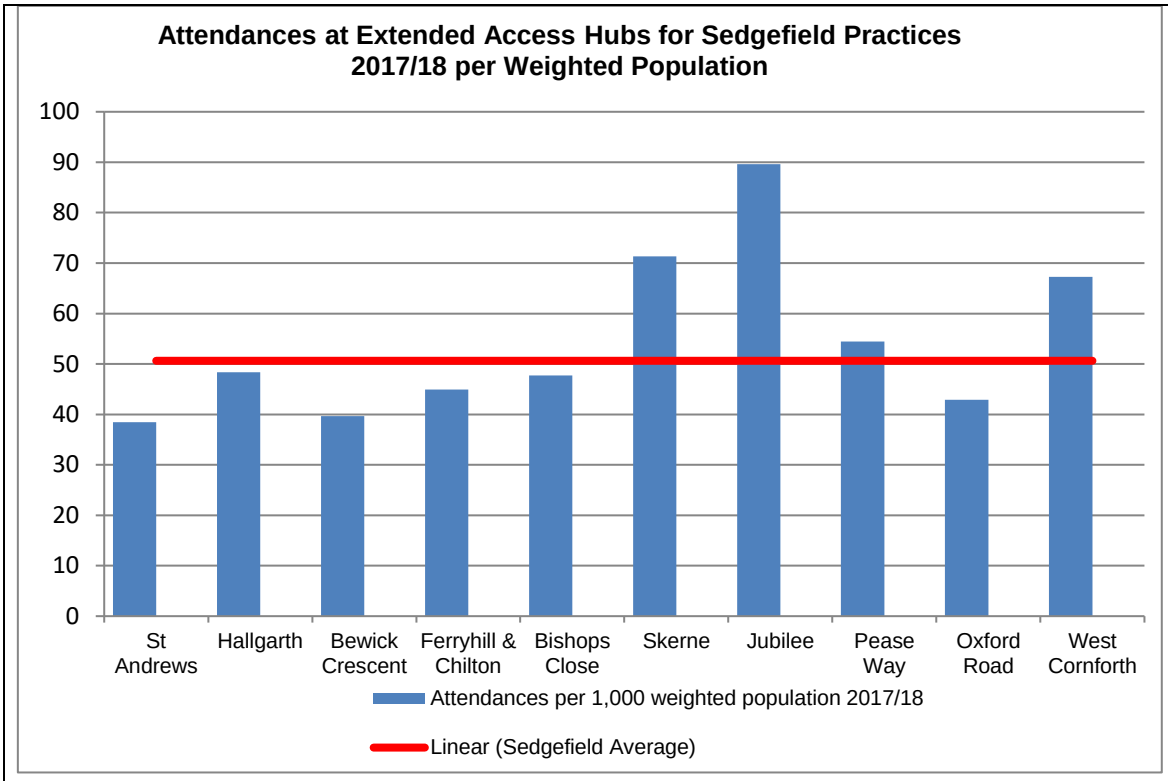
Prior to the PCS, there had been no Urgent Care Centres in that area although there had been extended weekend opening for the two previous years.

Use of primary care extended access services

The table below shows the number of patients accessing services throughout 2017/18. The data suggests that activity has been fairly steady throughout the year with an increase at evenings and weekends in the last 2 quarters.

Actual usage of services

Locality of site	Quarter	Weekday 8am-6pm	Weekday evenings 6pm-8pm	Weekend/Bank hol 8am-1pm	Contact outside of service hours	No date/time provided	Total
Sedgefield	Q1 2017/18	98	313	814	54	1	1,280
	Q2 2017/18	73	386	896	52		1,407
	Q3 2017/18	80	418	1,100	42	8	1,648
	Q4 2017/18	52	372	1,010	39		1,473
Sedgefield Total		**303**	**1,489**	**3,820**	**187**	**9**	**5,808**



Hub activity

Activity data has shown that now there is an average of:
Per weekday evenings 6pm-8pm 6 per evening
Weekend / bank holiday 8am-1pm 75 per weekend

This includes data for all three hubs.

Capacity provided

When the service changes were made in April 2017, work was undertaken to ensure that sufficient capacity was available. The additional capacity that was commissioned in the Sedgefield locality, which includes additional core primary care activity during weekdays plus the additional evening and weekend capacity is set out below:

Additional hours service per week

Hours	appointments	Total hours provided per week
8am – 6pm	88	22 hours
6pm – 8pm	105	26 hours
Weekend	108	27 hours
Total		75 hours

Appointment time used is 15 mins however please note many appointment take much longer than the 15 minutes allocated.

** GP Access standards set are required to provide 45 minutes by 1000 population – this equates to 73 hours required in additional capacity to meet the target.

Locality	Raw List Size - 1 April 2018	Hours Per Week
Sedgefield	97,525	73.14

Utilisation of this capacity varies by hub as follows:-

Hub	Utilisation rate Q1	Utilisation rate Q2	Utilisation rate Q3	Utilisation rate Q4	Utilisation rate Total
Newton Aycliffe	55%	66%	75%	60%	64%
Sedgefield	22%	25%	26%	25%	24%
Spennymoor	48%	47%	57%	51%	51%

The figures include telephone calls as well as face to face appointments

Cost per attendance
The table below shows the cost per attendance at each of the hubs:

Locality	Hub	Mon to Fri 6pm to 8pm	Sat and Sun 8am to 1pm	Total	Activity 17/18 12 months	Cost per case
Sedgefield	Sedgefield	62,237	93,162	155,399	959	162.04
	Spennymoor	62,237	93,162	155,399	1,987	78.21
	Newton Aycliffe	62,237	93,162	155,399	2,522	61.62
	Unknown site			0	340	
	Total			**£466,197**	**5808**	**80.27**

Impact of the changes on other services

Prior to implementation, an assessment was made at a geographical level based on the number of patients that may attend type 1 A&E services instead following the changes. A type 1 A&E department is a consultant led 24 hour service with full resuscitation facilities. Data for April 2017 to February 2018 has been compared with the same period in the previous year and type 1 A&E attendances have reduced by 4.2% (863).

The impact on type 3 attendances (MIU/Urgent Care Centres designed to treat illness/minor injury) has varied across the local sites. Type 3 attendances by Sedgefield locality patients have decreased by 24.9% (n. 3,181). This is in line with the expected decrease given that sites would no longer see walk in attendances for minor illness. Minor injuries and GP out of hours services continue to be delivered from these sites. During the same period there have been over 5,200 attendances in the extended and enhanced primary care hubs.

Patient Engagement feedback

From the information gathered Spennymoor had the highest return of surveys, with the majority of people attending after 6pm and on a weekend. The main reasons why patients attended was because they couldn't get an appointment with their GP / or their GP practice was closed.

The majority of patients got an appointment via NHS 111 and said their experience of the service was good or great.

When asked about their opinion on changing the number of sites, 37% of those who had commented, said that they would be happy with change as long it was somewhere convenient. 84% of patients who commented, stated they would travel 5+ miles to a PCS service, with 53% of those happy to travel 10+ miles. 87% of patients felt that the current opening times are convenient.

The majority of respondents did not think there was a better way to deliver PCS and did not comment on whether they thought that the service could be improved.

Views from practices

A summary of service activity data and patient feedback was shared with the practices in the monthly commissioning meeting. A survey was also issued to practices to capture any views that practices wanted to be considered. Due to conflicts of interest (as providers of the current services) practices are not able to make a decision on service configuration.

During weekdays practices felt that there should be either no or a limited overflow hub in place to provide urgent appointments. There were concerns raised that the NHS111 service may book patients into the overflow hub without trying to book into the practices first.

There was an initial consensus in the practice meeting that only one hub was required on weekday evenings and two hubs at weekends based in Newton Aycliffe and Spennymoor based on total activity levels. Views subsequently expressed via a practice survey suggested that there were differing views and activity volumes were revisited and a further discussion with practices was scheduled.

Activity data suggested that there was almost equal activity in the Northern hub (Spennymoor) and Southern hub (Newton Aycliffe). Transport links between these two areas were considered and it was felt that one hub (either North or South) would not provide adequate coverage for the population. Transport links between the North and South of the locality were poor therefore moving to one hub would make access difficult for patients.

Practices recognised that activity in the Sedgefield hub was low and often the hub staff were utilised dealing with telephone calls and that there was no demand for the evening hub in that area on week nights.

Taking this into account practices felt that two hubs would be necessary during weekday evening and three hubs at weekends as there was a risk that Sedgefield patients may need to travel to Stockton to access Tees services without a local weekend service.

Practices felt that additional planned access would be difficult to coordinate, but were interested in the views of patients as to what else could be delivered from the hubs whilst they were open.

Capacity calculations and assumptions based on Q4 per locality based on peak hour of demand

Sedgefield weekday activity	
Average daily demand peak hour	3.3 appointments

	per hour
Sedgefield weekend and bank holiday	
Average daily demand peak hour	9.1 appointments per hour

Transport and access for patients

Sedgefield Locality distance between hubs		
Skerne Medical Practice	St Andrews Medical Practice	9.2 miles
Skerne Medical Practice	Jubilee Medical Centre	7.3 miles
St Andrews Medical Practice	Jubilee Medical Centre	7.2 miles

As well as public transport, the CCG commissions the Durham Urgent Care Transport Service (DUCT). The DUCT service provides transport for any patients that are unable to attend an urgent appointment. All patients that are booked to attend services via NHS111 will be asked if they have access to transport to attend an appointment and if necessary transport will be booked. Those booked to attend via the hubs or the practices also have access to transport booking.

Other known issues to be considered

Pharmacy provision is limited at evenings and weekends.

Access to planned appointments for shift workers or those working away was highlighted during the previous public consultation and from practices.

The current service provides additional access for unplanned appointments whereas the national extended access requirements include the ability to pre book appointments.

Options - advantages and disadvantages

Option	**Advantages**	**Disadvantages**
1. No changes to current service delivery	Maintains status quo Provides access equally across the area Public support for services	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding Public perception of value for money of services
2. Reduce to one site (Newton Aycliffe) – overflow and 6-8 through the week and weekend	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services Easier for NHS111 to signpost patients Provides value for money	Distance to travel Difficulties with access for frail/housebound patients Patient perception of loss of services
3. Reduce to two sites(Newton Aycliffe / Spennymoor	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services	Distance to travel Difficulties with access for frail/housebound patients Patient perception of loss of services Duplication of service with the

	Easier for NHS111 to signpost patients Offers more patient choice Provide booked appointments Provides value for money	Urgent Treatment Centre/Out of Hours service
4. Reduce to one site (Newton Aycliffe) with home visiting outreach services for frail/housebound patients for all time	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Improves access for housebound patients, but is more value for money Easier for patients to understand available services Easier for NHS111 to signpost patients Provides value for money	Distance to travel for non-housebound rural patients Patient perception of loss of services
5. Reduce two two sites (Spennymoor and Newton Aycliffe) during weekday evening and retain three sites at weekends	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services Easier for NHS111 to signpost patients Offers more patient choice Provide booked appointments Provides value for money Offers local capacity at weekends and an alternative to hospital based services	Patient perception of loss of services

RECOMMENDATIONS

Based on the current utilisation data and patient feedback it is proposed that changes are made to service delivery.

