Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Thursday 7 March 2019**
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 special meeting held on 14 January 2019, the meeting on 18 January 2019 and of the special meeting on 21 February 2019 (Pages 3 - 24)
4. Declarations of Interest, if any
5. Media Issues (Pages 25 - 26)
6. Any Items from Co-opted Members or Interested Parties
7. Joint Update report for the Integrated Sexual Health Service - Joint Report and presentation by Amanda Healy, Director of Public Health Durham County Council and Paul Frank, Associate Director of Operations, County Durham and Darlington NHS Foundation Trust (Pages 27 - 60)
8. North East Ambulance Service NHS Foundation Trust - Presentation by Mark Cotton, Assistant Director of Communications and Engagement (Pages 61 - 84)
9. Durham Health and Wellbeing System Plan 2019/20 - Part A Adults; - Report and Presentation of Chief Officer, North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups (Pages 85 - 124)

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

Helen Lynch
Head of Legal and Democratic Services

County Hall
Durham
27 February 2019

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, P Jopling, C Kay, K Liddell, A Patterson, S Quinn, A Savory, M Simmons, H Smith, O Temple and C Wilson

Co-opted Members: Mrs R Hassoon and Mr D J Taylor Gooby
Co-opted Employees/Officers: Mr C Cunnington Shore

Contact: Jackie Graham **Tel: 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 **Monday 14 January 2019 at 12.00 pm**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, P Crathorne, R Crute, G Darkes, J Grant, T Henderson, E Huntington, C Kay, K Liddell, A Patterson, S Quinn, M Simmons, H Smith and O Temple

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

Also Present:
Councillor P Brookes and C Cunnington Shore (Healthwatch County Durham)

1 Apologies

Apologies for absence were received from Councillors R Bell, A Hopgood, P Jopling, A Savory and C Wilson

2 Substitute Members

There were no substitute members.

3 Declarations of Interest

Councillors P Brookes, J Robinson and Mrs Hassoon declared an interest in Item 6 as patients of Skerene Medical Group.

4 Any Items from Co-opted Members or Interested Parties

There were no items.

5 Minutes

The minutes of the meeting held on 15 November 2018 and of the special meeting held on 4 December 2018 were agreed as a correct record and signed by the Chairman.

6 Skerne Medical Group

The Committee received a report of the Director of Transformation and Partnerships (for copy see file of Minutes) and verbal update by representatives of Durham Dales, Easington and Sedgefield CCG Primary Care Commissioning Committee.

The Principal Overview and Scrutiny Officer referenced the accompany documents to the report from DDES CCG Primary Care Committee and highlighted the comments made by the Committee at the previous meetings.

The Chairman of the DDES CCG Primary Care Committee reported that extensive discussions had taken place before any decisions had been made and information had been received via MPs, local councillors, this committee and local residents. He confirmed that the PCC had given a rationale to support each decision and recommended the following:-

- That the proposal for the closure of Trimdon Village be supported.
- That the proposal to close Fishburn Village surgery be rejected.
- That the practice (Skerne Medical Group) conduct an urgent review regarding the medium to long term future of the surgery sites, engaging all patients and completed within 6-12 months.

The Primary Care Contract Manager, NHS England supported the decision taken by the CCG's Primary Care Committee.

The Chairman said that there had been a lot of concerns and uncertainty expressed throughout this whole process and asked how this could be a four year review when the situation was classed as urgent.

The Chief Clinical Officer, DDES CCG said that there had been a lot of misunderstanding about the long term review. He confirmed that the practice would need to finalise the re-configuration of the practice over the next two months.

Councillor Grant continued to be disappointed about the closure of the Trimdon Village practice but did acknowledge that people would still receive medical care at the Fishburn practice. She thanked the CCG for recognising that the engagement process was flawed as what patients were being informed was different to the information posted on the website. She pointed it that if it was recognised that the process had been flawed then surely the reasons to close Trimdon Village would also be flawed. She confirmed that there had been a lot of engagement with the practice from Trimdon Village Parish Council. However, when talking to a developer with regards to using S106 money for a new build the practice had remained silent. She added that the local pharmacists wanted Trimdon Village to remain open. Referring to the Chairman's earlier point about this being an urgent situation, she disagreed and said that the problems had been apparent for years. She would feed her concerns into the cross party working group.

The Chief Clinical Officer DDES CCG said that these points had been answered at previous meetings and stood by the decision. He could not say that the practice was not in crisis and that the CCG had to support the practice by making these decisions.

Referring to the number of GPs at the practice Mrs Hassoon asked how many salaried and how many locums were currently in the practice. The Director of Primary Care,

Partnerships and Engagement said that there had been a substantial reduction from 8 to 2.5 partners and therefore the number of sessions offered by GPs had reduced significantly. The Chief Clinical Officer added that the practice were still managing to offer above the number of consultations but that this depended on locums availability. He pointed out that locums could not offer the same service as a GP. The Chairman of DDES CCG Primary Care Committee said that this could be addressed by having discussions at the cross-party working group and that the CCG welcomed the opportunity to be involved.

Members were advised that page 64 of the pack showed the staffing levels.

Mr Taylor-Gooby said that the decline of GPs was noticed in other GPs surgeries and they were also having to use more locums and salaried GPs. He asked if there were any plans to merge GP practices into bigger organisations and pool the GPS that were available. The Chief Clinical Officer confirmed that nationally 30% of general practices under threat of closure, with 10% in the north east. He added that there had already been some closures of practices in the region.

On answering a further question from Mr Taylor-Gooby about whether practices were obliged to merge, the Chief Clinical Officer said that this would depend if the neighbouring practice had the capacity to take on extra patients. It was also noted that the closure of one practice could have a domino effect on other practices by creating extra pressures.

Councillor Kay asked for confirmation about the number of partners at the practice as the report stated that number had dropped dramatically. It was explained that since the engagement exercise and from writing the report, there had been one further retirement and one redundancy. It was confirmed that there were 2.1 partners remaining in the practice. The Chief Clinical Officer explained that this number had varied from month to month during a very difficult time for the practice.

Councillor Grant went on to say that she accepted that there were only 2.1 partners now but that the report should have explained this by saying that the numbers varied from month to month rather than showing that it had been a dramatic change since December last year.

It was acknowledged that the confusion had arisen over the number of GPs as there had been no previous written reports from the practice and the CCG report stated that the current staffing level was 4.67 whole time equivalent GP partners. The CCG representatives confirmed that this was the number at the time of writing the report to the Primary Care Committee.

Councillor Brookes said that he was disappointed that no-one from the practice was at this meeting as it would have been helpful to receive the figures from them. He went on the say that the Trimdon Village surgery had closed 10 days previously and asked how the CCG would monitor the impact of this closure. He further asked if any extra use at A&E as a result of this closure would be monitored. He asked how the use of the additional paramedic employed by practice would be monitored and what the footfall would be on the other surgeries in the area. He was concerned that people would still need medical care but would have to travel further to receive it. He asked for the timeline of the review and what that would mean in terms of the closure of Fishburn surgery.

Councillor Brookes went on to ask for transparency in what the future use of Sedgefield Community Hospital would be and if Skerne Medical Group would occupy this as a single site practice, and if there was a timeline for this. He asked what was being done to extend the minor ailment scheme at the pharmacists in Trimdon, as he was concerned that as people may not be able to afford to travel to their GP they would rely on the pharmacy. He asked what Skerne Medical Group were doing in terms of recruiting new GPs and asked what was being done to create a new health centre in Trimdon Village.

The Chief Clinical Officer said that he could not add to what had already been said at previous meetings. He advised that the practice did not need to be at the meeting as it was for the CCG to inform the committee of the decisions made by the Primary Care Committee. In terms of minor injuries, he advised that this area of work was constantly being reviewed but that there was no intention to extend at present. The offer of advice and support was part of the national contract. He added that it was up to the surgery to consult on the future plans but that this would need to be done within the next 6-12 months. With regards to Sedgefield Community Hospital he advised that costs were being developed around the future use of the site. The offer from a developer for Trimdon Village would be explored further but he confirmed that there would only be two sites in the future, not four and that Trimdon Village would be part of the review.
He advised that A&E was constantly monitored and daily data was collected. A report could come back to committee in six months time to show this information.

Councillor Crute commented that any plans for a public consultation should be presented to this committee first and he reminded officers that there was statutory duty to inform this committee.

With regards to the plans for Sedgefield Community Hospital, Councillor Crathorne asked that if Skerne Medical Group were to occupy would this be at a detriment to the wards and patients already there. The Chief Clinical Officer confirmed that the hospital was not used for clinical services and that wards were used for officers from the CCG.

The Chairman said that the offer from the developer to utilise the S106 funding needed to be expedited. He asked that staffing numbers from Skerne Medical Group were clarified and that they come back to committee with plans for the review, detailing the timelines and who would be involved. He asked that this be done before the commencement of the engagement process and that local councillors were involved.

Resolved:
That the update report and the decision of the CCG Primary care Committee be noted.

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 Council Chamber - County Hall, Durham on **Friday 18 January 2019 at 9.30 am**

Present:

Councillor J Robinson (Chairman)

Members of the Committee:
Councillors J Chaplow, R Bell, P Crathorne, R Crute, G Darkes, T Henderson, A Hopgood, E Huntington, C Kay, A Patterson, S Quinn, M Simmons and H Smith

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

Also Present:
Councillors J Allen, L Hovvels and S Zair

1 Apologies for absence

Apologies for absence were received from Councillors J Grant, A Savory, O Temple and C Wilson.

2 Substitute Members

There were no substitute members.

3 Declarations of Interest

There were no declarations of interest.

4 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 bosses in England say a new 10-year plan could save up to 500,000 lives by focusing on prevention and early detection.** GPs, mental health and community care will get the biggest funding increases to shift the focus away from hospitals. Prime Minister Theresa May hailed the launch of the plan as a "truly historic moment". But unions are concerned that staffing shortages could undermine the ambitions - one in 11 posts are currently vacant.

- **HEALTH bosses have recommended a proposal to shut the doors of a rural County Durham GP practice is rejected - but have advised the approval to close another branch.** Relates to the Skerne Medical Group proposals but also reflects members concerns about the state of GP service provision across County Durham which has prompted the proposed Review at Item 11.

- **Two GP practices serving nearly 8,000 patients are set to merge** after plans were given the go ahead by health bosses. Earlier this year, an application was lodged to merge Shotton Medical Practice and Station Road Practice in Shotton Colliery. Due to one practice partner's plans to retire in 2019, a bid was launched to rebrand the two surgeries under the name Bevan Medical Group. In a business case, the practices said the merger would "better absorb sickness and absence" and potentially allow longer opening hours in future.

- **A GP practice is still in special measures after being rated as "inadequate" for the second time in a year.** Phoenix Medical Group, which has three surgeries in east Durham, was given the rating by the Care Quality Commission (CQC).

5. Any Items from Co-opted Members or Interested Parties

There were no items from co-opted members or interested parties provided prior to the meeting, however Mr Taylor Gooby raised the issue of Air Pollution. The Chairman of Overview and Scrutiny advised that Environment and Sustainable Communities Overview and Scrutiny were looking at the issue and asked Mr Taylor Gooby to forward his concerns to the Principal Overview and Scrutiny Officer.

6 New Seaham Medical Group

The Committee considered a report of the Director of Transformation and Partnerships that advised of patient and stakeholder engagement being undertaken by the New Seaham Medical Group regarding future service provision across the practice locality (for copy see file of minutes).

The Chairman introduced Mr Antony White, Business Manager and Dr Robin Armstrong from the new Seaham Medical Group and Blackhall and Peterlee Practice.

Mr White provided members with the rationale behind the proposed changes and initial feedback from the engagement activity. He advised that they were currently working on a plan with partners who were retiring to ensure the practice would be more sustainable for the future including looking at the ways the practice could be structured to ensure the practice was more attractive to recruit new GPs in the future.

Dr Armstrong added that the main focus was delivering efficient and effective patient care and explained the difficulties in splitting resources between two sites. It was noted that if the Eastlea site were to close, it would leave no service provision to the West of Seaham. He explained that the Seaham Primary Care site was underutilised and there was another large practice on the same site, with a further two practices close by. The importance to rationalise the practice was highlighted in order to provide the best service for patients and economic consideration would be part of the decision making process.

Mr White informed members of the positive feedback received so far, with main issues of concern around transport, car parking and if the building itself was suitable. He advised that the building had recently undergone improvements to the waiting room area and there was provision to expand and create another six consulting rooms. They were exploring options regarding car parking and were currently in discussions with the community centre regarding shared parking arrangements and also enquiring about leasing or purchasing land next door for additional parking.