Of the options considered above, option 5 is the recommended option as it will deliver a service meeting a range of needs and reflects the high demand for services in each area, but also be better value for money. In addition to this it is proposed that the service operates with an element of additional access of planned appointments. This includes day time small scale overflow to flex up and down in times of surge, two hubs 6-8pm Monday to Friday andthree hubs at weekends and bank holidays.
It is recommended that further discussion takes place with the Sedgefield locality to discuss this due to the differing views across the locality and to understand if it would be appropriate to have any outreach arrangements in place in Sedgefield village.

It is recommended that the outcome of the review and the preferred alternative service model is presented to the OSC committee. Following this an outline consultation approach will be developed to support the development of final service configuration and seek patient views on the potential changes. The consultation plan be developed will be shared with the OSC for review, comment and input.

Current services in Easington

In the Easington locality, the Primary Care Services are offered from 8am – 8pm Monday to Friday and 8am -1pm on a Saturday and Sunday.
Service are delivered from ;

- Healthworks – Easington
- Peterlee Health Centre – Peterlee
- The Primary Care Centre – Seaham

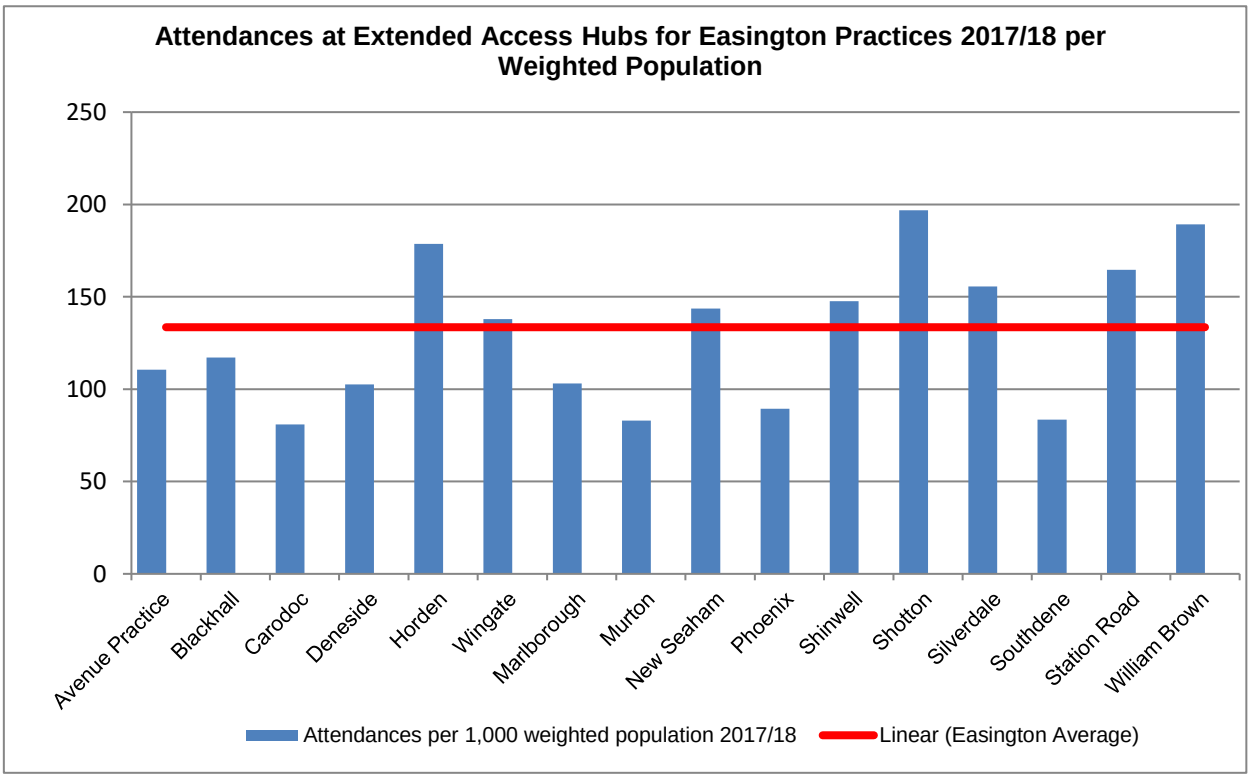
Use of primary care extended access services

The table below shows the number of patients accessing services throughout 2017/18. The data suggests that activity has been fairly steady throughout the year on weekdays 6pm – 8pm however has significantly increased during the day, weekdays in the last 2 quarters. Quarter 3 saw the most activity in October through to December (noting December had several bank holidays).

Number of contacts to GP extended hours services by locality of the site of the service

Number of contacts to GP extended hours services, by locality of the site of the service:							
Locality of site	Quarter	Weekday 8am-6pm	Weekday evenings 6pm-8pm	Weekend/Bank hol 8am-1pm	Contact outside of service hours	No date/time provided	Total
Easington	Q1 2017/18	2,110	746	1,233	82		4,171
	Q2 2017/18	1,854	715	1,187	95		3,851
	Q3 2017/18	2,306	990	1,285	135		4,716
	Q4 2017/18*	2,152	889	949	100		4,090
Easington Total		8,422	3,340	4,654	412		16,828

Attendance levels vary by practice as shown in the chart below:



Hub activity

Activity data has shown that there is an average of:

Per weekday 8am -6pm	34 per day
Per weekday evenings 6pm-8pm	14 per evening
Weekend / bank holiday 8am-1pm	97 per weekend

This is across all 3 hubs.

Capacity provided

When the service changes were made in April 2017, work was undertaken to ensure that sufficient capacity was available. The additional capacity that was commissioned is set out below:

Additional hours service provided per week

Hours	**Total**	Additional hours per week
8am – 6pm	860 appointments	215 hours
6pm – 8pm	140 appointments	35 hours
Weekend	162 appointments	40.5 hours
Total		290.5 hours

* Appointment time used is 15 mins however please note many appointment take much longer than the 15 minutes allocated.

** GP Access standards set are required to provide 45 minutes by 1000 population – this equates to 77 hours required in additional capacity to meet the target

Locality	**Raw List Size - 1 April 2018**	**Hours Per Week**
Easington	102,650	76.99 hours

Utilisation of this capacity varies by hub as follows: -

Hub site	**Utilisation rate Q1**	**Utilisation rate Q2**	**Utilisation rate Q3**	**Utilisation rate Q4**	**Utilisation rate Total**
Peterlee	38%	41%	46%	43%	42%
Easington	29%	22%	27%	29%	27%
Seaham	19%	19%	29%	30%	23%

These figures include telephone calls as well as face to face appointments.
GPs are not included in the capacity to calculate %, just ANPs. GPs have to be available as part of the commissioned service whether they are needed or not, so a bit confusing for usage calculations. They are not included in published slots, but are there as a backstop if patients need a second opinion of a GP or ANPs need advice.

Cost per attendance
The table below shows the cost per attendance at each of the hubs:

Hub	**Weekday Service** 8am to 6pm	**weekday service** 6pm - 8pm	**Funding Sat and Sun Service** 8am to 1pm	**Total Funding**	**Activity**	**Cost per case**
Easington	410,964	84,548	125,514	621,026	4747	132.82
Peterlee	410,964	84,548	93,162	588,674	8885	66.25

Seaham	295,183	62,237	93,162	450,582	3196	140.98
Total	**1,117,111**	**231,333**	**311,838**	**1,660,282**		**98.66**

Impact of the changes on other services

Prior to implementation, an assessment was made at a geographical level based on the number of patients that may attend type 1 A&E services instead following the changes. A type 1 A&E department is a consultant led 24 hour service with full resuscitation facilities. Data for April 2017 to February 2018 has been compared with the same period in the previous year and type 1 A&E attendances have reduced by 3.5% (721).

The impact on type 3 attendances (MIU/Urgent Care Centres designed to treat illness/minor injury) has varied across the local sites. Type 3 attendances by Easington locality patients have decreased by 65.2% (n. 22,890). This is in line with the expected decrease given that sites would no longer see walk in attendances for minor illness. Minor injuries and GP out of hours services continue to be delivered from these sites. During the same period there have been over 15,300 attendances in the extended and enhanced primary care hubs.

Patient engagement feedback

From the information gathered via the surveys, Peterlee is the busiest site with the majority of people attending between 8am and 6pm. The main reasons why patients attended was because they couldn't get an appointment with their GP or it was out of hours.

The majority of patients got an appointment via NHS 111 and had a positive experience of the service.

When asked about their opinion on the sites, 47% of those that commented said they would be happy with change.

The majority of people would be prepared to travel around 5-15 miles to a PCS service and said that the current opening times are convenient and the majority did not comment on whether they thought that the could be improved

Views from practices

A summary of service activity data and patient feedback was shared with the practices in the monthly commissioning meeting. A survey was also issued to practices to capture any views that practices wanted to be considered. Due to conflicts of interest (as providers of the current services) practices are not able to make a decision on service configuration. However their views based on population needs and the information provided was sought and is shown below.

During the week 8am – 6pm practices felt that patients should be seen in their own GP practices with 1 hub operating as an overflow service from 12 noon – 8pm.

This service could potentially offer more support to general practice around; a home visiting model, telephone triage support, planned appointments, support in times of surge with the capacity to flex up and down based on demand.

During weekday evenings 6pm – 8pm, practices felt 1 hub would be required and should be

included in the above overflow arrangements. Preferred location of the hub most commonly reflected the area the practice was based in.

During weekends and bank holidays practices felt that 2 hubs were needed suggesting sites at Peterlee and Seaham due to issues patients have around transport getting from Seaham to Peterlee. Easington practices felt that Easington should be considered as a site for a weekend hub.

Capacity calculations and assumptions based on Q4 per locality based on peak hour of demand

weekday activity	
Average daily demand peak hour	8.5 appointments
weekend and bank holiday activity	
Average daily demand peak hour	13.7 appointments

** These figures are minimum calculations

Q3 will have had higher peaks due to winter/ seasonal pressures. 4 slots per hour in the calculation above does not allow for staff breaks, overruns for complex cases, shut down time in last hour of day.

Daily variation is lost in this quarterly average – there can be peaks on particular days of the week or randomly on days of the year.

Staffing levels would need to be higher than the minimum to ensure resilience to the above factors affecting fluctuations in demand and capacity that can be offered.

Transport and access for patients

The distances between hubs are shown in the table below.

Easington Locality Distances between hubs		
Peterlee Health Centre	Seaham Primary Care Centre	7.8 miles
Peterlee Health Centre	Intrahealth @ Healthworks	2.9 miles
Intrahealth @ Healthworks	Seaham Primary Care Centre	5.7 miles

As well as public transport, the CCG commissions the Durham Urgent Care Transport Service (DUCT). The DUCT service provides transport for any patients that are unable to attend an urgent appointment. All patients that are booked to attend services via NHS111 will be asked if they have access to transport to attend an appointment and if necessary transport will be booked. Those booked to attend via the hubs or the practices also have access to transport booking.

Other known issues to be considered

Historically there has always been strong support for services in the locality and an expectation from patients as multiple services have been provided for many years.

Pharmacy provision is limited at evenings and weekends.

Access to planned appointments for shift workers or those working away was highlighted during the previous public consultation and from practices.

The current service provides additional access for unplanned appointments whereas the national extended access requirements include the ability to pre book appointments.

The majority of practices do not support the current service delivery model

Options appraisal

Option	Advantages	Disadvantages
1. No changes to current service delivery	Maintains status quo Provides access equally across the area Public support for services	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding Public perception of value for money of services Practices do not want the services as they are
2. Reduce to two sites with no overflow and no additional services	Provides more access across the locality Public support for services Creates capacity split equitably	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding GP practice may struggle with same day access GP practices may struggle to provide appointments and access in times of surge Not equitable for housebound patients and those pts not able to travel to services
3. Reduce to one site with no overflow and no additional services	Provides one service for patients therefore easier to navigate Easy to communicate Easier to staff	Staff morale and retention issues GP practice may struggle with same day access GP practices may struggle to provide appointments and access in times of surge Not equitable for housebound patients and those pts not able to travel to services
4. Reduce to two sites on a weekend and one overflow through the week 12 noon – 8pm with additional capacity and services created	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand available services Easier for NHS111 to signpost patients Close to MIU and out of hours service Provides value for money Provides access for frail and house bound pts Provides a home visiting element Provides a backup service for general practice	Poor value for money Staff morale and retention issues Unable to have a GP on all sites due to availability/funding Public perception of value for money of services Difficulty identifying the site due to geography
5. Reduce to one site on a weekend and one overflow through the week 12 noon – 8pm	Improves staff morale and retention GP and practitioner cover on one site creating more capacity Access to pharmacy close by Easier for patients to understand	Distance to travel Patient perception of loss of services

with additional capacity and services created	available services Easier for NHS111 to signpost patients Close to MIU and out of hours service Provides value for money Provides access for frail and house bound pts Provides a home visiting element Provides a backup service for general practice	

Recommendations

Based on the current utilisation data and patient feedback it is proposed that changes are made to service delivery.

Of the options considered above, option 4 is the recommended option as it will deliver a service meeting a range of needs, but also be better value for money. In addition to this it is proposed that the service operates with an element of additional access of planned appointments and still provides an outreach provision across the locality.

It is recommended that the outcome of the review and the preferred alternative service model is presented to the OSC committee. Following this an outline consultation approach will be developed to support the development of final service configuration and seek patient views on the potential changes. The consultation plan be developed will be shared with the OSC for review, comment and input.

Summary

This business case must be read in conjunction with the engagement report which details the public engagement that has taken place to date.

Based on the patient feedback received and the willingness to travel, practices views, utilisation rates of services and the average demand per hour we are recommending the following as a summary;

Durham Dales

That practices will continue to take all day same day access activity and provide overflow for weekday activity via one central hub per locality (the town with the highest demand would be suggested).

We recommend the overflow hub would cover all weekday evening activity and provide a service on a weekend and bank holidays; all services should be available to NHS 111 to book in direct appointments. In addition the service should provide an outreach service for housebound patients, those most vulnerable including home visiting and access for those in the rural areas and areas outside of the main towns.

Sedgefield

That practices will continue to take all day same day access activity and provide overflow for weekday activity via one central hub per locality (the town with the highest demand would be suggested).

We recommend two hubs are in place during evenings (Spennymoor and Newton Aycliffe) three at weekends/bank holidays (Spennymoor, Newton Aycliffe and Sedgefield).

Easington

That Easington practices will start to take all same day access activity however provide an overflow service for weekday activity via one central hub operating from 12 noon until 8pm (the town with the highest demand and transport links would be suggested).

We recommend the overflow will cover all weekday evening activity and provide a service on a weekend and bank holidays; all services should be available to NHS 111 to book in direct appointments. In addition the service should provide an outreach service for housebound patients, those most vulnerable including home visiting and access for those in other towns that currently have a service.

We recommend two hubs are in place during weekends/bank holidays sited in Peterlee and one other area, but that further engagement is done with Easington practices and patients to understand any further outreach arrangements required.

The CCG would also recommend that all localities include some pre booked capacity to meet the GP access standards and provides at least the minimum level of access based on the standards. We would also promote the use of our transport facilities more widely to patients and the practices to ensure that patients can access centralised services.

It is proposed that a 6-8 week consultation is undertaken with patients/public/stakeholders and hat this covers the whole DDES population, but focusses on the areas where change is proposed.

Next Steps

The following is required:

Development of a comprehensive communications and engagement plan including liaison with key stakeholders e.g. Healthwatch, Patient Reference Groups including the development of options to be consulted on

Commence discussions with the current providers on potential service changes

Briefing the CCG Governing Body on the proposed consultation process

Recommendations

The Executive Committee is asked to:

- Consider the case for change to the current service model
- Note the views of patients in relation to current services contained in the engagement report alongside this business case
- Support the recommendations contained in this report
- Note the intention to present this report to the Health OSC with the recommendation that a formal consultation is undertaken to discuss the proposals with patients and stakeholders.
- Note the intention to share this report with the Governing Body for information.
- Note that a consultation and engagement plan will be developed and

presented to the executive committee for consideration before it is presented to the OSC for comment/input/advice
- Note the intended consultation period (6-8) which will be confirmed following discussion with OSC

Authorised and supported by

Sarah Burns – Sponsor Director and Director of Commissioning
DDES CCG

Date – June 2018

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Adults, Wellbeing & Health Overview and Scrutiny Committee

6 July 2018

Adult and Health Services Update

Report of Corporate Management Team

Jane Robinson, Corporate Director of Adult and Health Services

Councillor Lucy Hovvels, Portfolio Holder for Adult and Health Services

Purpose of the Report

1 The purpose of this report is to provide an update to Adults, Wellbeing & Health scrutiny on developments across Adult and Health Services.

Background

2 The report outlines progress on a number of key areas across Adult and Health Services; both nationally and locally; including an outline of the Governments thinking in respect of the forthcoming Green Paper; and the integration of health and social care in County Durham.

3 This is the latest in a series of reports to Cabinet detailing developments in health and social care services with a specific emphasis on integrated care delivery.

Green Paper on care and support for older people – March 2018

4 As part of World Social Work Day, the Secretary of State for Health and Social Care outlined the seven key principles that will guide the Government's thinking ahead of the Social Care Green Paper, on care and support for older people, which is due to be published later in 2018. The seven key principles are as follows:

- **Quality** – Recent local system reviews conducted by the Care Quality Commission (CQC) have highlighted variation in performance between local authorities across a range of measures, including how the local authority commissions care from local providers. One of the questions the Green Paper will pose is whether the Government can build on the learning from the introduction of independent Ofsted-style ratings for providers to spread best practice to commissioners.

- **Whole Person Integrated Care** - Centred around the person, with one plan covering all their health and social care needs based on a joint

assessment by both systems. Gloucestershire, Lincolnshire and Nottinghamshire will pilot this over the next two years.

- **Control** – Personalisation is not new, but key to it is information and advice to help people make informed choices. The Department of Health and Social Care (DoHSC) will consult on Personal Health Budgets, in order to achieve better integration for those with the greatest ongoing social and / or health needs. Over the next two years every single person in Gloucestershire, Lincolnshire and Nottinghamshire with a joint care plan will also be offered an integrated health and care personal budget.

- **Workforce** – To respect and nurture the social care workforce and to think about health care workforce issues in a joined up way. Later this year the DoHSC will publish an NHS and social care 10 year workforce strategy instead of an NHS 10 year workforce strategy, with the needs of both sectors considered together and fully aligned.

- **Supporting families and carers** – To make the needs of carers central to the new social care strategy. Ahead of the Green Paper the DoHSC will publish an action plan to support carers and will work with the Minister for Loneliness, as they develop the Green Paper, to address the underlying causes of loneliness by building an active and creative partnership between the state, individuals and wider civil society.

- **A sustainable funding model for social care supported by a diverse, vibrant and stable market** – DoHSC will look at how the Government can prime innovation in the market, develop evidence for new models of services, and encourage new models of care provision to expand at scale. This will specifically include looking at the role of housing, including how to better support people through well-designed aids and adaptations.

- **Security for all** - People's financial wellbeing in old age ends up defined less by their industry and service during their working lives, and more by the lottery of which illness they get. A system that includes an element of risk-pooling is needed and the DoHSC will bring forward ideas as to how to do this alongside potential costs in the Green Paper.

Health and Social Care Plan for County Durham

5 Cabinet agreed a report on developing a Health and Social Care plan for County Durham on the 11 April 2018. Adults, Wellbeing and Health Overview and Scrutiny Committee were then updated on the plan by the Director of Integration on 2 May 2018. The key elements of the plan are to develop a joint strategic commissioning function and integrated governance arrangements, for the management of the integrated community services function. The report has now been through and supported by the Clinical Commissioning Groups Governing Body meeting which met on 15 May 2018.

6 The next phase in the development of this plan will see the implementation of the governance arrangements over the next few months and the appointment of a Director for Integrated Community Services.

Better Care Fund (BCF) Plan 2017/19 / Improved Better Care Fund

7 A Cabinet report dated 15 March 2017 entitled “Integration of Health and Social Care Services Update” provided detail on the Better Care Fund (BCF) which has been invested across the following seven key area: .

a. Short-term intervention services;

b. Equipment and disability adaptations;

c. Prevention services to support independent living;

d. Prevention services focussing on social isolation;

e. Services to support Carers;

f. Care Home support;

g. Maintaining Transforming Care.

8 As the only mandatory policy to facilitate integration through a pooled budget, the BCF allocations were augmented with additional resources in 2017/18 – the Improved Better Care Fund (iBCF). The iBCF allocations are additional monies payable to councils to support adult social care budgets.

9 The Cabinet report dated 18th October 2017 provided an update in respect of the Improved Better Care Fund (iBCF) allocations and proposed expenditure plans.

10 The main areas of focus within the iBCF allocation for 2017/18 is; supporting the market, prevention, alleviating NHS pressure and system support. The examples below provide an update on the impact of that spend.

a. **Falls** - Two rounds of specialist falls training for care homes has been delivered and a third cohort is being planned for summer / autumn 2018. The first two rounds of training have seen 32 care homes access training, with 124 care workers in total having completed the course. This is delivered by the North East Ambulance Services (NEAS) and feedback from attendees has been very positive. The next round of training will proactively target homes who have a high incidence of ambulance call-out in relation to falls and who have not been able to attend training already. For the next cohort, it will be possible to deliver training in specific homes if required to aid providers to release maximum numbers of staff.