Responding to queries from Councillor Crathorne regarding distances from other practice and the number of patients from the Seaham practice that would be affected, Dr Armstrong replied that the distance between both buildings was approximately 1.5 miles. A large practice shares the Seaham Primary Care site with over 10,000 patients and another two practices were within quarter of a mile. It was estimated that 2,500 patients use the Seaham Primary Care practice regularly.

Councillor H Smith questioned if patients choose not to move to the Eastlea site and register with other practices in the area, would other practices have capacity for an influx of new patients. Dr Armstrong responded that there were no closed lists in the area and capacity was dependent on number of patients that withdraw from the Seaham practice. He added that since the notification of proposals, the surgery had lost in the region of 40 patients. After speaking with other practices in the area, he advised that there would be no difficulties for patients registering elsewhere, however, was unsure of the number of patients that may wish to transfer in the future.

In response to a query from Councillor H Smith regarding public transport links between the two sites, Dr Armstrong advised that the topic was discussed at a recent meeting with members of the public and there would be no difficulty as public transport runs via a circular route.

Councillor Crathorne commented that the practice would be affected financially if a significant amount of patients were to register elsewhere. Dr Armstrong responded that they had already factored in a maximum 10% loss of the practice list, which would not be an issue for the financial viability of the practice. Mr White added that once the Eastlea site was fully operational, it was anticipated that a number of patients would return.

Resolved:
That the information presented and contained in the report be noted.

7 Future of Ward Six, Bishop Auckland Hospital

The Chairman welcomed Sue Jacques, Chief Executive, County Durham and Darlington NHS Foundation Trust (CDDFT), Lisa Cole, General Manager, Integrated Medical Specialties and Strategic Lead for Stroke, Gillian Curry, Head of Communications and Charity and explained the procedure to the members of the public that had indicated they wished to speak on the item.

The Committee received a report and presentation from the Chief Executive, County Durham and Darlington NHS Foundation Trust (CDDFT) that provided an update on the process undertaken to date, the proposed communications and engagement approach to support the development of options for a future model of care to be provided at Bishop Auckland Hospital (BAH) and the next steps in the process (for copy of report and slides, see file of minutes).

Mr Stenson questioned if the Trust would make any savings by closing ward six, as the patients no longer able to use the ward may still require care home provision. He asked what the cost implication were for the County Council to cover those costs. The Chief Executive CDDFT ensured that a full analysis including implications for organisations together with implications for the wider economy would be reported back to the Committee in April 2019.

Ms Hackworth-Young felt that the public should have been involved in the process sooner and requested a comprehensive consultation exercise take place for members of the public to be able to share their experiences. Referring to financial implication, Ms Hackworth-Young asked the Trust to indicate where the necessary savings would be made if the decision was taken to retain services at ward six. The Chief Executive CDDFT advised that through the engagement process they would work together to gain better optimal solutions while mindful of the demographic population and wider health system.

Councillor Patterson referred to the financial pressure on the Council and asked about proposals for engaging with wider partners. She felt more should be included in the questionnaire to better understand the rationale behind the responses.

Councillor R Bell stated that he would have preferred the Committee to have been engaged earlier in the process of reviewing future provision at ward six and suggested that the consultation process must be open and transparent. He raised concerns regarding community service support if the facility closed and felt that the cost implications were just transferring from the Health Service to the Council. He added that extra investment would be required for community services to be able to deliver the same standard of care.

Referring to the questionnaire, Councillor Kay was delighted with the positive responses regarding the care patients had received from ward six. He highlighted the extra burden that would be placed on the social care system and felt that the health service were abdication financial responsibility by placing that responsibility on the council tax payers in County Durham. He reiterated his previous comments that the matter would be referred to the Secretary of State should the final proposal be to close the ward.

The Chief Executive CDDFT clarified that a decision to close ward six had never been agreed at any point. It was agreed to work closely with Adults, Wellbeing and Health Overview and Scrutiny Committee and staff engagement. She ensured that recommendations and feedback would be shared with the Integration Board, chaired by the Corporate Director of Adult and Health Services and proposals would be reported to Adults, Wellbeing and Health Overview and Scrutiny Committee after April 2019. The Chief Executive CDDFT agreed the importance of understanding the negative responses and advised that the patient questionnaire and staff consultation feedback echoed the benefit of the work undertaken on ward six and staff ideas and proposals would be perused.

Councillor Patterson pointed out the reason ward six was called in to scrutiny was due to the planned closure. The Chairman added that he wrote a letter to the Trust as the Committee were informed that ward six would be closing on the 15 November 2018.

Councillor Chaplow referred to the questionnaire and commented on the length of time some patient have to wait for the ambulance service, which contributes to patient's negative experience when transferring.

David Taylor Gooby commented on public perception and financial pressures the NHS was under and highlighted the importance of partnership working to seek common solutions.

In response to the question from Councillor Patterson regarding engaging wider partners, the Chief Executive CDDFT advised that they have approached Health Watch to assist with the process as they have a great deal of expertise it this area and will then advise on interaction and engagement approach. She asked the Committee to note that they would be unable to carry out the necessary work before the April meeting, therefore the date would have to be amended.

The Chairman requested a copy of the recommendations from Healthwatch to reassure members of the engagement process and asked that a member of Healthwatch attend the April meeting to explain the approach.

Councillor Allen, Governor on the Trust noted that the Trust had acknowledged mistakes had been made during the initial consultation exercise and felt they had responded positively. The decision to involve Healthwatch and the next steps outlined in the report were welcomed. Referring to engagement timescales, Councillor Allen asked if the process had started yet and when engaging patients/public/carers, that families who could give valuable feedback for the way forward be included. She emphasised the importance of working together to provide the best outcome for patients and residents of County Durham.

Councillor Zair asked for figures for patients who had been discharged from ward six who were then re-admitted to hospital within 28 days of being discharged. He also queried the number of employees that had left ward six and sought alternative employment since the announcement was made to close the ward.

The Chief Executive CDDFT advised that she would provide the Principal Scrutiny Officer with both sets of figures to be forwarded to Councillor Zair. Regarding the engagement process, the Chief Executive CDDFT confirmed that engagement would include families and carers and responses would be built into the business case. The process would start as soon as the Health Watch Board approve the proposal, following that, work would begin on developing a business case.

If the response following the consultation process was for ward six to remain open, Councillor Zair asked if this was still an option for the Trust or would the Trust still close the Ward. The Chief Executive CDDFT confirmed that keeping the ward open was still an option. Proposals would be reported to this committee and members would have the opportunity to feed back at that stage. She ensured that a comprehensive engagement process would be carried out involving other bodies and the assessment detailing criteria and how the conclusion was drawn would be presented.

Resolved:
That the engagement approach outlined in report be noted and the business case be received at a future meeting.

8 Review of Stroke Rehabilitation Services in County Durham

The Chairman introduced Sarah Burns, Director of Commissioning, DDES CCG, Rachel Rooney, Commissioning and Development Manager, North Durham CCG and Gillian Curry, Head of Communications and Charity CDDFT.

The Commissioning and Development Manager outlined some of the key areas of feedback that was received as part of a targeted engagement exercise in relation to stroke rehabilitation services that was undertaken over an eight week period (for copy see file of minutes).

Gaps and key points were highlighted which would be addressed during the ongoing review in relation to:

- communication challenges;
- emotional wellbeing and support;
- inconsistency of community rehabilitation provision;
- people who appreciate a longer period of therapy once discharged from a hospital setting.

The Commissioning and Development Manager advised that the exercise would include representation from community and hospital based clinicians, primary care, regional clinical network and the Stroke Association. A business case would be developed and presented to Adults, Wellbeing and Health Overview and Scrutiny Committee in April 2019.

The Chairman referred to the County Durham and Darlington Stroke Rehab Improvement Group membership and asked if none health organisations were involved. He also questioned where the money was coming from to fund the community service and would it affect hospital beds in University Hospital North Durham, Bishop Auckland and Darlington. The Commissioning and Development Manager replied that the group had representations from the Stroke Associations, CCGs and the clinical network to focus on clinical best practice. She confirmed that there would be investment in community services as stroke rehabilitation was a priority and they were currently identifying which areas to target with further detail to be included in the business case. She added that the aim was not to reduce beds and they were focusing on the outcomes that could be improved.

Councillor R Bell suggested that there were parallels between the Stroke Rehabilitation service review and the ward six issue in terms of the reliance on community services to pick up on service demand under revised service models and the need for appropriate resource investment to enable that to happen. He also noted the positive experience of stroke rehabilitation services expressed by patients as part of the engagement process.

Councillor Darkes referred to improvement health outcomes for those that had suffered a stroke and asked if there would be engagement and integration with the ambulance service to respond within the magic hour. The Commissioning and Development Manager advised of work carried out to move to a single site model and information was available on improvements made regarding response times which would be shared with the Committee.

Mr Taylor Gooby referred to concerns regarding public health cuts and questioned if it was the NHS Trust, CCG or the Local Authority who was ultimately responsible for providing provision in the community. The Director of Commissioning advised that the CCG was responsible for ensuring appropriate resources to meet the needs of patients.

She explained they were engaging patients and carers to better understand the gaps and needs of the population and were working collectively with partners to address those issues. There was an obligation to the Adults, Wellbeing and Health Overview and Scrutiny Committee, County Durham and Darlington NHS FT's governing body and NHS England to ensure that any proposed changes to clinical pathways were based upon robust clinical evidence and subject to the statutory consultation and engagement processes.

The Chairman reiterated the Council's concerns regarding the threat of losing £19 million in Public Health Care Funding.

Councillor Hopgood commented on the importance of engaging families, as patient's responses can be very different from the families' perspective. The Commissioning and Development Manager agreed that family involvement was crucial and clarified that the term 'carer' also incorporates family engagement.

Councillor Patterson reiterated her concerns about the reliance of community based services and also the difficulties of accessing services in such a large geographical area as County Durham. It was important that community service provision and stroke rehabilitation services were delivered in a timely manner to assist in recovery.

The Principal Overview and Scrutiny Officer advised that members had previously raised issues around transportation and the involvement of NEAS. The NEAS representative was unable to attend the meeting, however advised that the review of stroke rehabilitation was in the early stages of development and that NEAS would be fully engaged in the review process through the Local Area Development Board.

Resolved:
That the key themes from feedback and the process for further development of the stroke rehabilitation services across County Durham and Darlington be noted.

Councillors J Robinson and J Chaplow left the meeting at 10.50am

Councillor R Crute in the Chair

9 Quarter 2 2018/19 Performance Management

The Committee considered a report of the Director of Transformation and Partnerships that presented progress against the Council's corporate performance framework for the Altogether Healthier priority theme for the second quarter of the 2018/19 financial year (for copy see file of minutes).

The Strategy Team Leader, Health and Adult Services reminded members that consultation to develop the new vison for County Durham would closed at the end of the day. Feedback would be used to develop a draft Durham 2030 Vision which would be subject to a further consultation period.

Councillor Crute referred to page 177 of the report and queried if there was reason for concern in relation to the male and female life expectancy figures.

In response to a query from Mr Taylor Gooby regarding the risk for social care payments, the Corporate Director of Adult and Health Services explained that the risk relates to the new charging policy for deferred payments that had changed and was more about the monitoring and ensuring that policy was applied.

Councillor Hopgood referred to the take way food performance indicated and highlighted concerns with applicants opening and serving different food from what had been approved on the initial application and queried if any enforcement was in place.

The Principal Overview and Scrutiny Officer referred to the recent Overview and Scrutiny Visioning Workshop and advised that feedback from the workshop was currently being compiled and would be submitted as part of a formal scrutiny response and issues identified would be reported to COSMB.

Resolved:
That the information contained in the report be noted.

10 Budget Revenue and Capital Forecast Q2 2018/19

The Committee considered a report of the Corporate Director of Resources that provided details of the forecast outturn budget position for the Adult and Health Services (AHS) service grouping, highlighting major variances in comparison with the budget for the year, based on the position to the end of September 2018 as reported to Cabinet in November. A presentation was given by the Finance Manager, Adult and Health Services (for copy of report and slides, see file of minutes).

In response to a question from Councillor Patterson regarding the adult social care precept the Finance Manager, Adult and Health Services advised that an extra 2% social care precept was expected to be agreed at Council in February and they were waiting to find out the overall fair funding arrangements for the future. He added that they have taken a prudent view of what the position would be in the future as it was anticipated that more savings would have to be made.

Responding to a query from Councillor R Bell, the Corporate Director of Adult and Health Services was disappointed with the delayed publishing of the social care green paper which was now expected April 2019. With the publication of the NHS Plan, it was felt there had been missed opportunities not publishing the documents at the same time, given the close relationship between the NHS and social care.

Councillor Crute agreed that it was a missed opportunity with the launch of the NHS 10 year plan and felt that the NHS plan and the social care green paper should be considered collectively.

Councillor Hopgood asked for further detail regarding the £1.942 million saving for direct care related activity. The Corporate Director of Adult and Health Services explained that the approach was to improve people's independence ensuring that following a patients discharge from hospital, they are able to return to the level of independence they had previously. The benefit would be improvements to quality of life for the individual and to see reductions in ongoing care related costs in the longer term.

Resolved:
That the information contained in the report be noted.

11 Scrutiny Review of GP Service Provision Across County Durham - Proposed Scoping Document

The Committee considered a report of the Director of Transformation and Partnerships that provided details of the proposed scoping document in respect of the Scrutiny Review of GP Service provision across County Durham (for copy see file of minutes).

The Principal Overview and Scrutiny Officer advised that Adults Wellbeing and Health Overview and Scrutiny Committee had been involved in a number of consultations and engagement processes undertaken by GP practices that involved a range of issues including branch mergers, closures and service provisions across County Durham.

Members were advised of key objectives and were informed that sessions would include engagement with representations from NHS England, Clinical Commissioning Groups, GP practices and the Care Quality Commission to look at the inspection process. The Principal Overview and Scrutiny Officer highlighted the importance of looking at the inspection processes and work already undertaken by Clinical Commissioning Group colleagues to address key issues already identified.

The Committee were advised that the membership would include Councillors J Robinson (Chairman) and J Chaplow (Vice-Chairman) R Crute, A Patterson, H Smith, O Temple, P Jopling, P Crathorne and T Henderson; Mr David Taylor-Gooby, Non-voting Co-optee and Chris Cunningham-Shore from Healthwatch County Durham. The Principal Overview and Scrutiny Officer added that a couple of vacancies were still available if any other members of the committee wished to be involved.

The Principal Overview and Scrutiny Officer added that sessions would be taking place from January to May 2019 and findings and recommendations would be reported to the Adults Wellbeing and Health Overview and Scrutiny Committee, Cabinet and Health and Wellbeing Board thereafter.

Resolved:
That the terms of reference and project plan for the review be agreed.

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DURHAM COUNTY COUNCIL

At a Meeting of **Adults, Wellbeing and Health Overview and Scrutiny Committee** held in Committee Room 2 - County Hall, Durham on **Thursday 21 February 2019 at 9.30 am**

Present:

Councillor J Chaplow (Chairman)

Members of the Committee:
Councillors P Crathorne, G Darkes, A Hopgood, P Jopling, A Patterson, S Quinn, M Simmons and O Temple

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

Also Present:
Councillors M Clarke, L Hovvels, I Jewell, B Kellett, A Shield and A Watson

1 Apologies for Absence

Apologies for absence were received from Councillors J Robinson, R Bell, R Crute, J Grant, T Henderson, E Huntington, C Kay, K Liddell, A Savory, H Smith, C Wilson and Mr C Cunnington Shore (Healthwatch County Durham)

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

Mrs Hassoon raised concerns about the lack of medical cover at Fishburn Medical Practice. She was aware that due to planned leave Skerne Medical Group had indicated that there would be no cover this week however, she reported that there was no cover available last week either. She was also aware from local residents that this has happened on numerous occasions. She asked that the cross party review group take this on board and monitor the situation.

The Principal Overview and Scrutiny Officer advised that the Chairman had raised concerns with the practice and that the Practice Manager had informed him of the pre-planned holidays for this week. He advised that the CCG were working closely with the practice to monitor the issues raised. With reference to the review group he informed Mrs

Hassoon that it was not within the remit of the group to look at individual practices. However, this would be raised as part of the deliberations from the group.

5 Shotley Bridge Community Hospital

The Committee received a report of North Durham Clinical Commissioning Group that provided an update on the communications and engagement plan (for copy see file of Minutes).

The Commissioning and Development Manager referred the Committee to the papers circulated for the meeting that included an outline communications and engagement plan; engagement narrative and a supporting data pack. She assured members that no decisions had been made and there was an opportunity to engage with all stakeholders and relevant key people. She thanked the Scrutiny members for providing feedback at the last meeting which gave the CCG some reflective points to pick up on including looking at the options that would not be feasible moving forward. She referred to the range of data included with the papers that covered the population of DH7, 8 & 9 and NE16 & 17. Members were advised that the scope of the review covered the services currently delivered from Shotley Bridge Hospital including:-

- Range of outpatients
- Rehabilitation bed provision
- Urgent care
- Diagnostics
- Chemotherapy
- Theatre
- Endoscopy

The Commissioning and Development Manager confirmed that the only two services that were being proposed to be delivered from main hospital sites would be 'Theatre' and 'Endoscopy'. It was noted that Endoscopy services had not been carried out at Shotley Bridge for the last 12 months as there was an issue with equipment and due to the lack of sufficient workforce. The same reasoning applied for Theatre and the need to review the equipment in line with best value principles. The data available shows that the facility would not be fully utilised to justify the costs required to provide a suitable facility. One of the areas that the CCG were keen to have conversations about was the rehabilitation bed provision. There were currently 8 beds and 7 intermediate care beds and the proposals were to continue with this, or to have 16 beds within the health facility or to have all beds available within the independent sector.

Members were informed that the language used in the engagement document were around scenarios rather than options as it was important for people to be able to give feedback. Following the engagement exercise information would be consolidated and used to form the consultation business case. It was likely that the consultation would run from June for a period of 12 weeks. Following this decisions would be made in September/October 2019.

The Commissioning and Development Manager reported that there had been some recent changes within the NHS and the CCG were keen to progress this as soon as possible.

Councillor Jopling asked that if services would no longer be provided at Shotley Bridge, had the hospitals in Durham, Darlington and Bishop Auckland been made aware that they would have to take up the slack and what provisions had been made for this. The Medical Director and Endoscopy, Colorectal and General Surgeon at Shotley Bridge Hospital explained that this was multi-factorial in that they would have different ways of working and different patterns of working. As endoscopy services had not been carried out at Shotley Bridge for the last 12 months, this new way of working had already been built in to the main hospital sites.

Councillor Patterson referred to a previous recommendation from the Committee asking for projected demand based on needs base, and she was disappointed that this information was still not available. The Commissioning and Development Manager said that demand had been taken into account including public health information on the growing population, younger and ageing populations. With regards to future demand it had been recognised that with advances in medicine, there was a move away from always needing to be on a hospital site. She advised that Health Care Planners were aware of the increase in population.

Councillor Patterson asked that the recommendation from the meeting on 4 December be read out. The Principal Overview and Scrutiny Officer confirmed that the recommendations were as follows:-

(i) The previously requested health care needs analysis data and information on a postcode basis and based upon healthcare demands on the local population be shared with the Adults Wellbeing and Health Overview and Scrutiny Committee as a matter of urgency and;

(ii) Further work on the development of a full range of future service model options be undertaken prior to the commencement of any pre-consultation engagement to ensure that the engagement process is not prejudiced by an inadequate range of options put to key stakeholders and the population of the county.

The Commissioning and Development Manager said that it would depend on what was meant by demand as the data had been looked at for the post code areas. The number of people who attended UHND, Darlington and Bishop Auckland were known together with the number of people attending Shotley Bridge from other areas. She advised that the standard percentage built in was used by the Health Care Planners as this is what they based their work on.

Further to a question from Mr Taylor Gooby regarding funding for the new facility, the Commissioning and Development Manager confirmed that £16.9m of funding had already been agreed to develop a new health care facility. It should be noted however, that as this was agreed two years previous costs of new buildings will have increased hence the need to move swiftly on this.

Referring to page 6 of the papers, Councillor Darkes pointed out that the CCG would have to demonstrate that alternative provision, such as increased GP or community services, was in place ahead of any bed closures. He asked if this could be guaranteed due to the

national problem with the shortage of GPs and the difficulties in recruitment and retention. The Commissioning and Development Manager confirmed that there would be no issues with cover as the only areas requiring GP services was at urgent care and the nurse led bed provision. She assured the Committee that she was happy that they had sufficient provision.

Councillor Temple welcomed the report which he believed was honest about the real choices. He said that it was important for the people of the area to have a first class community hospital. However, he believed that the three options around bed provision should not be offered as it had already been reported at previous meetings that 8 beds were not viable. Therefore, he said that the choices should be 16 beds or to be provided entirely independently as should the 8 beds remain as a choice people would opt for that. As with the medical reasons why endoscopy services would not be delivered the same reasons for the bed provision were needed for the engagement document. With reference to the September meeting minutes, Councillor Temple said that an analysis by postcode was requested and that it was important to receive an indication of the clinics that people were travelling elsewhere to for treatment. He added that it was important to know what services could be provided at a new facility rather than engaging on the current services that may not be viable in the new facility.

The Director of Operations confirmed that although a costly way of doing things, the 8 bed option was still viable. The Medical Director added that it was not the intention to re-create a main hospital site such as UHND or Darlington but to create as many general services as they could. He said that 5% of outpatients were from the surrounding postcodes of Shotley Bridge Hospital.

Councillor Temple re-iterated his point that no details had been received as to what services they were and so the lack of information requested last year was still causing problems of not fully understanding the situation.

The Commissioning and Development Manager advised that the level of details could be provided and she would arrange for a narrative around the figures to be circulated.

The Director of Integration commented that the issue around bed provision in community hospitals was about cost-effectiveness and that the smaller the number of beds, the more difficult it was for the trust to provide. Councillor Temple said that the report last year stated that 16 beds was the minimum number to achieve efficiency. The Commissioning and Development Manager reported that the current provision was included in the engagement plan as these were the early stages of thinking and the 8 bed option was not being ruled out at this stage.

Moving on, Mrs Hassoon referred to the NHS 10 year plan and asked how this development fit in with it. The Commissioning and Development Manager confirmed that it did support and align to the 10 year plan and that the local NHS were already adapting how services were delivered. Referring back to bed provision, Mrs Hassoon asked which was the most cost effective method; in house or community care. She was advised that information on this issue was being collated as part of the engagement process with key stakeholders. All information including costs would be appraised following the engagement process.

Councillor Jopling also referred to the report where it stated that 8 beds were not viable, and she referred to the recent issue at Bishop Auckland Hospital's ward 6 which caused concerns about the future of in house bed provision. She commented that care in the community setting was not as good as that provided in a hospital setting.

Councillor Quinn disagreed with the comment about care from independent community carers as she knew first hand that the level of care provided was excellent. She suggested that throughout the engagement process the CCG consult with patients who would be able to comment about the level of care received.

Referring to the earlier point about moving theatre provision to main hospital sites, Councillor Crathorne asked if waiting lists would increase at these facilities and she asked if the CCG had thought about how patients from the Shotley Bridge area would travel to these other locations. The Medical Director reported that Shotley Bridge did not have enough nursing staff in order for the theatres to be used safely and it was therefore not being used currently. He added that there were a number of criteria that would have to be met in order for surgery to be performed at Shotley Bridge and at present there were not enough of those patients to make it a viable option. He advised that waiting lists would be better managed and he guaranteed that they would not increase as a result of the proposed changes. The Commissioning and Development Manager confirmed that transport issues would be part of the discussions and questions of the engagement process.

Councillor Crathorne picked up on Councillor Jopling's earlier comment about Bishop Auckland, and asked how long the operating theatres would remain at this facility. The Medical Director confirmed that £600,000 had been invested in the theatre provision at Bishop Auckland and that there were no plans to make any changes.

Councillor Hopgood referred to the bed provision issue and said that the previous report was either true or not true, and that 8 beds was either viable or not viable. She felt that the option to include 8 beds in the process if not viable was wrong. If included people would chose it and then she believed the CCG would come back on that option and say that it was not deliverable. She asked if the transfer of funding had been explored should the provision move from in house to community led, and therefore moving from the NHS to the Council's responsibility of picking up the cost.

The Director of Integration explained that the September report was about general community hospitals and the review of community beds. She also referred to a separate Shotley Bridge report which made reference to the financial effectiveness of bed provision and a reference in the Carter Review which stated that it was more cost effective to provide for over 8 beds.

Councillor Hopgood asked if the majority of people preferred the 8 bed option would the CCG proceed with it. She asked again about the transfer of funding responsibility and the Director of Integration confirmed that there would be an expectation that the funding would be provided from the CCG.