Care Connect have also been commissioned to provide a falls response service, in partnership with NEAS, which involves Care Connect responding to a fall which has been classified by the ambulance service as non-injury and where the person requires assistance and support but not medical care. This releases pressure on NEAS and supports the principle of medical resources being utilised on those who require them. The system has been introduced to Durham following a successful pilot in the north of the region. The scheme began operating in March 2018, and in first 6 weeks they have dealt with 18 cases. Further awareness raising of the scheme is due to take place.

b. **Brokerage** – Commissioners are working on a procurement exercise to provide a brokerage service for those leaving hospital who need to move to a care home. Such individuals can be delayed before discharge, as a result of family / friends not being available to assist promptly, or by needing help to view the options available to them. The brokerage service will work with the person, the hospital, social care and the care providers to assist with getting the best service for the individual, taking into account vacancies, geography and individual needs and wishes.

c. **Supporting the Provider Market / Additional Commissioning and Practice Development Resources** – Specific funding has been allocated to support provider markets in Durham and help to ensure that providers have a robust, well-trained and responsive workforce, as well as the opportunity to innovate in terms of their service delivery. This may involve assisting with recruitment of care workers in rural areas of Durham, promoting social care as an employment opportunity, establishing a 'care academy' training hub and/or assisting providers to introduce technology to their service to lower dependency on hands-on care where safe to do so. Dedicated posts are being recruited to AHS commissioning and practice development teams to support this work. The roles will also analyse performance information on providers more closely, to identify those who require support at an early stage and ensure that those services are helped to maintain and improve standards.

d. **Dementia Care Advisors** – the contract for dementia care advisors, which has been piloted in Durham during the last two financial years, has now been extended until 2020. This service works with people who have recently been diagnosed with dementia, or may simply have worries about their memory, to provide advice, support and signposting. Where required, the service will provide assistance to those living with dementia and their carers over the length of their journey with dementia. The Dementia Care Advisor service is delivered countywide by the Alzheimers Society and has received very positive feedback, with high referral rates and strong stakeholder engagement. In 2017/18 the service received 949 referrals.

In 2016/17, it received 991 referrals, so demand remains high with almost 2000 people being referred to the service in its first two years.

e. **Area Action Partnerships** - In 2018/19 £350k of funding has been allocated across the 14 AAP's (i.e. £25k each) to be used on reducing social isolation. It is recognised that AAP's are best placed to know about issues in their own areas and have strong links with local, often third sector organisations who deliver services. AAP's will be able to target funding to help address isolation, using a prevention approach which in turn supports vulnerable local people and reduces medium and longer term pressure on social care services.

11 Many of these initiatives will operate until 2020 as the money (c£13m) will carry forward. The additional iBCF allocations for 2018/19 (c£8m) and 2019/20 (c£4m) have been built into MTFP and will be utilised to delay adult care-related MTFP savings.

12 Funding beyond 2020/21 is as yet unknown.

Adult Social Care Support Grant 2018-2019

13 Allocated according to relative needs, Durham received circa £1.7m. In effect this money supplements the iBCF and locally they are collectively referred to as the Adult Care Transformation and Innovation Fund (ACTIF). A breakdown of how these additional monies are being utilised can be found at Appendix 2.

14 The examples below provide an update on the impact of that spend:

- **Developing Commissioning Capacity** - Increased capacity within the commissioning team for 2 years to deliver initiatives around key priority areas including the Mental Health Review and implementation of a new model; developing services to alleviate Social Isolation; supporting the voluntary and community services infrastructure; supporting the residential care market.

- **Supporting Intermediate Care+ resilience (Alleviating NHS pressure)** - Additional funding for 2018/19 to enable the 3 Intermediate Care Team managers to recruit additional short term agency social work staff to sustain assessment and discharge planning functions during times of surge, i.e. winter pressure, Easter.

- **Learning Disability high cost complex case reviews (alleviate financial pressures/ service efficiencies)** - Provide additional staffing capacity to undertake targeted proactive reviews of high cost/ complex packages for service users in specialist residential care provision and those that come under the umbrella of the Accountable Care Partnership. This will enable the development of business cases for more cost effective service models that achieve better outcomes. This will help to alleviate budget pressures and support the delivery of a new Commissioning Strategy, within Learning Disability Services.

Delayed Transfers of Care (DToC)

15 Supporting people to leave hospital quickly and safely and reducing Delayed Transfers of Care (DToC) is a national priority for the NHS and Social Care. Improving the timeliness of discharge is the right thing to do for patient care and experience, it improves operational flow through the system and makes best use of the resources across health and social care.

16 The Government Statistical Service, in May 2018, published the latest (March 2018) national data on DToC. From a Durham perspective the key findings (April – March 2018) are:

- Durham had the 4th lowest rate (per population) of delays in England;
- Compared to the same period last year there has been a 5.6% decrease in reported delays in Durham;
- When comparing Durham with the same period in 2016 there has been an 5.4% decrease in the total of reported delays;
- Nationally 66.3% of delays occur in an acute hospital setting, the figure is significantly lower in Durham (49%);
- Social care reasons for delay in Durham in March 2018 were (20%) compared to the national picture of (30.7%) for social care delays.

17 It is expected that increased scrutiny of DToC will continue throughout 2018/19.

18 Durham has established a cross-agency Discharge Management Group and a number of initiatives are currently underway to improve the offer to people leaving hospital, including a number of schemes such as those outlined earlier in this report; funded through the Improved Better Cared Fund (iBCF).

Prevention

19 The County Durham Partnership Update report to Cabinet in March 2018 focused on prevention.

20 The County Durham Partnership (CDP) has agreed to develop a more proactive approach to prevention across the Partnership and drive a decisive shift in all parts of the system through a Prevention Steering Group and three workstreams:

a. **Building on Best Practice** is being taken forward in conjunction with Area Action Partnerships, considering links between local priorities and strategic agendas, and reviewing commissioning processes.

b. Systems, capacity and management are being developed in terms of **maximising external funding opportunities.**

c. In order to **reduce demand for services** the workstream is looking to maximise the impact of the voluntary sector including further roll out of the 'Making Every Contact Count' approach, enhancing navigation systems and targeting support to high demand users of services.

21 In addition, the Local Government Association (LGA) Prevention at Scale offer provides 20 days of a Support Manager and expert advice focused on supporting a local area to deliver at scale a preventative approach for a particular condition or risk factor that will have a significant impact on health improvement for the local population and add value to existing interventions. The project sponsor for this work is the Corporate Director of Adult and Health Services as chair of the County Durham Partnership Prevention Steering Group.

22 An outline plan in relation to mental health as a key prevention priority that cuts across a number of partnerships was submitted to the LGA, who advised a narrower focus would be beneficial to the programme. The CDP Prevention Steering Group and Mental Health Partnership Board held a joint workshop and Suicide Prevention was agreed as the area of attention, with a focus on capacity building, workforce development and reducing discrimination and stigma.

23 County Durham is a national outlier with regard to suicide, with higher rates in males in the lowest socio-economic groups. Whilst the numbers are small, suicide has a big impact on families and the local community and there is an opportunity to develop the work across a number of settings and stages of the life course.

24 Timescales for the LGA project are from September 2017 – September 2018. The chosen prevention area will be evaluated to see the impact on health outcomes. There are 10-15 sites chosen for this prevention at scale work and it is an opportunity for Durham to share best practice with other areas, following completion of the project.

25 Representatives from Durham attended an LGA Prevention at Scale Academy in Warwick on 16 and 17 April 2018, where a series of masterclasses will be delivered on the key issues identified across the programme. Clinics will be made available with the facilitators and experts and delegates will have the opportunity to work with other authorities involved in the programme. The Director of Public Health, is chairing a task and finish group to ensure progress with this work.

26 The Health and Wellbeing Board leads the county's work on mental health and wellbeing, as a priority within the Joint Health and Wellbeing Strategy. A multi-agency group has been set up to progress the prevention at scale work and regular updates on progress will be reported to the Mental Health Partnership Board through to the Health and Wellbeing Board.

Local Safeguarding Adults Board – Peer Review

27 As part of the Local Safeguarding Adults Board (LSAB) strategic objectives covering the period 2015-2018 the Board agreed to undertake an LGA peer review by the end of March 2018.

28 Peer reviews work on the basis of there being no surprises from the process and acting as 'critical friends', to bring added value to the direction of travel of the LSAB. The whole approach is that of reflection and improvement.

29 The LSAB Peer Review took place over three days, 13-15 March 2018, funded from existing resources held in the Business Unit. Feedback was given on the final day followed by an action-planning workshop.

30 The review was led by the Independent Chair of the Safeguarding Adults Board from Warrington, with Jill Emery from Impact Change as the LGA Challenge Manager.

31 The focus of the review of the LSAB, agreed at the Board Development Session held on 23 January 2018, included:

- Governance: the extent to which partners work together and how accountability operates at the LSAB;
- Impact: the extent to which Making Safeguarding Personal (MSP) is embedded in the work of partners, and what interventions are supporting a wider preventative approach;
- The user and carer voice: how is the LSAB hearing the voice of those who access services and how it can do so better in the future?

32 Evidence of the LSAB achievements and future work were also included within the review, as well as links to wider partnership Boards including the County Durham Partnership and Area Action Partnerships.

33 Initial feedback following the Peer Review was very positive, with the Peer Review Team generally impressed with the work undertaken in Durham relating to safeguarding adults. Areas of Strength include partners demonstrating accountability and positive engagement, and a robust training programme accessed by a wide range of partners including the Community and Voluntary sectors.

34 The Peer Review identified a number of themes for further consideration as highlighted below:

- Consider the setting up of an Executive/Business Group of statutory partners;
- Identify possible potential risks around new arrangements for the Chair to preserve the integrity of the Board;

- Consider future 360º appraisal of Chair to ensure the expectations of Board Members are being met and any development needs are identified;

- Review performance management information to ensure it is meaningful, narrative and that identified issues are addressed and available to Board members;

- Increase awareness of Safeguarding criteria and methodology to ensure learning opportunities are not missed;

- Review the use of Making Safeguarding Personal as a 'brand' and use language that practitioners and communities understand.

35 New chairing arrangements have been implemented with the Director of Integration recently appointed and chairing her first board meeting at the end of April. The new chair will oversee the development of actions from the Peer Review that will inform the LSAB's direction from April 2018 onward. A progress report will be presented to Cabinet in November 2018.

North East and Cumbria Learning Disability Transformation Programme

36 Nationally the Learning Disabilities Transforming Care Programme aims to reshape services for people with learning disabilities and/or autism with a mental health problem or challenging behaviour, to ensure that more services are provided in the community and closer to home rather than in hospital settings. The programme arose as a result of Sir Stephen Bubb's review of the Winterbourne View concordat in 2014.

37 North East and Cumbria is one of five fast track sites selected because of high numbers of people with learning disabilities in hospital settings. Fast track areas have access to a share of a £8.2 million transformation fund to accelerate service redesign. An overarching North East & Cumbria (NE&C) plan was submitted with each of the 13 Local Authority areas presenting their own plans alongside it, which outline how they will reduce the need for admission to hospital.

38 Discussions are continuing both nationally and locally to agree guidelines relating to dowry funding and associated transforming care issues. From a Durham perspective the aim is to ensure that the initial principle that local authorities would not be financially disadvantaged by moving service users into community settings is adhered to. The authority is feeding into a regional finance group.

39 The latest local discussions suggest an interim applicable "dowry" of £64k per person from the NHS, with the balance of the additional costs subject in most cases to s117 arrangements, equating to a 50/50 proportional split for Durham.

40 An Integrated Learning Disability (LD) Steering Group has been established comprising senior officers across the Local Authority, CCG's and TEWV. At its first meeting in March 2018 the Integrated LD Steering Group agreed to look to further develop our strategic priorities and improve how collective resources are pooled going forward. The Integrated LD Steering Group is expected to form part of the proposed new governance structure for integration.

14+ year Transitions Review

41 An independent review of the 14+ years transitional arrangements between Children's Services, Adult Services and other relevant transitional pathways was undertaken between January – March 2018. This was commissioned by the Corporate Directors of Children and Young People Services and Adult and Health Services.