Mr Taylor Gooby asked that the engagement plan made reference to the 8 beds being used as step down beds if the demand was there for them.

The Chairman asked the Shotley Bridge Reference Group for any questions on the report.

Councillor Hovvels thanked the working group for their contribution to this process and believed that they had achieved a more transparent and open way forward. She added that as we were living in a complex world which was changing at such a fast pace, it was important to provide quality facilities. She commented that she was delighted that the people from the Derwentside area had been offered the facilities they deserved as they were very passionate about Shotley Bridge Hospital. She asked that the committee agree that the engagement process commences as there could be a risk with the funding available to build a new facility, but that conversations still continue about what people want and to make sure that voices were heard. She referred to the current state of the building and the problems on site with ongoing maintenance. In conclusion, Councillor Hovvels welcomed the proposals and asked that engagement was wide with no hidden agenda as we were all in this together to ensure that a fit for purpose facility was developed.

The Commissioning and Development Manager thanked Councillor Hovvels and the reference group for helping to support and shape the document, and that it had been a very useful process. She confirmed that it was very much still a draft document and that all comments from the group and from the Committee had been listened to and would be reflected upon. With regards to funding, she added that the nature of the NHS had changed and was still changing and although there had been no mention of the funding being at risk she wanted to ensure that there was progression as the funding had been agreed two years previous, and in that two years building costs had increased. The CCG wanted to provide value for money with a new state of the art facility that was fit for purpose. The Director of Operations reported that there were significant costs associated with essential maintenance works in the tower block, which were crucial to keep the building safe. This is not something that the hospital would chose to do with this money but that it had to be done to keep the building safe.

Councillor Jewell said that many of the questions asked today had been well rehearsed via the reference group and he understood the concerns raised about the lack of progress, however the barriers to enable progress needed to be moved. He said that everyone wanted a quality service but like the Council, the NHS were also working to constraints. He commented that the people of Derwentside deserved a better facility and that the time to commit to the £16.9 million should be progressed whilst continuing to have those discussions.

Referring to national guidelines around population Councillor Shield reported that 10% increase in the Derwentside area from 2001-2017 would continue to increase. This increase would also affect the two most vulnerable age group of the over 65's and the under 14's by 5%. He pointed out that on page 9 of the pack of papers statistics showed that 34% of the population was aged 50+ and that this would increase to around 40% by 2020, and that 8% of the population was aged 75 which would rise to 10% by 2020. He asked that the engagement process could commence so that the public could have their voices heard and that progress be brought to a future meeting.

Councillor Watson also asked that the engagement process was progressed as he was concerned about any further delays in terms of the risk to funding. He was pleased that

there had been a constructive debate at this meeting but that the time was right to allow the public to have their say.

The Chairman invited questions from members of the public who had indicated they wished to speak on the item.

Sandra Burton was pleased to see that the document had changed and now made no reference to the current Shotley Bridge hospital being used. She felt that what was now been offered was a downgrade and more of a health facility than a community hospital when the statistics clearly showed a growing population. She asked how this could be justified. The Commissioning and Development Manager disagreed that this was a downgrade and confirmed that the main usage would be around outpatients and the urgent care centre. As the hospital had a limited workforce the CCG were being open and honest about the situation. There were no issues around waiting lists due to endoscopy services being delivered from main hospital sites over the last 12 months. A new local facility was wanted providing local services from a community hospital setting. The Medical Director added that it was not just a workforce issue but also a quality issue. A much more therapeutic service was offered from the main hospital sites in relation to endoscopy that could not be offered from Shotley Bridge.

Ms Burton also asked why certain services had not been included in the list of outpatients services. The Commissioning and Development Manager explained that a lot of conditions were met by community services and the CCG were looking to enhance the therapeutic services in the community. However, she confirmed that therapy staff would still be available at Shotley Bridge. She added that where they could they would deliver outpatient services.

Councillor Patterson pointed out that delivery from Shotley Bridge was not included and she was informed that the data would be looked at.

Kevin Earley asked for a vision that the community could get behind and become involved with. He reminded everyone that the NHS was about people and the people needed something that they could relate to. The Commissioning and Development Manager explained that the focus of the document was around the current CCG service provision. She added that conversations had started with social colleagues to see if there was an appetite to further develop and that those key people would be part of the engagement process.

Paul Lamb asked that services that would remain at the new facility be included in the document. He also expressed concerns about transport, especially for the elderly and for those who had to rely on public transport. As in effect this could mean two or three buses each way. The Commissioning and Development Manager agreed that transport was important and questions would be asked about accessibility and the opportunities for future service provision.

Keith Little asked that the CCG keep in mind the importance of transport issues and the people who had to use it.

Emma Rogan asked that a lot more detail was included in the engagement document. For example, with regards to bed provision she asked that more details and financial

implications were included to allow more open discussions. With regards to the planning process and the comments from the Carter review in relation to outpatients it would be helpful to include community activity clinics. She asked that the full range of services currently delivered from Shotley Bridge were included including community services, that more information be given from the Accountable Care Networks on Teams Around the Patients data. She asked that a definition on the Derwentside area be stated and what was meant by non-integrated care beds. The Commissioning and Development Manager thanked Ms Rogan for her points and would ensure that this information was included in the final document.

Emma Heenan from Laura Pidcock MP's office asked for a guarantee that the statistics on future demand would be shared as she was aware that the County Durham Plan made reference to more people moving into that area.

Councillor Hopgood asked that during the engagement process families and carers of patients were also asked for feedback as often the patients themselves just wanted to return home, even if it wasn't in their best interests. The Commissioning and Development Manager confirmed that they would be included.

Councillor Temple asked that the Newcastle Hospital Trust also be included and asked for feedback.

Councillor Patterson thanked everyone for attending the meeting and providing valuable comments. She asked that the CCG report back to Committee with the findings from the engagement process and before any consultation process commenced.

Resolved:

(i) That the timescales for engagement and consultation together with the outlined process be agreed.

(ii) That the engagement narrative document be used to inform the engagement process be reviewed in the light of comments made at today's meeting and shared with the AHWOSC membership.

(iii) That the Committee would receive and review data associated with the local population in scope.

(iv) That the Committee would receive regular updates on progress throughout the engagement and consultation.

Adults Wellbeing and Health OSC
7 March 2019 – Media Slide

Waiting lists 'guarantee' over Shotley Bridge hospital changes – Northern Echo 21 February 2019

Ambulance service launches campaign to mend broken hearts as it seeks more defibrillators – Evening Chronicle 14 February 2019

Could patients become their own doctors? – BBC Website 12 February 2019

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Adults Wellbeing and Health Overview and Scrutiny Committee

7 March 2019

Joint Update Report for the Integrated Sexual Heath Service

Report of Amanda Healy, Director of Public Health, Durham County Council and Paul Frank, Associate Director of Operations, County Durham and Darlington Foundation Trust

Electoral divisions affected:

Countywide

Purpose of the Report

1 The purpose of this report is to provide the Health and Wellbeing Overview and Scrutiny Committee with an update regarding the Integrated Sexual Health Service (ISHS) delivered by County Durham and Darlington Foundation Trust (CDDFT).

Executive summary

Commissioned Service

2 Sexual health is an important area of public health. The majority of the adult population of England are sexually active and access to quality sexual health services improves the health and wellbeing of both individuals and the population.

3 The Government set outs ambitions for improving sexual health in its publication, A Framework for Sexual Health Improvement in England (Department of Health, 2013).

4 The Health and Social Care Act 2012 devolved responsibility for commissioning sexual health services to Public Health in the local authority from April 2013. In line with this mandated responsibility, Durham County Council (DCC) is required to commission comprehensive, open access sexual health services including free sexually transmitted infections (STI) testing and treatment, notification

of sexual partners of infected persons and free provision of contraception.

5 This contract included provision of Genito-urinary medicine (GUM), contraception and sexual health (CaSH), and a sexual health improvement and screening team (SHIST) including human immunodeficiency virus (HIV) prevention, pregnancy prevention, young parent support, lesbian, gay, bisexual, and transgender (LGBT) support and chlamydia screening.

6 A detailed service review and procurement exercise was undertaken by the council in 2017 to recommission the service. In July 2017 CDDFT were awarded the new contract, with a start date of 1 January 2018. The contract awarded was for three years with the option to extend for up to a further 24 months.

7 The service specification for the current contract also incorporates responsibility and the associated budget for the provider to manage GP provision of Long Acting Reversible Contraception (LARC), for which the local authority previously contracted directly with GP practices, and pharmacy delivery of Emergency Oral Hormonal Contraception (EOHC). An additional new requirement was for the ISHS to provide 24 hour online testing to those aged 16+ to enable service users to order home testing kits for chlamydia, gonorrhoea, syphilis and HIV.

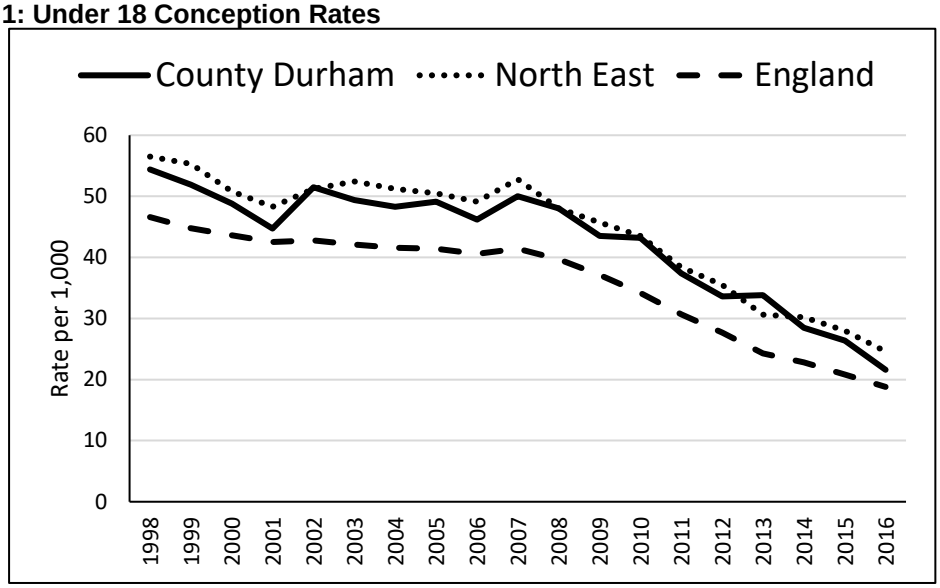
8 The decision to integrate key sexual health services, including outreach and additional community based services that support the main clinics ensured that prevention is centre to service development and that health inequalities are addressed, narrowing the gap for vulnerable groups.

9 Integrating key components of previously individually commissioned services, has reduced overheads and allowed a budget efficiency saving of 3.6% to be achieved.

Under 18 Conceptions

10 Whilst teenage contraception rates have reduced significantly over the last 25 years County Durham's rates remain significantly higher than the England average; Figure 1 below highlights this persistent positive trend.

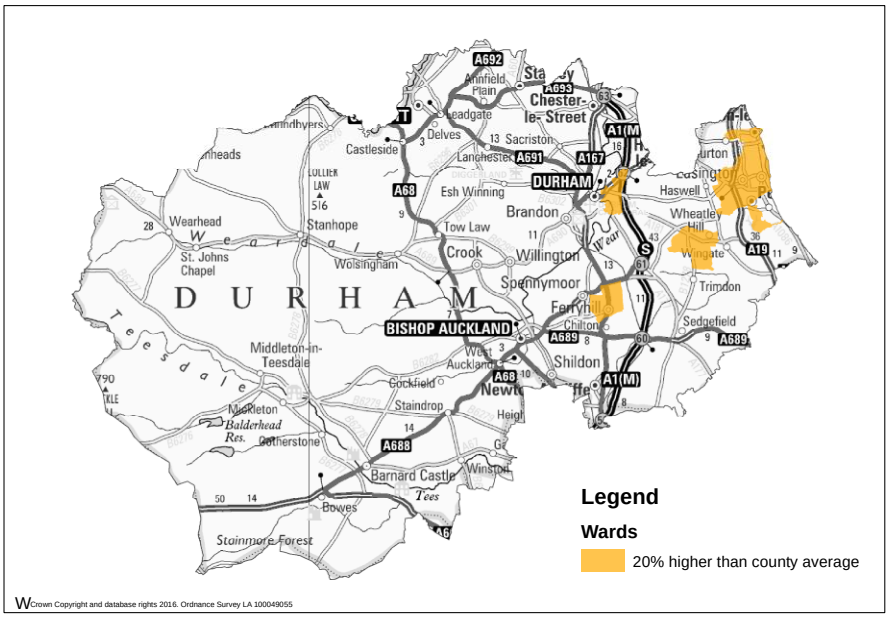
Figure 1: Under 18 Conception Rates



11 The psycho-social impacts on teenage parents are significant, with high levels of parental stress, higher risk of developing mental health problems, and poorer physical health outcomes when compared to non-teenage parents. Research has demonstrated that the outcomes for teenage parents and their children are poor, associated with poorer physical, emotional and economic health and wellbeing for both the parent and child.

12 Additional targeted intervention is provided in areas where teenage conceptions are persistently 20% higher than the County Durham average as illustrated in Figure 2 below.

Figure 2: Areas where teenage conceptions are persistently 20% higher than the County Durham average



Sexually Transmitted Infections

Durham County Council's Joint Strategic Needs Assessment (JSNA) factsheet, supported by data from Public Health Outcomes Framework key messages against indicators state:

- County Durham has seen a steady decline of new sexually transmitted infection diagnoses and is significantly better than the England average.
- The percentage of girls aged 12 – 13 years who have received all 3 doses of the Human Papilloma Virus vaccine is higher in County Durham and the North East compared to England. This has increased over time and shows a high level of vaccination coverage.
- The rate of chlamydia detection per 100,000 young people (aged 15-24) has stayed fairly steady within County Durham from 2015 to 2017; however this rate is much lower than the England average. The rate in the North East has fallen significantly from 2013 to 2017 however remains higher than the England average.
- The percentage of adults (15 and over) receiving a late HIV diagnosis is considerably less in County Durham than for both the North East and for England. This figure has been declining over time showing a trend towards earlier diagnosis.
- The rate of terminations of pregnancy continue to fall with County Durham being lower than the North East average and the England average.

Transition and Mobilisation

13 Some early indicators of good practice have emerged since implementation of the current ISHS these include;

- The development of bespoke sexual health training programmes for Foster carers, residential staff and staff within the Young People's Service to ensure that we are meeting the needs of our Looked After Children and Care Leavers;
- The development of CDDFT's digital offer through improvements to online services
- Increased attendance of Lesbian, Gay, Bisexual, Transgender, and Questioning+ (LGBTQ+) young people and adults attending mainstream services through the implementation of the outreach model;
- Delivery of training to Pharmacies across County Durham

14 In addition, a number of operational challenges have been identified through mobilisation and contract management arrangements, these have included:

- Delivery across a minimum of 20 facilities ensuring an equitable spread of service that considers the needs of vulnerable groups and areas where teenage conceptions are persistently more than 20% higher than the County Durham average;
- Adequate opportunities for attendance at a combination of walk – in and appointment based clinics across County Durham
- Clinic opportunities 6 days per week across County Durham
- Transition and delivery of GP LARC provision from the Local Authority to CDDFT, including the introduction of a revised pricing structure.

15 A range of mitigating actions as set out in paragraph 52 to 58 have been put in place to ensure that the challenges identified are addressed in a timely manner and that the service continues to successfully serve the population of County Durham and address health inequalities across County Durham.

Recommendations

16 Members of the Health and Wellbeing Overview and Scrutiny Committee are recommended to:

(a) Note the content of this report

(b) Acknowledge the actions to being taken to reduce inequalities and meet the sexual health needs of residents in County Durham

Background

17 Sexual ill health is not equally distributed amongst the population with certain groups being at greater risk. These include:

- Young people
- Women
- Men who have sex with men
- People from African communities
- People living with HIV
- Victims of sexual and domestic violence
- Other marginalized or vulnerable groups including prisoners.

18 A Framework for Sexual Health in England 2013, outlined the clear link between poor sexual health and deprivation and social exclusion. Groups (outside of those above) which are commonly identified as being at increased risk of sexual ill health include: young people not in education, training or employment (NEETs); asylum seekers and refugees; sex workers; drug users who inject; people with learning difficulties; homeless people.

19 Of all these at risk groups, young people (aged 16-24) are at the greatest risk - although making up approximately just 12% of the population, young people account for 65% of all chlamydia, 50% of all genital warts, and 50% of all gonorrhoea infections diagnosed in GUM clinics. (JSNA 2016)

20 STIs are one of the most important causes of poor sexual health due to infectious diseases among young people. However, good sexual health is equally important for people of all ages and reducing rates of STIs in the population is a key preventative public health measure. To monitor this, the Sexual Reproductive Health tool contains an indicator which reports the rate of all new STI diagnosis (excluding Chlamydia in under-25 year olds). A high diagnosis rate is indicative of a high burden of infection, however a low diagnosis rate may be explained by other factors as well.

CDDFT Implementation and Service Delivery

The Clinics

21 The service specification required the ISHS to be geographically based on need, utilising a wide range of outreach settings including schools, colleges and pharmacies. It was also set out that the core services should be delivered from 2 population centres of Durham City and Bishop Auckland.

22 Outreach services would have the ability to provide contraception and genito-urinary services (sexually transmitted infections screening, testing and treatment), including HIV. ‘Test and Go’ sessions are offered in the clinics for asymptomatic service users so that they can be seen quickly.

23 Between January 2018 and January 2019, the following attendances were made at the clinics:

Table 1: Clinic Attendance

Venue	Weekly clinics	Service user consultations
Durham Hub	10	6333
Bishop Auckland Hub	11	3980
Community Spokes	23	12,329
Outreach Clinics (schools / colleges)	5	449
Total	49	23,091

24 Appendix 2 highlights the areas of persistently high teenage conceptions, current location of CASH Clinics alongside active GP LARC provision.

25 Appendix 3, is the current CaSH timetable. This timetable highlights the times and locations of the clinics and specifies which are Teen Plus clinics (priority given to under 25's)

26 In addition, CDDFT offers outreach clinics for young people in the clinical venues and in schools, liaising with the School Nurse to promote services.

27 Work is ongoing between public health commissioners and CDDFT to further understand the levels of need across the county and to ensure that there is clarity on the location of each facility and delivery of clinics which considers the needs of vulnerable groups, areas of deprivation and areas where teenage conceptions are persistently 20% higher than the County Durham average.

28 Other outreach sessions include working with vulnerable groups, such as a LGBTQ+ group, working with the Princes Trust and a residential unit for looked after young people.

29 CDDFT seeks to work with vulnerable people and to ensure that the services offered are accessible and welcoming.

Sexual health promotion / prevention sessions

30 The sexual health service works with a broad range of groups, providing key prevention messages, C Card registrations and Chlamydia

screening. These sessions also inform participants about what services are available to them, and how to access them.

31 Between July – December 2018 (since records began) CDDFT have delivered 1704 Sexual Health Promotion sessions to a broad range of services and settings including colleges, Durham University, Investing In Children Extreme Group for young people with Special Educational Needs and Disabilities (SEND) and the LGBTQ+ Health and Wellbeing group.

32 In line with the outcomes of the recent Looked After Children and Care Leavers Health Needs Assessment, further work is being developed to enhance the sexual health promotion and prevention offer for this group of vulnerable young people. This offer will include bespoke training packages for foster carers and residential staff and will be incorporated into the wider review of clinics to ensure that their needs are being met and inequalities addressed. This work is reported to the LAC Strategic Partnership and will inform the work of the Corporate Parenting Panel.

33 CDDFT have engaged with the development of other key services including Children's Services Pre Birth programme.

Emergency contraception and C Card

34 There are 106 pharmacies (84% of the County Durham total) in the emergency contraception scheme, which CDDFT sub-contracts and supports. The scheme is for women aged 13 years and over to access emergency contraception, and is mostly used by young people aged 16-25 years (approximately 40% of all users).

35 Table 2 below shows figures for Emergency Contraception delivered through pharmacies and C Card outlet attendance between January 2018 and January 2019.

Table 2: Emergency Contraception and C Card Attendance

Service	Outlets	Service user consultations
Emergency contraception pharmacies	106	4963
C card	203	5383

36 In 2018, 4963 consultations took place. CDDFT provides regular training events for the current and new pharmacists. Pharmacists are encouraged to recommend contraception from the clinics, and offer Chlamydia tests.

37 There are 203 active C-Card outlets, where young people aged under 25 years can access free condoms, after they have had a 'condom teach'. Areas that have persistently high teenage conception rates, areas of deprivation are considered alongside the ability to meet the needs of vulnerable groups.

38 In 2018, 2533 young people were registered for the scheme, making 5383 visits, an increase from 5103 (5%) in 2017. Of these 60% were young men. Staff in the C Card outlets are given training regarding basic contraception, supporting young people and local service provision in order to sign post effectively. In 2018, 234 staff from a range of services attended c card training, this included youth workers, Voluntary and Community Sector (VCS) representatives, School Nurses and Children's and Young People's Services staff.

Long Acting Reversible Contraception (LARC)

39 LARC's consist of implants and intrauterine devices (IUS / coils) and are provided by the sexual health clinics and through sub-contracting arrangements with general practice.

40 Historically, GP Practices were contracted directly by the Local Authority. During this time 72 GP Practices entered into a Service Level Agreement (SLA) and 55 practices actively engaged in the provision of this service.

41 Since transferring this element of the contract to CDDFT, and the implementation of the revised pricing tariff, the numbers of GP practices engaging decreased from 55 to 24**.**

42 Initially GP's raised concerns regarding the change of provider, revised tariff and identified billing issues through their respective GP Federations. The Local Authority and CDDFT gave a joint presentation at a recent meeting to explain in detail the rationale behind the changes with CDDFT providing a number of improved communication plans that have since resolved a number of issues.

43 Whilst the number of GP practices that have entered into an SLA agreement has remained the same, action is being taken to ensure that there is a consistent growth in the delivery of GP LARC fittings.

44 Appendix 2 illustrates the current active delivery of LARC provision, alongside CaSH Clinic locations, overlaid on areas where teenage

conceptions are persistently 20% higher than the County Durham average.

45 Table 3 below highlights the number of LARC's fitted between January 2018 and January 2019.

Table 3: LARC Fittings

Service	Service user consultations (fittings)
LARCs in sexual health clinics	2937
LARCs in general practice	1958
Total	4895

Online provision

46 CDDFT sub-contracts SH:24 to provide online provision, whereby residents of County Durham can order STI tests to be delivered directly to their own home.

47 In 95% of cases, the service user receives their diagnosis within 48 hours. In 2018, 3141 tests were ordered with a return rate of approximately 80%. There were 230 reactive tests throughout the year. In these cases, service users are referred into the sexual health clinics for confirmation of the diagnosis and potential treatment.

48 Table 4 below highlights current usage online provision usage between January 2018 and January 2019.

Table 4: Online Testing

Service	STI testing packs sent to service users	Reactive tests
Online STI testing	3141	230

Young parents

49 CDDFT actively supports young parents and in 2018 saw 128 young mothers and arranged contraception plans for them, as well as offering training to 13 midwifery teams. The Support Workers ensure that young

people are able to access services and to help them get other support they may need. CDDFT have also engaged with the Teenage Pregnancy Steering Group.

Human Papillomavirus (HPV) programme

50 The HPV programme is funded through NHS England and is a vaccine targeting MSM aged under 45 years who attend sexual health clinics. CDDFT commenced this programme in January 2019 and has administered the first vaccination for 33 men.

Cervical Screening

51 Although many practices are reaching the 80% target for cervical screening coverage, there are a number of practices who do not meet this. CDDFT has arranged a contract with NHSE to support general practice in providing cervical screening, working in conjunction with general practice. In 2018, sexual health services provided 869 cervical smears.

Next Steps

52 In order to fully deliver all aspects of the ISHS and ensure that health inequalities are addressed, a number of areas for development have been highlighted.

53 CaSH clinics will be delivered across a minimum of 20 different facilities, over 6 days each week. These services will consider the needs of vulnerable groups, areas of deprivation and areas where teenage conceptions are persistently more than 20% higher than the County Durham average.

54 CDDFT will be undertaking significant activity to capture the views of key stakeholders including service users and young people between 4 March 2019 and the 5 April 2019. The findings of this exercise will contribute to the evidence base on which to further enhance and develop services. This will ensure that additional clinics are located in the most appropriate venues and at times that are convenient to service users, with particular focus addressing inequality.

55 The CaSH timetable will be revised to ensure that there are more opportunities for walk in facilities and that Teen Plus clinics are at times and locations that meet the needs of young people.

56 Further work is being carried out in partnership with GP Federations to enhance the provision of LARC's under the new arrangements.