42 The recommendations from the review will be considered by a Transitions Steering Group and action will be formulated that seek to further develop key pathways and make improvements where deemed necessary.

Commissioning Developments

43 At the Health and Wellbeing Board in July 2017 it was reported that there had been a rise in the rate of emergency admissions in both falls and injuries and hip fractures in the over 65s in 2015/16, higher than the national average for the same period and an increase from the rate in 2014/15 period. The Joint Commissioning Group has established a Task and Finish Group to investigate this issue and a report outlining their findings will be considered by the Health and Wellbeing Board in July 2018.

44 Following protracted negotiations agreement has now been reached in respect of the fee rates for residential and nursing care provision. We are currently finalising the detail of the contract with the provider representatives, which will run until 2021.

County Durham Care and Support Review

45 The review of County Durham Care & Support (CDCS), the AHS in-house provider, is nearing its conclusion. In September 2016, Cabinet agreed that two services, Reablement and Supported Living, should be transferred to the independent sector. A contract has now been awarded to a new supported living provider and a procurement process in respect of Reablement is in progress.

46 The Cabinet report also set out that Extra Care and Respite (Hawthorn House) services would be retained and subject to review and restructure to ensure they were fit for the future. This work is progressing well, with changes to Hawthorn House, including widening the scope of the service and increased partnership working, starting to gain momentum.

Work on extra care is scheduled for summer / autumn 2018 when tender activity on the linked Reablement service is complete.

47 Cabinet also agreed that AHS should investigate the potential to establish an Employee Led Mutual (ELM), covering three of the CDCS services, Pathways Day Services, Support & Recovery and Shared Lives. This work has been undertaken, with the assistance of an external consultant specialising in public sector spin-out. The work on ELM's identified concerns about levels of risk in terms of business planning and future viability, as well as the level of financial support required by the Council to set up the new organisation. Consequently, the decision has been taken not to proceed with the ELM. Services will instead be retained and subject to future business review activity in the same way as all other Council services.

48 Overall MTFP savings requirements relating to the CDCS review remain on target. Expected additional savings from the tender on supported living will be used to offset any shortfalls from other services and will help to reduce savings pressures.

Review of the Social Services Information Database (SSID)

49 Since October 2017, a core element of work for the Adults SSID replacement Project Team has been the delivery of a rigorous soft market testing exercise and preparing the launch of the procurement exercise. To date:

- Interest in the soft market testing events has been received from four of the main system suppliers;
- Staff engagement through the process has been very positive with a wide range of teams participating in a series of full system demos, as well as bespoke focused sessions considering specific areas of system functionality;
- Key stakeholders and partners such as Clinical Commissioning Groups (CCG's), County Durham and Darlington Foundation Trust (CDDFT) and Tees, Esk and Wear Valleys Foundation Trust (TEWV) are engaged with the project;
- As the tender documentation has been developed there has been constructive engagement with health partners, through the Health and Social Care Integration Board, to ensure that any system purchased supports the county's aspirations in relation to closer health and social care integration;
- The procurement documentation was issued to the market on 18 January 2018 with the deadline for tender submissions of 2 March 2018;

- Plans are in place with staff to support the evaluation of bids received, and this is scheduled to conclude in May 2018. The evaluation process includes hands-on testing by staff;

- Workstreams are developing draft service designs / processes to be configured and refined when a new system has been selected.

50 Alongside the procurement preparation the Project Team have been working on maximising the opportunities that implementation of a new system has to transform our ways of working. This includes:

- A comprehensive programme of business process reviews based on using Lean Methodology have commenced. These are considering current practice within Adult Social Care, identifying areas for improvement and developing 'to be maps' which will support ICT system configuration;

- Reviewing the approach to document management and options for future document storage.

51 It is anticipated that the contract award will be in June 2018 and detailed discussions with the new supplier will start in July 2018 to develop an implementation plan. It is anticipated that the new system will 'go live' in autumn 2019.

World Social Work Day

52 World Social Work Day (WSWD), held this year on 20 March 2018, is the key day in the year that social workers worldwide stand together to celebrate the achievements of the profession and take the theme message into their communities, workplaces and to their governments to raise awareness of the social work contributions and need for further action.

53 This year highlights 'Promoting Community and Environmental Sustainability', which relates to the third pillar of the Global Agenda for Social Work and Social Development.

54 As part of World Social Work Day:

- The Secretary of State for Health and Social Care outlined the seven key principles that will guide the Government's thinking ahead of the social care green paper, to be published later in 2018; and

- The Department for Education announced that Lord Patel of Bradford, a former social worker, will chair the new dedicated social work regulator, Social Work England.

55 Durham also held an event to mark World Social Work Day, with social workers from both adult and children's services invited to County Hall on 20 March 2018 to reflect on the role they play in society and to celebrate the contribution they make to children, young people, adults, families and the wider community in Durham.

Performance

56 Durham's care and support services are still achieving the outcomes that matter most to people[1], against a backdrop of continued austerity and a nationally recognised shortfall in adult social care funding, with increasing demands upon social care services as a result of an ageing population who are living longer with complex needs:

- Durham service users have reported a higher level of satisfaction with their care and support than what was reported nationally for 4 of the last 5 years;

- Carers in Durham have indicated a higher level of satisfaction with social services than nationally for the last 3 years the survey has been carried out. Overall satisfaction of carers with social services is 43.3% compared to 39.0% nationally;

- Durham service users have responded more positively to this question than the national average this year and for 5 out of the 6 previous years. The proportion of people who use services who say that those services have made them feel safe and secure is 89.3% compared to 86.4% nationally.

Conclusion

57 The report highlights the wide breadth of work being undertaken across Adult and Health Services. The greatest challenge we face is securing a long term financial solution for Adult Social Care. While the funding from the iBCF and the Adult Social Care Support Grant are welcome and help to support our challenges and alleviate pressures in the short term they don't provide the stability of long term funding.

58 The development of a Health and Social Care Plan for County Durham, the Review and Replacement of SSID, the Partnership Approach to Prevention and the Review of County Durham Care and Support represent major change programmes that feed into the Councils Corporate Transformation Programme.

[1] Adult Social Care Outcomes Framework (ASCOF) Measures (2016/17). NHS Digital (October 2017)

59 Overall, the report provides a positive picture that reflects joined up and integrated working across services within the Council and with our Key Partners in the delivery of Health and Social Care.

Recommendations

60 Adults, Wellbeing & Health scrutiny is recommended to:

a. Note the contents of this report.

b. Agree to receive further updates in relation to Adult and Health Service developments on a six monthly basis.

Contact: Lee Alexander, Interim Head of Adult Care
Tel: 03000 268180

Appendix 1: Implications

Finance – Durham received circa £1.7m non-recurring money from the Social Care Support Grant 2018-19. The iBCF Allocation to be utilised for supporting the market; prevention; alleviating NHS pressures and provides system support is circa £13.1m.

Staffing – The delivery of adult and health services will depend upon a suitably trained and skilled workforce.

Risk – Well documented Funding and Demographic pressures facing adult social care presents significant risks to the ongoing sustainability of the sector. It is hoped that the Green Paper and the fair funding review will alleviate these risks and provide a longer term funding solution.

Equality and Diversity / Public Sector Equality Duty – Not applicable.

Accommodation – No direct implications.

Crime and Disorder – No direct implications.

Human Rights – No direct implications.

Consultation – Not applicable.

Procurement – No direct implications.

Disability Issues – No implications at this stage.

Legal Implications – There are a number of key legislative and policy developments/initiatives that have led the way and contributed to developments within adult and health services. All changes must be compliant with legal requirements

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Adults, Wellbeing and Health Overview and Scrutiny Committee

6 July 2018

Quarter Four 2017/18 Performance Management Report

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

Purpose of the Report

1 To present progress against the council's corporate performance framework for the Altogether Healthier priority theme for the fourth quarter of the 2017/18 financial year.

Performance Reporting Arrangements for 2017/18

2 Our performance reporting arrangements have been developed around a series of key performance questions aligned to the Altogether framework of six priority themes, and are designed to facilitate greater scrutiny of performance. The set of performance measures provides an indication to help answer these questions for those with corporate governance responsibilities.

3 There are other areas of performance that are measured through more detailed monitoring across service groupings and if performance issues arise, these will be escalated for consideration by including them in the corporate report on an exception basis.

4 The performance indicators are still reported against two indicator types which comprise of:

(a) key target indicators – targets are set for indicators where improvements can be measured regularly and where improvement can be actively influenced by the council and its partners; and

(b) key tracker indicators – performance is tracked but no targets are set for indicators which are long-term and/or which the council and its partners only partially influence.

5 This report sets out our key performance messages from data released this quarter and a visual summary for the Altogether Healthier priority theme that presents key data messages from the new performance framework showing the latest position in trends and how we compare with others. A comprehensive table of key performance questions and performance data is presented in Appendix 3. An explanation of symbols used and the groups we use to compare ourselves is in Appendix 2.

6 To support the complete indicator set, a guide is available which provides full details of indicator definitions and data sources for the 2017/18 corporate indicator set. This is available to view and can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

Key Performance Messages from Data Released this Quarter

7 Positive progress has been made across some key health measures including improved self-reported wellbeing and 1,860 smoking quitters between April and December 2017, exceeding the contracted target. In terms of adult social care, low levels of delayed transfers of care from hospital continue, better than the same period last year and national and regional averages. Although the number of adults admitted on a permanent basis to residential or nursing care was higher than target, the number of bed days commissioned has reduced by 3% in 2017/18. Funding for adult social care was announced by Government in the Spring 2017 budget and as part of the Improved Better Care Fund, Durham was allocated £25 million (£13 million was allocated for 2017/18, a further £8 million for 2018/19 and a final £4 million for 2019/20). This money was additional to current budgeted spend to be used for the purposes of meeting adult social care needs; reducing pressures on the NHS and stabilising the social care provider market.

8 Two ongoing performance challenges reported throughout this year are:
(a) Breastfeeding prevalence;
(b) Mothers smoking at time of delivery:

9 Although breastfeeding prevalence has increased from last year, this is still an issue, as levels remain low. Evidence clearly shows that breastfeeding improves the health of both mother and baby and yet there remains inequalities in women choosing to breastfeed. Plans to support the active promotion of breastfeeding across the County include a multi-agency communication plan and a review and relaunch of the breastfeeding friendly business scheme in June 2018. Revised public health priorities and ambitions identify aspirational improvement targets for the next 10 years to reduce inequalities and narrow the gap both within the County and against England.

10 Mothers smoking at time of delivery has increased and is significantly higher than national and regional rates. Durham Dales, Easington and Sedgefield (DDES) has the second highest rate in the North East and sixth highest of all CCGs in England. The best start in life is a public health strategic priority for County Durham, which aligns with national and regional policy direction. Reducing smoking at time of delivery will impact significantly on clinical and safety outcomes for both mothers and babies and will work to address significant health inequalities. The incentive scheme to reduce smoking in pregnancy, currently being implemented in DDES, aims to address the high variance in smoking in pregnancy between DDES and North Durham. Early data is showing good retention in the stop smoking service amongst these women. However, the challenges of reducing smoking in pregnancy is evident as 61% of those recruited to the scheme live with a smoker. The full evaluation of the incentive scheme will be available late summer 2018. Between April and December 2017, 179 pregnant women set a quit date with

the Stop Smoking Service of whom 119 (66%) women quit (self-reported) which is an improvement from the same period in 2016/17 (56%).