57 CDDFT will offer additional training and support where necessary and review on a quarterly basis those engaging in the scheme alongside their own provision to ensure that there is adequate coverage across County Durham and that health inequalities are addressed.

58 A detailed Communications Plan is under development to ensure key messages are clearly communicated to all stakeholders.

Conclusion

59 Since implementation of the ISHS in January 2018, the benefits of providing a more integrated approach to sexual health are emerging. This can be seen in the development of the pharmacy provision and some innovative practice linked to vulnerable groups including Looked after and Children and Care Leavers.

60 There are a number of key areas for development underway to ensure that residents of County Durham are able to access high quality sexual health services that meet their needs and address health inequalities.

Contact: Helen Riddell Tel: 03000 268603

Appendix 1: Implications

Legal Implications

Mandatory provision of sexual health services

Finance – n/a

Consultation

CDDFT will gather service user feedback in line with their organisational polices to ensure services are located and developed based on need

Equality and Diversity / Public Sector Equality Duty

An equality impact assessment was completed as part of the service review

Human Rights

Any service should support sexual health through legal and other mechanisms that are consistent with human rights standards and their own human rights obligations.

Crime and Disorder n/a

Staffing – n/a

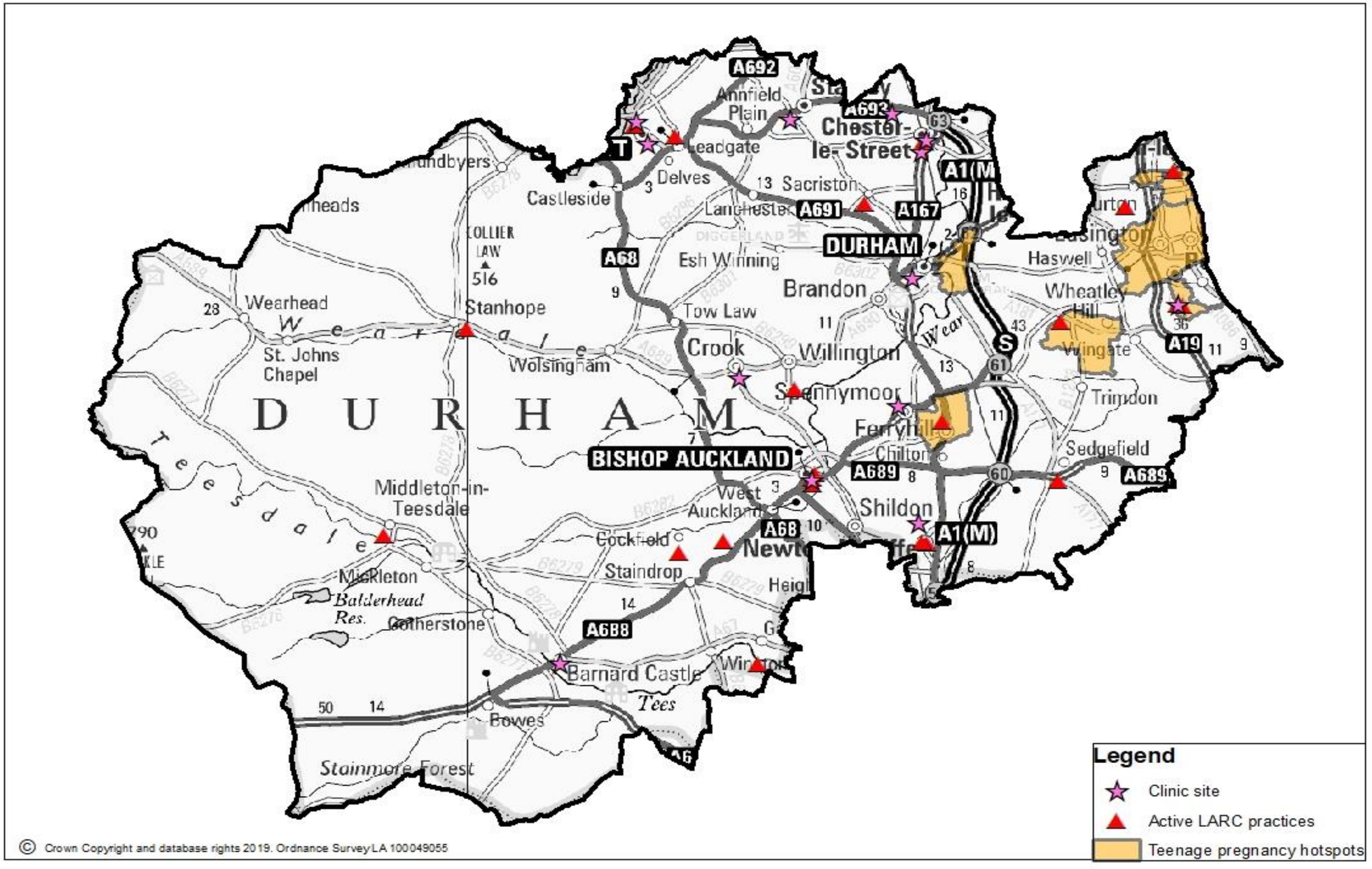
Accommodation – n/a

Risk - n/a

Procurement

DCC Procurement policies were followed for the procurement of this service.

Appendix 2:


A692
Annfield Plain
Chester-le-Street
A693
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Castleside
Delves
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A691
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DURHAM
A68
Esh Winning
Brandon
Haswell
Wheatley Hill
Wingate
A19
Wearhead
Stanhope
Tow Law
Crook
Willington
Wear
St. Johns Chapel
Wolsingham
Sunnymoor
Trimdon
Sedgefield
A689
BISHOP AUCKLAND
Middleton-in-Teesdale
West Auckland
Shildon
Cockfield
Staindrop
A68
A1(M)
Balderhead Res.
Gotherstone
A688
Barnard Castle
Tees
Bowes
Stainmore Forest
Legend
Clinic site
Active LARC practices
Teenage pregnancy hotspots
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Appendix 3: CaSH Clinic Timetable

Some clinics can be contacted directly during opening times	Monday	Tuesday	Wednesday	Thursday	Friday
Teen Plus Under 25's sessions available as below (walk in)					
Chester-le-Street Hospital, Ground Floor, Chester-le-Street Co Durham DH3 3AT ☎ 0191 387 6301				**5.30 – 7.30pm**	
Chester-le-Street HUB, One Point HUB, Burns Green, Chester-le-Street, Co Durham DH3 3QH ☎ 07810 054 066	**9.30am – 12.00midday**				
Pelton Lavender Centre, Unit 1, Pelton Lane, Pelton, Co Durham DH2 1HS - ☎ 07823 536 229				**2.00 – 4.30pm** ***(Closed every 3rd Thursday)***	
University Hospital of North Durham, North Road, Durham DH1 5TW ☎ 07824 406977		**1.30 – 4.30pm** ***(Procedure Clinic)*** **5.00 – 7.00pm**			
Shotley Bridge Hospital, Ante Natal Department, Tower Block, Shotley Bridge, Consett, DH8 0NB ☎ 01207 594471		**5.30 – 7.30pm**			
Stanley Primary Care Centre, Clifford Road, Stanley, Co Durham DH9 0AB ☎ 01207 285400	**2.00 – 5.00pm**		**2.00 – 4.00pm** ***(Procedure Clinic)*** **4.30 – 7.30pm**		
Glenroyd House, Medomsley Road, Consett, DH8 5HL ☎ 07824 868 821				**10.00am – 4.30pm** ***(Includes Teen Plus session 4–4.30pm)***	

Peterlee Health Centre Bede Way, Peterlee, Co Durham SR8 1AD ☎ 07785 542 004	**12.30 – 6.30pm** ***(Includes Teen Plus session 2.30 – 4.00pm)*** **2.00 – 5.00pm** ***(Procedure Clinic)***		**2.30 – 4.30pm** ***(Teen Plus session)*** **5.00 – 7.00pm**	**9.30am – 12.30pm**	
Spennymoor Health Centre, Bishop's Close, Spennymoor, Co Durham DL16 6ED ☎ 07825 655 590		**1.30 – 4.30pm** ***(Includes Teen Plus session 3.00–4 .30pm)***			
Ferryhill Health Centre,Chapel Terrace, Ferryhill, Co Durham DL17 8JL ☎ 07768 537 998			***Suspended***		
Pioneering Care Centre Carers Way, Newton Aycliffe DL5 4SF ☎ 07887 752 927	**2.30 – 4.30pm**				
Bishop Auckland Hospital, Centre for Sexual Health, Co Durham DL14 6AD ☎ 01388 455702		**9.30am – 12.00midday**	**1.30 –4 .00pm *(Procedure Clinic)*** **4.00 – 5.00pm** ***(Teen Plus session)*** **5.00–7.00pm**		**1.00 – 4.00pm** ***(Includes Teen Plus session 3.00 – 4.00pm)***
Richardson Hospital, Victoria Road, Barnard Castle DL12 8HT - ☎ 01833 696542		**5.00 – 7.00pm**			
Crook Health Centre, Hope Street, Crook, Co Durham DL15 9HU - ☎ 01388 455950				**3.00 – 4.00pm** ***(Teen Plus session)***	

Health and Wellbeing Overview and Scrutiny Presentation

Joint Update Presentation for the Integrated Sexual Health Service (ISHS)

Michelle Baldwin,
Public Health, Strategic Manager, DCC

March 2019

Paul Frank,
Associate Director of Operations, CDDFT

Altogether better

Durham County Council

Our priorities 2018 - 2020

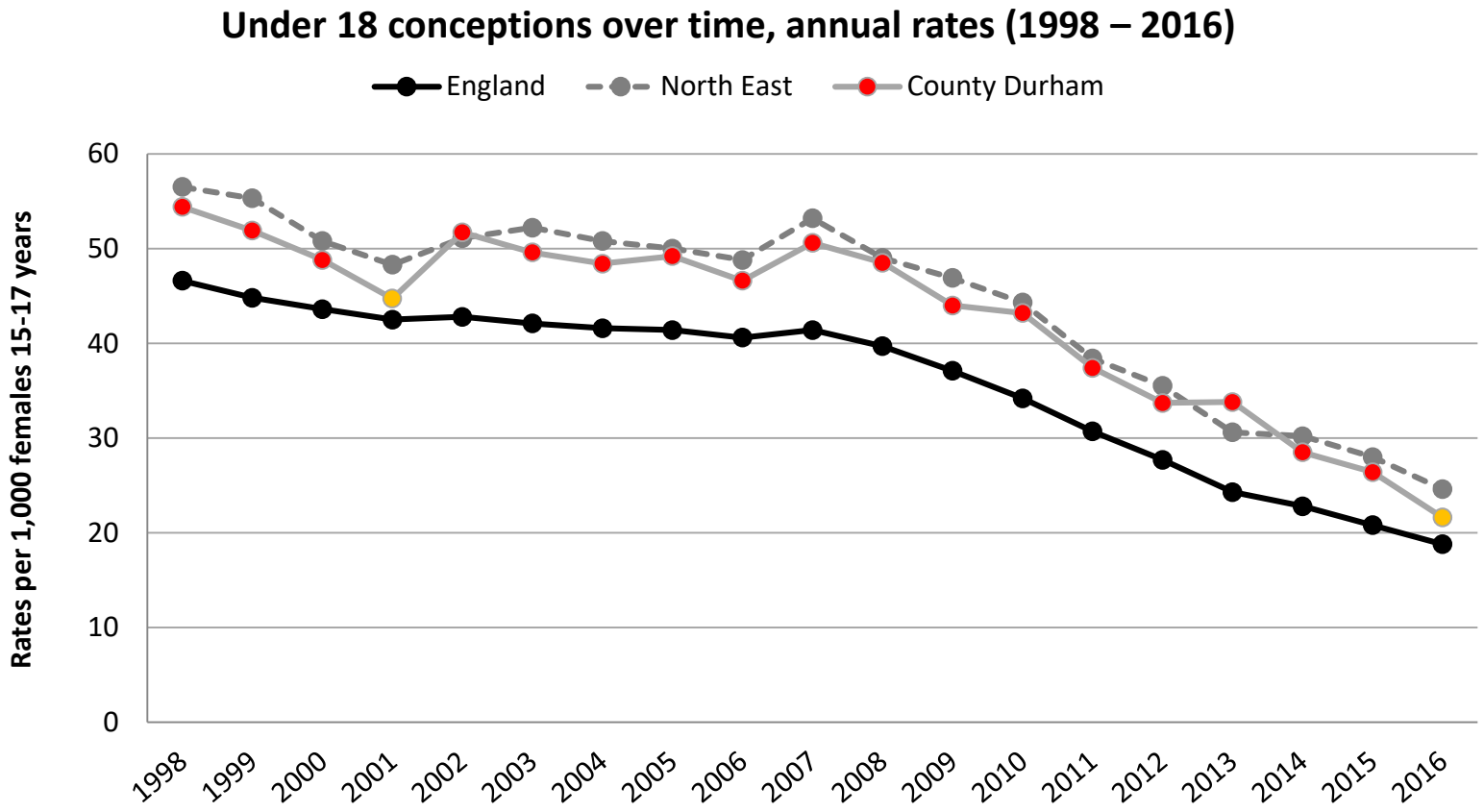
- Promoting positive behaviours
- Every child to have the best start in life
- Healthy workforce
- Mental Health at scale
- Good jobs and places to live, learn and play
- Better quality of life through integrated health and care services
- High quality drug and alcohol services