11 New data released this quarter highlight the following issues:
(a) Life expectancy;
(b) Healthy life expectancy;
(c) Mortality rate from preventable causes.

12 Life expectancy and healthy life expectancy can be used as important measures of the overall health of County Durham's population. Mortality can also be used as an effective measure of health and wellbeing and inequality within and between areas. Reductions in premature mortality over time can demonstrate improvement in the health status of the population as a whole and results in increases in life expectancy. The data shows that people in County Durham are living longer but that there is still a significant gap between the life expectancy of men and women in County Durham and the England average. Healthy life expectancy is the average number of years a person would expect to live in very good or good health and although this has increased since the previous reporting period (2013 - 2015), there is also still a significant gap between County Durham and England for both men and women. The mortality rate from causes considered preventable continues to decrease and the gap between England and County Durham has narrowed, although it remains significantly higher. The overarching public health priority for County Durham is to reduce the gap in healthy life expectancy, which includes work to reduce smoking levels and developing work on a health and social care plan for County Durham.

13 Key performance messages reported to other overview and scrutiny committees which may be of interest to this committee are as follows:

14 In relation to child health, under 18 conceptions continue to reduce; they are now at the lowest level since recording began in 1998. However, the level in County Durham remains significantly higher than the England rate. The Public Health Intelligence Team are to analyse data to identify hotspots in the County and enable targeted action to be taken. County Durham's Teenage Pregnancy Partnership Board continues to implement the 2016-18 action plan delivering both universal and targeted interventions.

15 Although there have been more successful completions of those in drug and alcohol treatment compared to the same period last year, levels remain below target. Successful completions for opiate users are however, in line with national averages. The newly commissioned drug and alcohol recovery service in County Durham was launched on 1 February 2018 and a comprehensive contract monitoring process has been established to monitor future progress.

Risk Management

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

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

Key Data Messages by Altogether Theme

18 The next section provides a summary of key data messages for the Altogether Healthier priority theme. The format of the Altogether theme provides a snap shot overview aimed to ensure that key performance messages are easy to identify[1]. The Altogether theme is supplemented by information and data relating to the complete indicator set, provided at Appendix 3.

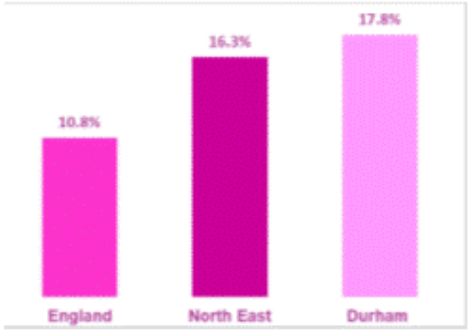
[1] Images designed by Freepik from Flaticon

Altogether Healthier

Health of our residents

Mothers smoking at time of delivery Oct - Dec 2017

- Worse than same period last year (17.4%)
- Worse than England and North East
- Data ranges from 13.7% in North Durham to 21% in DDES CCG
- Challenging target set for 2017/18 - 15.9%



Smoking quitters - April - December 2017

1860 people quit smoking following support between Apr and Dec 2017, exceeding the target of 1705

Mortality Rate - per 100,000 pop from preventable causes (2014 - 2016)

- Better than 2013-15 (226.1)
- Worse than England
- Better than North East

Low wellbeing (self reported) (2014 - 2016)

6.9% Durham (11.5% 2013 - 2015)

England (8.5%)

North East (8.7%)

Health of our residents

Life Expectancy (LE) and Healthy Life Expectancy (HLE) 2014 - 2016

- Male and Female LE increasing over time but still below national and in line with North East
- Female HLE increased from 2013-15 but still 4.9 below national and in line with North East (60.6yrs)
- Male HLE increased from 2013-15 but still 4.2 below national and in line with North East (59.7yrs)

78 years (LE)
59.1 years (HLE)

81.3 years (LE)
59 years (HLE)

England
79.5 years (LE)
63.3 years (HLE)

England
83.1 years (LE)
63.9 years (HLE)

Prevalence of breastfeeding at 6 -8 weeks

28.9% (Jan - Mar 2018)

26.8% (Jan - Mar 2017)

Although performance has increased, levels are still low and it is still an issue.

Adult Social Care

Daily Delayed transfers of care beds per 100,000 population - February 2018

3.4 (February 2018)

3.7 (February 2017)

Better than England (10.3), North East (8) and Unitary average (11)

86.4% of people received an assessment/review within the last 12 months (year ended Mar 2018), down from 87.2% (Mar 2017)

Adults aged 65+ per 100,000 population admitted to care on a permanent basis: Apr 2017 to Feb 2018

740 (691.7 per 100,00 pop) 804(764.1)(Mar 17) Target 677

Recommendations and reasons

19 That the Adults, Wellbeing and Health Overview and Scrutiny Committee receive the report and consider any performance issues arising therewith.

Contact:	**Jenny Haworth**	**Tel:**	**03000 268071**

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

Appendix 1: Implications

Finance - Latest performance information is being used to inform corporate, service and financial planning.

Staffing - Performance against a number of relevant corporate health Performance Indicators (PIs) has been included to monitor staffing issues.

Risk - Reporting of significant risks and their interaction with performance is integrated into the quarterly monitoring report.

Equality and Diversity / Public Sector Equality Duty - Corporate health PIs are monitored as part of the performance monitoring process.

Accommodation - Not applicable

Crime and Disorder - A number of PIs and key actions relating to crime and disorder are continually monitored in partnership with Durham Constabulary.

Human Rights - Not applicable

Consultation - Not applicable

Procurement - Not applicable

Disability Issues - Employees with a disability are monitored as part of the performance monitoring process.

Legal Implications - Not applicable

Appendix 2: Report key

Performance Indicators:

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

✓ Performance is good or better than comparable period/benchmark

✗ Performance is poor or worse than comparable period/benchmark

↔ Performance has remained static or is in line with comparable period/benchmark

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

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

Nearest Neighbour Benchmarking:
The nearest neighbour model was developed by the Chartered Institute of Public Finance and Accountancy (CIPFA), one of the professional accountancy bodies in the UK. CIPFA has produced a list of 15 local authorities which Durham is statistically close to when you look at a number of characteristics. The 15 authorities that are in the nearest statistical neighbours group for Durham using the CIPFA model are: Barnsley, Wakefield, Doncaster, Rotherham, Wigan, Kirklees, St Helens, Calderdale, Dudley, Northumberland, Tameside, Sheffield, Gateshead, Stockton-On-Tees and Stoke-on-Trent.

We also use other neighbour groups to compare our performance. More detail of these can be requested from the Corporate Planning and Performance Team at performance@durham.gov.uk.

Appendix 3: Summary of Key Performance Indicators

Table 1: Key Target and Tracker Indicators

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
Altogether Healthier												
1. Are our services improving the health of our residents?												
63	AHS12	Percentage of mothers smoking at time of delivery	17.8	Oct - Dec 2017	15.9	17.4	RED	10.8	RED	16.3*	RED	Oct - Dec 2017
64	AHS13	Four week smoking quitters per 100,000 smoking population	2,463	Apr - Dec 2017	2,258	2,025	GREEN					
65	AHS7	Male life expectancy at birth (years) [1]	78.0	2014-2016	Tracker	78.1	AMBER	79.5	AMBER	77.8*	GREEN	2014-2016
66	AHS8	Female life expectancy at birth (years) [1]	81.3	2014-2016	Tracker	81.2	GREEN	83.1	RED	81.5*	AMBER	2014-2016
67	AHS9	Healthy life expectancy at birth [Female]	59	2014-2016	Tracker	57	GREEN	63.9	RED	60.6*	RED	2014-2016
68	AHS10	Healthy life expectancy at birth [Male]	59.1	2014-2016	Tracker	58	GREEN	63.3	RED	59.7*	AMBER	2014-2016
69	AHS14	Excess weight in adults (Proportion of adults classified as overweight or obese)	67.5	2015/16	Tracker	New indicator	NA	61.3	RED	66.3*	AMBER	2015/16
70	AHS11	Suicide rate (deaths from suicide and injury of undetermined	12.6	2014 - 2016	Tracker	15.7	GREEN	9.9	RED	11.6*	RED	2014 - 2016

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
		intent) per 100,000 population										
71	AHS38	Prevalence of breastfeeding at 6-8 weeks from birth	28.9	Jan - Mar 2018	Tracker	26.8	GREEN	43.7	Not comparable	33*	Not comparable	Oct - Dec 2017
72	AHS40	Estimated smoking prevalence of persons aged 18 and over	17.9	2016	Tracker	19.0	GREEN	15.5	RED	17.2*	RED	2016
73	AHS41	Self-reported wellbeing - people with a low happiness score	6.9	2016/17	Tracker	11.5	GREEN	8.5	GREEN	8.7*	GREEN	2016/17
74	NS21	Participation in Sport and Physical Activity: active	60.9	May 2016 - May 2017	Tracker	62.2	RED	60.6	GREEN			May 2016 - May 2017
75	NS22	Participation in Sport and Physical Activity: inactive	24.5	May 2016 - May 2017	Tracker	25.4	GREEN	25.6	GREEN			May 2016 - May 2017
2. Are people needing adult social care supported to live safe, healthy and independent lives?												
76	AHS18	Adults aged 65+ per 100,000 population admitted on a permanent basis in the year to residential or nursing care	691.7	Apr 2017 - Feb 2018	677.0	764.1	GREEN	628.2	Not comparable	843*	Not comparable	2015/16
77	AHS20	Proportion of older people who were still at home 91 days after discharge from	89.1	Jan - Dec 2018	85.9	87.8	GREEN	82.7	Not comparable	85.5*	Not comparable	2015/16

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
		hospital into reablement/ rehabilitation services										
78	AHS16	Percentage of individuals who achieved their desired outcomes from the adult safeguarding process	96.2	Apr 2017 - Mar 2018	Tracker	95.6	GREEN					
79	AHS17	Percentage of service users receiving an Assessment or Review within the last 12 months	86.4	Apr 2017 - Mar 2018	Tracker	87.2	AMBER					
80	AHS21	Overall satisfaction of people who use services with their care and support	63.6	2016/17	Tracker	New indicator	NA	64.4	Not comparable	67.2*	Not comparable	2015/16
81	AHS22	Overall satisfaction of carers with the support and services they receive	43.3	2016/17	Tracker	New indicator	NA	41.2	Not comparable	49.3*	Not comparable	2014/15
82	AHS19	Daily Delayed transfers of care beds, all per hospital per 100,000 population age 18+	3.4	Feb 2018	Tracker	3.6	GREEN	11.9	GREEN		GREEN	At November 2017

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
83	AHS23	The proportion of adult social care service users who report they have enough choice over the care and support services they receive	73.1	2016/17	Tracker	New indicator	NA	67.6	GREEN	NA		2016/17