Background: PH Mandated Function

The Health and Social Care Act 2012 states Public Health are required to:

- Provision of Open access Sexual Health Service
- Prevent the spread of Sexually Transmitted Infections (STI's)
- Treatment, testing and caring from people with STI's
- Partner notification
- Access to contraception
- Advice on preventing unintended pregnancy

Local Need: Teenage Conceptions

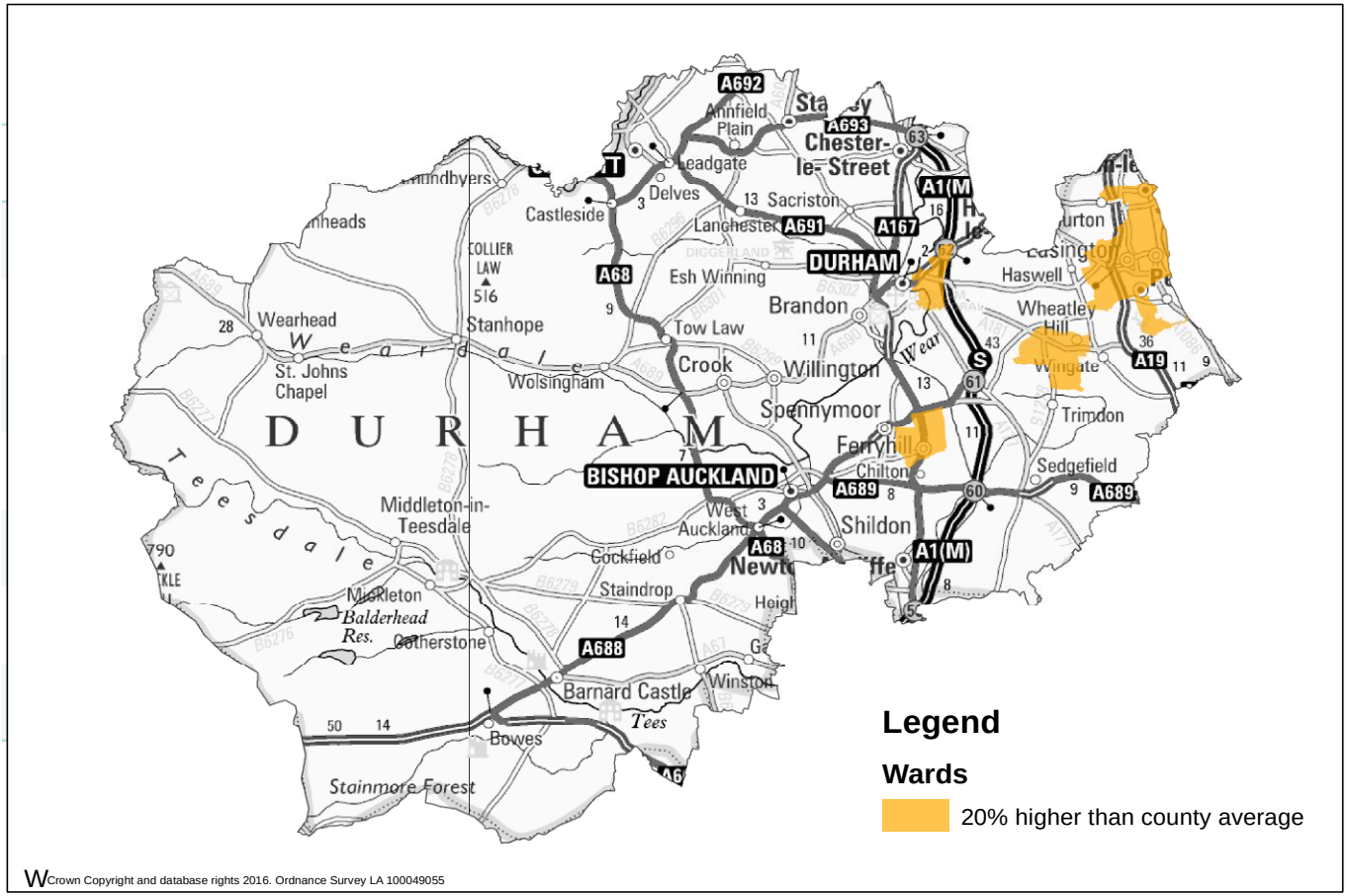


Altogether better

Durham County Council

Local Need: Teenage Conceptions

Wards that are 20% higher than County Durham average for 4 time periods*



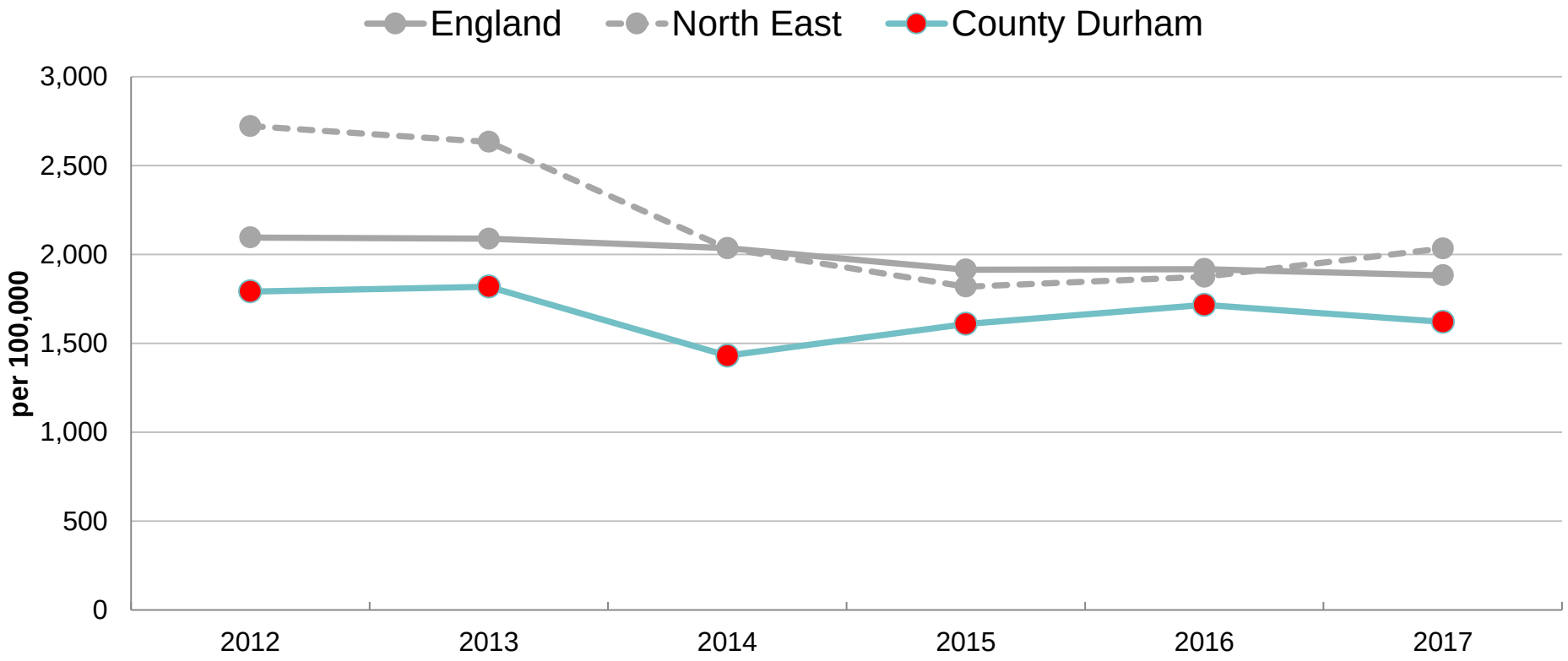
*2009-11, 2010-13, 2011-13, 2012-14

Altogether better

Durham County Council

Local Need: Chlamydia Detection

Rate of chlamydia detection per 100,000 young people aged 15 to 24, 2012-2015



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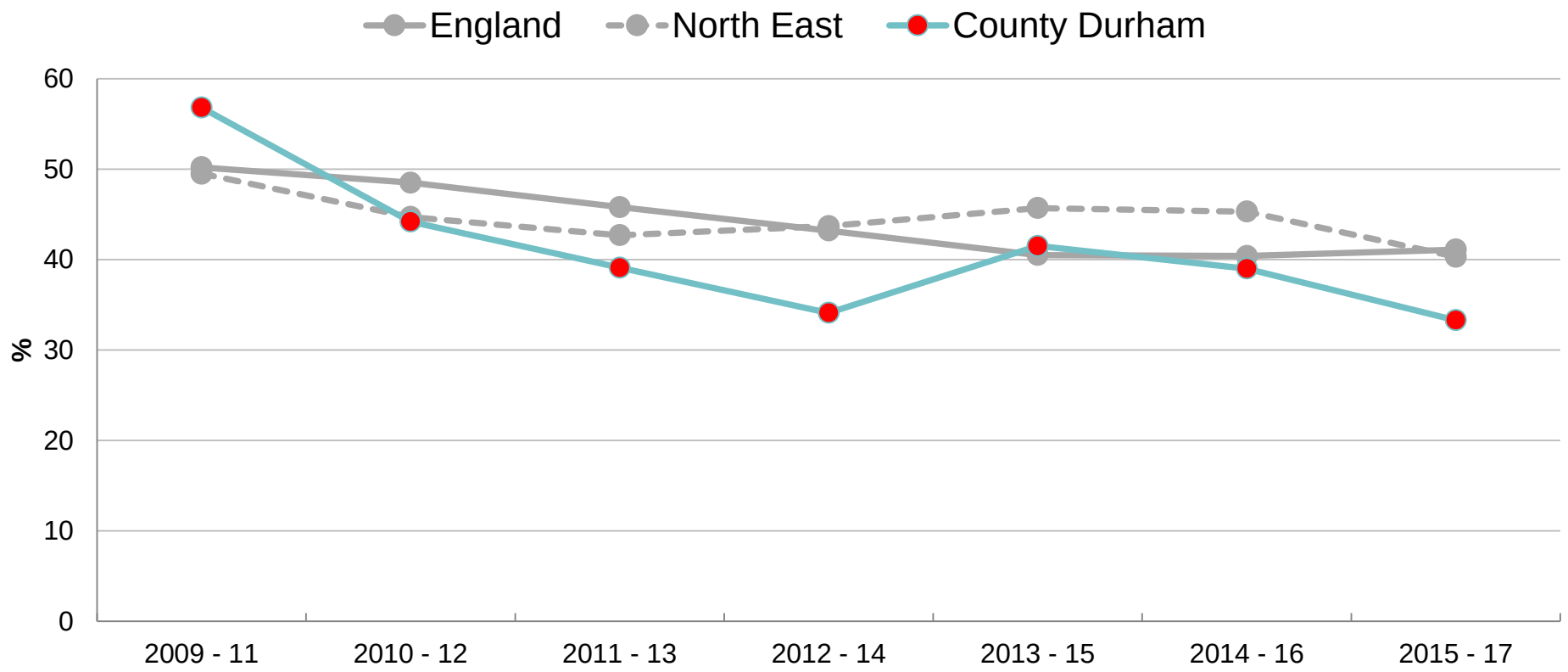
Durham County Council

Local Need: HIV Late Diagnosis

Percentage of adults (aged 15 or above) newly diagnosed at a late stage with HIV



Altogether better

Durham County Council

Why Integrate Services?