[1] Data 12 months earlier amended/refreshed

Table 2: Other additional relevant indicators

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
Altogether Better for Children and Young People												
1. Are children, young people and families in receipt of universal services appropriately supported?												
33	AHS1	Under 18 conception rate per 1,000 girls aged 15 to 17	21.6	Jan 2016 - Dec 2016	Tracker	26.4	GREEN	18.8	RED	24.6*	GREEN	Jan 2016 - Dec 2016
34	AHS2	Proportion of five year old children free from dental decay	64.9	2014/15	Tracker	New indicator	NA	75.2	RED	72*	RED	2014/15
35	AHS3	Alcohol specific hospital admissions for under 18's (rate per 100,000)	67.5	2013/14 - 2015/16	Tracker	72.8	GREEN	37.4	RED	66.9*	AMBER	2013/14 - 2015/16
36	AHS4	Young people aged 10-24 admitted to hospital as a result of self-harm	489.4	2011/12 - 2013/14	Tracker	504.8	GREEN	367.3	RED	532.2 *	GREEN	England - 2011/12 - 2013/14 NE - 2010/11 - 2012/13
37	AHS5	Percentage of children aged 4 to 5 years classified as overweight or obese	24.1	2016/17 ac yr	Tracker	24.3	GREEN	22.6	RED	24.5*	GREEN	2016/17 ac yr
38	ASH6	Percentage of children aged 10 to 11 years classified as overweight or obese	37.7	2016/17 ac yr	Tracker	37.0	AMBER	34.2	RED	37.3*	AMBER	2016/17 ac yr

Ref	PI ref	Description	Latest data	Period covered	Period target	Data 12 months earlier	Performance compared to 12 months earlier	Performance compared to National figure		Performance compared to *North East figure **Nearest statistical neighbour figure		Period covered
3. How well do we reduce misuse of drugs and alcohol?												
92	AHS31	Percentage of successful completions of those in alcohol treatment	31.9	Oct 2016 - Sep 2017 with reps to Mar 2018	38.4	28.6	GREEN	38.6	RED	30.8*	GREEN	Oct 2016 - Sep 2017 with reps to Mar 2018
93	AHS32	Percentage of successful completions of those in drug treatment - opiates	6.4	Oct 2016 - Sep 2017 with reps to Mar 2018	7.8	6.2	GREEN	6.6	GREEN	5.2*	GREEN	Oct 2016 - Sep 2017 with reps to Mar 2018
94	AHS33	Percentage of successful completions of those in drug treatment - non-opiates	30.1	Oct 2016 - Sep 2017 with reps to Mar 2018	44.2	26.9	GREEN	36.6	RED	27.4*	GREEN	Oct 2016 - Sep 2017 with reps to Mar 2018

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Adults Wellbeing and Health Overview and Scrutiny

6 July 2018

NHS Quality Accounts 2017-18 Adults Wellbeing and Health OSC Responses

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

1. Purpose of the Report

1.1 To inform members of the Adults Wellbeing and Health Overview and Scrutiny Committee of the responses made on behalf of the Committee in respect of NHS Foundation Trust Draft Quality Accounts 2017/18.

2 Background

2.1 At a special meeting held on 9 May 2018, the Adults, Wellbeing and Health Overview and Scrutiny Committee considered a report detailing proposals to respond to Draft Quality Accounts for 2017/18 from:-

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

2.2 The Health Act 2009 requires the NHS Foundation Trusts to publish an annual Quality Account report. The purpose of the Quality Account report is for each of the Trusts to assess quality across all of the healthcare services they offer by reporting information on 2017/18 performance and identifying priorities for improvement during the forthcoming year and how they will be achieved and measured.

3 Draft Quality Accounts

3.1 Draft Quality Accounts documents were received as follows:-

Foundation Trust	Date Received
Tees Esk and Wear Valleys NHS Foundation Trust	16 April 2018
County Durham and Darlington NHS Foundation Trust	18 April 2018
North East Ambulance Service NHS Foundation Trust	20 April 2018

3.2. The Draft Quality Accounts' priorities for the three Trusts were circulated electronically to the membership of the Committee and comments invited thereon.

3.3 Responses to the documents were drafted on behalf of the Committee, signed off by the Statutory Scrutiny Officer and sent to the respective organisations. A copy of each response is attached to this report.

3.4 All responses were submitted to the respective NHS Organisations within the statutory deadlines set out in legislation.

4. Recommendations

4.1 Members of the Adults Wellbeing and Health Overview and Scrutiny Committee are asked to note the report and endorse the responses to NHS Organisations' draft Quality Accounts contained therein.

Background Papers
NHS Quality Accounts Report to Special Adults Wellbeing and Health Overview and Scrutiny Committee – 9 May 2018

County Durham and Darlington NHS Foundation Trust Draft Quality Account 2017/18

Tees, Esk and Wear Valleys NHS Foundation Trust Draft Quality Account 2017/18

North East Ambulance Service Draft Quality Account 2017/18

Contact: Stephen Gwillym, Principal Overview and Scrutiny Officer Tel: 03000 268140
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Appendix 1: Implications

Finance – None.

Staffing - None

Equality and Diversity - None

Accommodation – None.

Crime and Disorder – None.

Human Rights – None

Consultation – The Adults Wellbeing and Health Overview and Scrutiny Committee have been invited to comment on the NHS Foundation Trust Draft Quality Accounts documents 2017/18 as outlined in this report.

Procurement – None

Disability Discrimination Act – None

Legal Implications – This report has been produced to reflect the requirements of the Health Act 2009.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

The Committee welcomes Tees, Esk and Wear Valleys NHS Foundation Trust's Quality Account 2017/18 and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2017/18 including undertaking a post implementation examination following the review of Inpatient Dementia Wards serving County Durham and Darlington and associated mitigation plans for the reimbursement of additional travelling costs; the service reconfigurations arising from structural issues at Roseberry Park, Middlesbrough; the development of an Accountable Care Partnership and the merger of mental health rehabilitation services for adults into Willow Ward, West Park, Darlington.

The Committee considers that the Quality Account is clearly set out and that progress made against 2017/18 priorities is clearly identified. The Trust has made significant progress against these priorities and the Committee welcome the completion of 35 of the 37 actions identified by the Trust under the 5 priorities. Of the 2 actions that are reported as having been missed, the Committee acknowledge that:-

(i) In respect of the preventable deaths priority and training carried out in relation to leave and time away from the ward, the action has not been achieved because real time data for compliance is not yet available from the Trust's IT systems. However, the Committee are assured that this will be addressed during 2018/19;
(ii) In respect of the transitions priority, the production of an evaluation report of the implementation of the new transitions protocol has been delayed and will not now be completed until the end of June 2018.

In considering those quality metrics where the Trust has missed its target, the Committee note that the percentage of patients who reported "yes-always" to the question "do you feel safe on the ward" for the Durham and Darlington locality whilst below the Trust-wide target is the closest to target at 69.5%. The Committee is however concerned that there appears to be a contradiction between this safety metric and the percentage of patients who reported their overall experience as excellent or good (90.38%).

The Committee is satisfied that whilst Trust-wide the average length of stay for patients in mental health services for older people assessment and treatment wards is below target and is largely due to failings in respect of delayed transfers of care, this is not the case across County Durham.

The Committee acknowledges all of the 2018/19 priorities identified within the draft Quality Account and agrees that from the information received from the Trust, they are a fair reflection of healthcare services provided by the Trust. The Committee are particularly pleased to see that the Trust is to develop a Trust-wide approach to dual diagnosis which ensures that people with substance misuse issues can access appropriate and effective

mental health services. The move to more personalised care plans is also supported by the Committee.

During consideration of the progress made against the Trust's 2017/18 Quality Account priorities and performance metrics, the Committee have sought assurances that robust improvement action plans are in place to improve those below target metrics and would welcome sight of these plans in due course.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2018/19 priorities and performance targets in November 2018.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

The Committee welcomes County Durham and Darlington NHS Foundation Trust's Quality Account and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2017/18 including maternity services at Darlington Memorial Hospital; inpatient bed reductions at Richardson Hospital, Barnard Castle, Weardale Hospital, Stanhope and Sedgefield Community Hospital; community health services; winter pressures and the work of the local A&E Delivery board; the review of stroke rehabilitation services; the Trust's CQC Re-inspection report and action plan and the County Durham Integrated Care Partnership and the development of teams around patients.

The Quality Account is clearly set out and the Committee noted the positive performance set out within the document in respect of care of patients with dementia; patient safety incidents resulting in severe injury or death; the introduction of new local patient safety standards; end of life care and the proposed introduction of consultant paediatric clinics in GP surgeries.

During previous years, the Committee has considered the improvements identified within the Trust's CQC Inspection Improvement plan and commended the actions planned by the Trust to improve quality and performance within the organisation. Members are therefore concerned that the recent re-inspection report from the Care Quality Commission reaffirmed a "requires improvement" judgement. To this end, the Committee would seek assurances that the Trust continues to place the highest importance on delivering the required levels of improvements across its services and that this is reflected within ongoing priorities for the Trust for 2018/19 and beyond.

The Committee has also requested further information to be brought back to future meetings in respect of the work being done by the Trust regarding the treatment of Sepsis as well as the numbers of planned/elective surgery procedures that were cancelled due to pressures within the Trust in respect of urgent and emergency care.

In summary, it is considered from the information received from the Trust that the identified priorities for 2018/19 are a fair reflection of healthcare services provided by the Trust and the Committee note the progress made against the 2017/18 priorities.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee would request a six monthly progress report on delivery of 2018/19 priorities and performance targets as well as the CQC Re-inspection action plan in November 2018.

DURHAM COUNTY COUNCIL ADULTS WELLBEING AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST QUALITY ACCOUNT FOR 2017/18

The Committee welcomes North East Ambulance Service (NEAS) NHS Foundation Trust's Quality Account and the opportunity to provide comment on it. The Committee are mindful of their statutory health scrutiny role and the need to demonstrate a robust mechanism for providing assurance to the residents of County Durham that health service provision is efficient and effective. The quality account process provides the Committee with one such mechanism.

The Committee has engaged with the Trust on a number of issues during the course of 2016/17 including the post implementation progress in respect of Durham Dales, Easington and Sedgefield CCG'S A&E Ambulance Service Review and Urgent Care Review; the National Ambulance Response programme; NEAS performance across County Durham; the impact upon NEAS on the Sunderland and South Tyneside NHS Partnership Path to Excellence programme and its progress against the 2017/18 Quality Account priorities.

The Committee considers that the Quality Account is clearly set out and acknowledges up front that performance during 2017/18 has again been challenging, set against a context of a considerable increase in demand for the service both regionally and nationally.

In commenting upon the Quality Account, the Committee:-

- Welcomes the steps taken by the Trust in the early identification of sepsis amongst its patients, noting that performance in terms of compliance with Sepsis Care Bundle performance is above target. The Committee would suggest that this target should be further stretched for 2018/19;
- Supports the work to undertake regular audits of ambulance waits to determine whether the patient came to any harm whilst noting that average job cycle times have almost doubled from 52 minutes in 2006 to 1 hour 43 minutes in 2018;
- Acknowledges that the development and implementation of a safeguarding tool to support clinicians' decision making has been delayed, although members are pleased that the appropriateness of safeguarding referral is 100% across the Trust and that the accuracy of referral is improving within the Trust as a result of shared learning via staff training.

The Committee continue to be concerned at the Trust performance across County Durham in comparison to Trust wide performance and have asked for regular updates back to the Committee as the new National Ambulance Response programme targets are embedded across the organisation. The previously identified issue of the increase in the duration of job cycle times coupled with the increase in the number of patients with complex health needs and conditions being seen by NEAS staff is noted as a potential contributing factor to this.

The Committee would also take the opportunity to reiterate their concerns regarding the potential impact upon NEAS response times of any service change proposals arising from NHS Sustainability and Transformation Plans which could impact upon acute hospital services across the region and seek assurances that NEAS will ensure its continued input into such plans.

The Committee consider that from the information received from the Trust, the identified priorities for 2018/19 are clearly expressed and will contribute to improvements in the healthcare system generally.

Finally, in order to ensure that it continues to provide a robust Health scrutiny function and assurances in this respect to the residents of County Durham, the Committee will continue to receive and consider performance overview information. As in previous years, the Committee would request a six monthly progress report on delivery of 2018/19 priorities and performance targets in November 2018.

Adults Wellbeing and Health Overview and Scrutiny Committee

6 July 2018

Review of the Committee's Work Programme 2018-19

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

Purpose of the Report

1. To provide for Members consideration an updated work programme for the Adults Wellbeing and Health Overview and Scrutiny Committee for 2018 - 19.

Background

2. At its meeting on 13 April 2018, the Adults Wellbeing and Health Overview and Scrutiny Committee considered the actions identified within the Council Plan 2016 – 2019 for the Altogether Healthier priority theme and agreed to refresh its work programme to include a number of these actions. In addition, topics have been identified that are in line with the Cabinet's Forward Plan of Key Decisions, the Sustainable Community Strategy, forthcoming Government Legislation, outcomes form Quarterly Performance reports and other plans and strategies accordingly.

Detail

3. In accordance with this decision, a work programme for 2018 – 2019 has been prepared and is attached at Appendix 2.

4. The Committee has undertaken a piece of in-depth scrutiny review activity in respect of Suicide Rates and Mental Health and Wellbeing in County Durham and the review report will be submitted to the Committee for consideration and comment prior to referral to Cabinet.

Recommendation

5. Members of the Committee are asked to agree the new work programme for the coming year.

Background Papers

Council Plan 2016 – 2019
AWH OSC Report 13 April 2018 – Council Plan 2016-19 – Refresh of Work Programme for Adults Wellbeing and Health Overview and Scrutiny Committee

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Appendix 1: Implications

Finance – The Council Plan sets out the corporate priorities of the Council for the next 3 years. The Medium Term Financial Plan aligns revenue and capital investment to priorities within the Council Plan.

Staffing – None

Risk - 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

OVERVIEW AND SCRUTINY WORK PROGRAMME 2018 TO 2019

OVERVIEW AND SCRUTINY WORK PROGRAMME 2017 TO 2018 **Adults, Well-being and Health OSC** **Lead Officer**: Stephen Gwillym **IPG contact**: Andrea Petty	**Note:** **O/S Review** - A systematic 6 monthly review of progress against recommendations/Action Plan **Scrutiny/Working Group** – In depth Review **Overview/progress** – information on an issue; opportunity to comment, shape, influence, progress with a scrutiny review **Performance** – ongoing monitoring (quarterly) performance reports/budgets

Committee	**When**	**Who**	**Outcome**	**Comment**
Adults' and Health Services including Public Health				
O/S Review				
Suicide Rates and Mental Health and Wellbeing in County Durham	1 October 2018	Public Health/NHS Partners	To report the findings of a Review into Suicide Rates in County Durham and Mental Wellbeing	Scrutiny Review

Overview/Progress				
Public Health Overview and Update	6 July 2018	Amanda Healey, Director of Public Health	To inform members of the Council's mandated public health responsibilities and on the latest developments in respect of Public Health	This item provides members with an opportunity to consider the Council's statutory responsibilities regarding public health
Adult Social Care Update	6 July 2018 18 January 2019	Jane Robinson	To advise members of the latest policy and service developments in respect of Adult Social Care including associated funding	
Director of Public Health Report	1 October 2018	Amanda Healey	Update on Public Health priorities arising from DPH Annual Report	To receive the DPH annual report and reflect upon its content within the context of the Committee's work programme priorities for 2018/19 and beyond
Health and Wellbeing Board – Annual Report	1 October 2018	Cllr Lucy Hovvels/Gordon Elliott	To provide members with an update of the ley delivery plan actions against the JHWS	To receive the Health and Wellbeing Board annual report and reflect upon its content within the context of the Committee's work programme priorities for 2018/19 and beyond
Safeguarding Adults Annual Report	1 October 2018	Gordon Elliott	Update on Annual Report	To receive the Safeguarding Adults annual report and reflect upon its content within the context of the Committee's work programme priorities for 2018/19 and beyond

Integration of Health and Social Care Services	TBC	Lesley Jeavons – Director of Integration	To provide an update on the integration of health and social care services	To ensure that members are aware of the ongoing progress being made in respect of the Integration of health and social care within County Durham as well as details of the Community Services Contract implementation
Oral Health Strategy	7 March 2019	Amanda Healy - DPH Gill O'Neill - Deputy Director of Public Health	To inform members of the development of the Oral Health Strategy	To allow members to comment upon the strategy and the key actions therein.
Joint Health and Wellbeing Strategy	19 January 2019	Andrea Petty – Strategic Manager Partnerships	To inform members of the development of the County Durham Health and Wellbeing Strategy	To allow members to comment upon the strategy and the key actions therein.
Performance and Budget Reporting				
Performance	Performance Quarterly update Reports 2017/18 Q4 Outturn – 6 July 2018 2018/19 Q1 – 1 October 2018 2018/19 Q2 – 18 January 2019	 T Gorman T Gorman T Gorman	Members using performance management information to inform the Work Programme and possible Review Activity	Summary information to members

Budget Outturn	2018/19 Q3 – 1 April 2019	T Gorman	Quarterly update key issues	Summary information to members
	2017/18 Q4 Outturn – 1 October 2018	Andrew Gilmore		
	2018/19 Q1 – 1 October 2018	Andrew Gilmore		
	2018/19 Q2 – 18 January 2018	Andrew Gilmore		
	2018/19 Q3 – 7 March 2018	Andrew Gilmore		

2. NHS commissioners (North Durham CCG; DDES CCG and NHS England Regional Team) and provider organisations	When	Who	Outcome	Comment
NHS Service change - Updates to AWHOSC				
North East Ambulance Service – Post Implementation Audit of the New National Ambulance Response Standards	18 January 2019	Mark Cotton, NEAS	Members are appraised of the impact upon NEAS of the new Ambulance Response Standards and also the performance against these across County Durham	To consider the implications for Ambulance Performance across County Durham of the new Ambulance Performance standards.
Durham Dales Easington and Sedgefield CCG – Review of Urgent Care Services	6 July 2018	DDES CCG	Members are appraised of the post implementation of the Review of Urgent Care Services.	Continued engagement of members following the Review of Urgent Care Services.
Updates in respect of ongoing remedial works to Roseberry Park Hospital – Tees Esk and Wear Valleys NHS FT	January 2019	TEWV/North Durham and DDES CCGs	Members appraised of the ongoing work in respect of the provision of mental health services for residents of County Durham	Continued engagement of members and Community into the development of mental health services within County Durham
Statutory Health Scrutiny Consultations				
NHS England Review of Specialised Vascular Services in the North East	1 June 2018	NHS England County Durham CCGs	Details of proposed changes to Specialised Vascular Services across the North East reported to members as part of consultation /engagement	Potential Statutory Health Consultation
South Tyneside and Sunderland Path to Excellence - Phase 1 Update and proposals for Phase 2	TBC	South Tyneside and Sunderland NHS Partnership	Details of the outcome of Phase 1 of the Path to Excellence	Potential Statutory Health Consultation

		County Durham CCGs	programme and proposals for Phase 2 Consultation and Engagement reported to members as part of consultation /engagement	
Overview/Progress				
Quality Accounts 2017/18 – Overview and Scrutiny Response Monitoring Updates	6 July 2018 15 November 2018	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Formal Responses by AWHOSC Monitoring Updates on 2016/17 Quality Accounts Priorities	To provide Committee endorsement of the formal Quality Account responses To provide Committee with assurance that QA priority actions are being delivered and agree Committee feedback on areas of under-performance
Quality Accounts 2018/19 – Preparation of Overview and Scrutiny Input and Commentary	1 April 2019	County Durham and Darlington NHS Foundation Trust Tees Esk and Wear Valleys NHS Foundation Trust North East Ambulance Service	Process of shaping and OSC commentary on 2017/18 Quality Accounts	Members agree timetable for 2018/19 Quality Account consideration and response
Proposed Review of Stroke Rehabilitation Pathway/Services across County Durham	6 July 2018 7 September 2018	North Durham CCG DDES CCG	Assurance from CCGs that the proposal will improve stroke rehabilitation pathways/ services across County Durham and increase the performance	Referral from Special AWH OSC 2 May 2018 – Request for information from CCGs in respect of the proposals to include information on service

			measures associated with access to stroke service discharge teams.	user and carer engagement undertaken as part of the review process, the rationale behind the proposed change in service model including evidence from Stroke service practitioners and the impact assessment undertaken as part of the process
North Durham and DDES CCGs 2 year Operational Plans	15 November 2018	North Durham CCG DDES CCG	To advise members of the detail of the County Durham CCGs 2 year Operational Plans	To consider CCG Operational plans within the context of the AWHOSC Work programme and consultations
County Durham and Darlington NHS FT – CQC Re-inspection and Improvement Action Plan Update	TBC	Sue Jacques, CDDNHS FT	To report upon the progress against the CQC Re-inspection Action Plan for CDDFT	To provide member assurance regarding the proposed CDDFT Re-inspection action plan
Improved Access to Psychological Therapies Model Development – Post Implementation Update	1 April 2019	Mike Brierley, North Durham CCG	To report upon the outcomes delivered as part of the IAPT Model Development agreed in April 2018	To assess the progress made in delivering improved access to IAPT services
North Durham CCG Rapid Specialist Opinion Service – Post Implementation Review	7 March 2019	Dr Neil O'Brien, North Durham CCG	To report upon the outcomes delivered as part of the extension of the North Durham CCG RSO service.	To consider the outcomes from the ND CCG RSO process in terms of health improvement outcomes and early/appropriate treatment interventions

Other – Regional				
Northumberland, Tyne and Wear and North Durham Draft STP	TBC	Mark Adams – NTWND STP Lead Officer	AWHOSC Formal consultation in respect of the Northumberland, Tyne and Wear and North Durham Draft STP proposals	Statutory Health Service Consultation
Durham Darlington Teesside Hambleton Richmondshire and Whitby Draft STP	TBC	Alan Foster – DDTHRW STP Lead Officer	AWHOSC Formal consultation in respect of the Durham Darlington Teesside Hambleton Richmondshire and Whitby Draft STP proposals	Statutory Health Service Consultation
Regional Joint Health OSC – Update	15 November 2018	Principal OSO	Member update on the work of the Regional Joint Health OSC	To ensure regular input of the AWHOSC into those health scrutiny issues determined at Regional Health OSC