- Ensure that prevention is centre to service development and delivery
- Effectively address health inequalities
- Narrow the gap for vulnerable groups
- Ability to reduce overheads

Service Specification

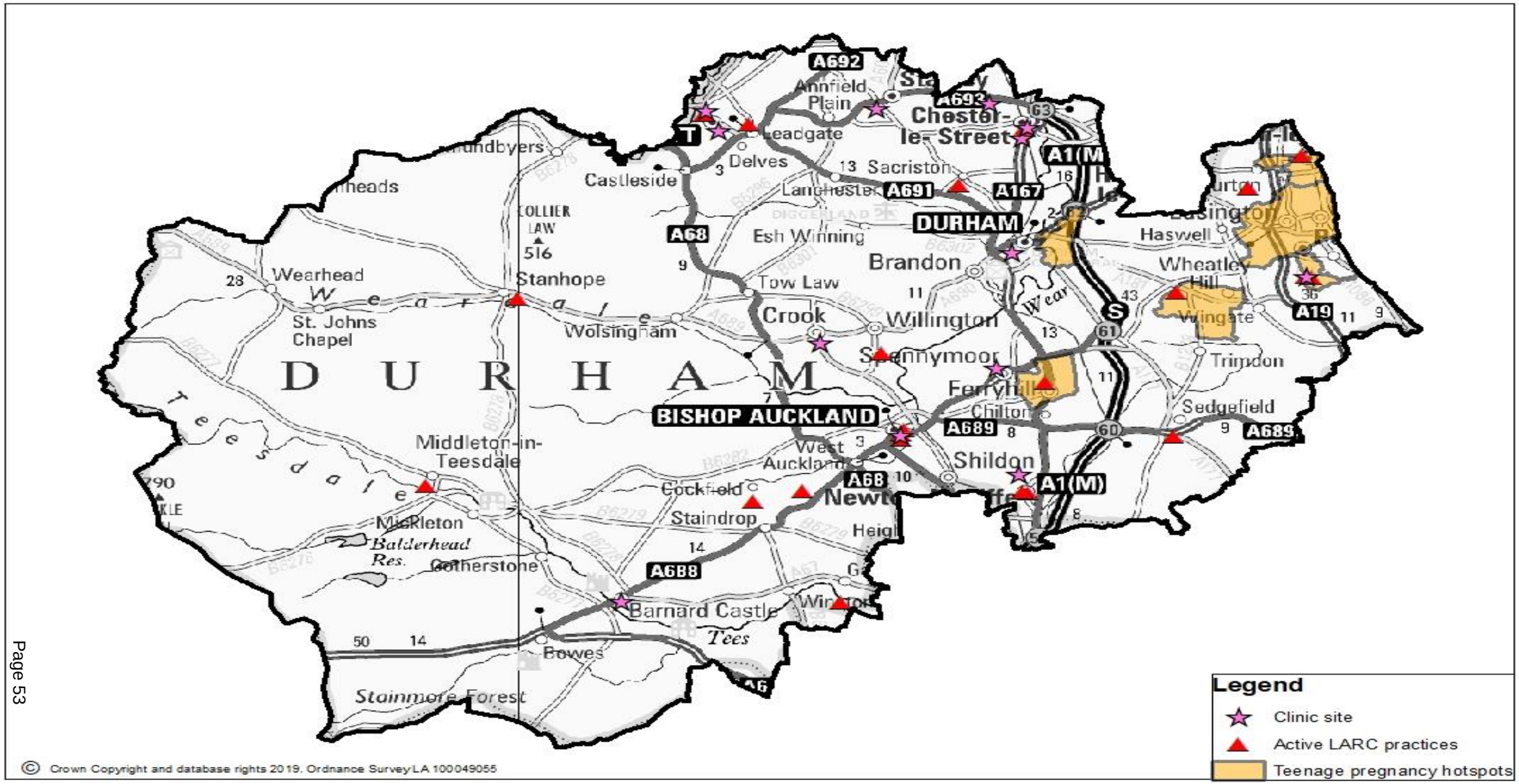
- Community based services and Outreach provision
- Integration of Contraception services and GUM inc. out of area
- Management of Community Pharmacy Emergency Oral Hormonal Contraception (EHOC)
- Transfer of contracting arrangements for GP Long Acting Removable Contraception (LARC)
- 24 hour online testing
- Carry out consultation with key stakeholders

CDDFT: Integrated Sexual Health Service

Contraception and Sexual Health (CaSH) Clinics

- 2 Centralised Hubs – UHND/Bishop Auckland Hospital
- 13 Community facilities
- 4 Secondary Schools
- 5 Day service delivery

CDDFT: Integrated Sexual Health Service



CDDFT: Integrated Sexual Health Service

Sexual Health Promotion:

- Health promotion events
- C Card Training
- Group facilitation
- Bespoke training (LAC/CL)
- Local and national campaigns
- Targeting vulnerable groups

CDDFT: Integrated Sexual Health Service

Emergency Contraception & C Card

Service	Outlets	Consultations
Emergency Contraception (Pharmacies)	106	4963
C card	203	5383

Altogether better

Durham County Council

CDDFT: Integrated Sexual Health Service

LARC:

- 72 GP Practice Service Level Agreements Signed
- 24 GP Practice's Actively Delivering

Service	Service user consultations (fittings)
LARCs in sexual health clinics	2937
LARCs in general practice	1958
Total	4895

CDDFT: Integrated Sexual Health Service

Online Testing:

Service	STI testing packs sent to service users	Reactive tests
Online STI testing	3141	230

CDDFT: Integrated Sexual Health Service

Examples of Good Practice

- The development of bespoke sexual health training programmes for Foster carers, residential staff and staff within the Young People's Service to ensure that we are meeting the needs of our Looked After Children and Care Leavers;
- The development of CDDFT's digital offer through improvements to online services
- Increased attendance of Lesbian, Gay, Bisexual, Transgender, and Questioning+ (LGBTQ+) young people and adults attending mainstream services through the implementation of the outreach model;
- Delivery of training to Pharmacies across County Durham

CDDFT: Integrated Sexual Health Service

Areas for Development:

- Increase number of community based facilities
- Increase service delivery to 6 days per week
- Ensure that CaSH services are targeted to areas of greatest need
- Enhance LARC provision

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North East Ambulance Service NHS
NHS Foundation Trust

ForLife

Adults Wellbeing & Health Scrutiny

Performance: ambulance response standards progress

Mark Cotton, Assistant Director

Ambulance Standards

New response performance standards

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

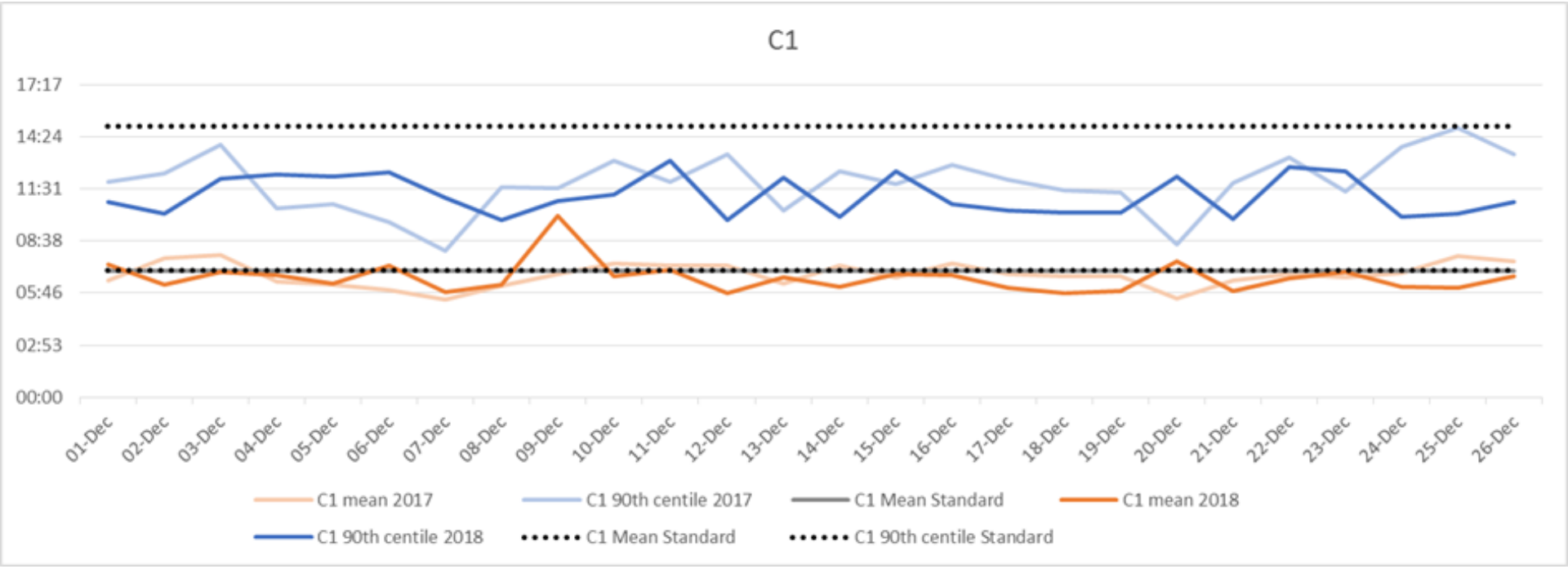
Ambulance Standards

New response performance standards (YTD to 31 Jan 2019)

Call type	Call definition	Average response time (100% of all cases)	90% response time
Category 1	Time-critical life-threatening event	00:06:11	00:10:35
Category 2	Potentially serious conditions	00:20:51	00:43:48
Category 3	Urgent problems not immediately life-threatening		02:49:57
Category 4	Non-urgent; needs telephone or face-to-face assessment		02:52:03

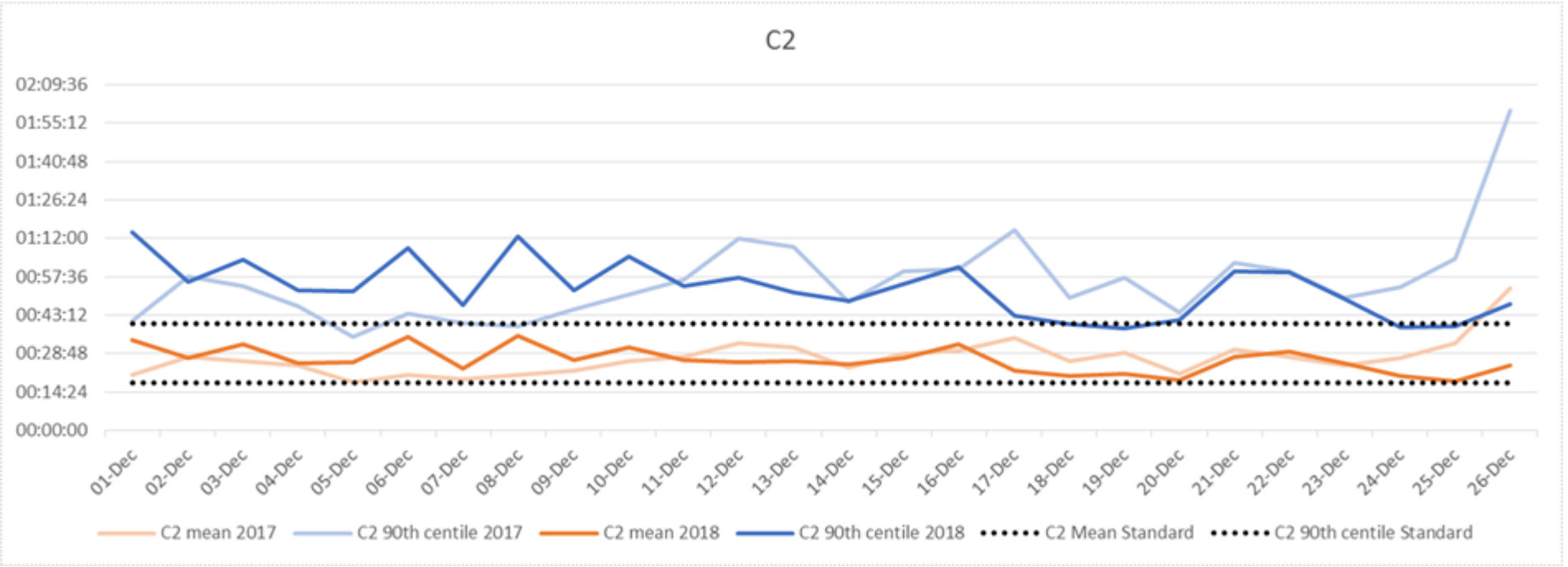
Comparison with last December

Category 1 performance in December 2017 and 2018



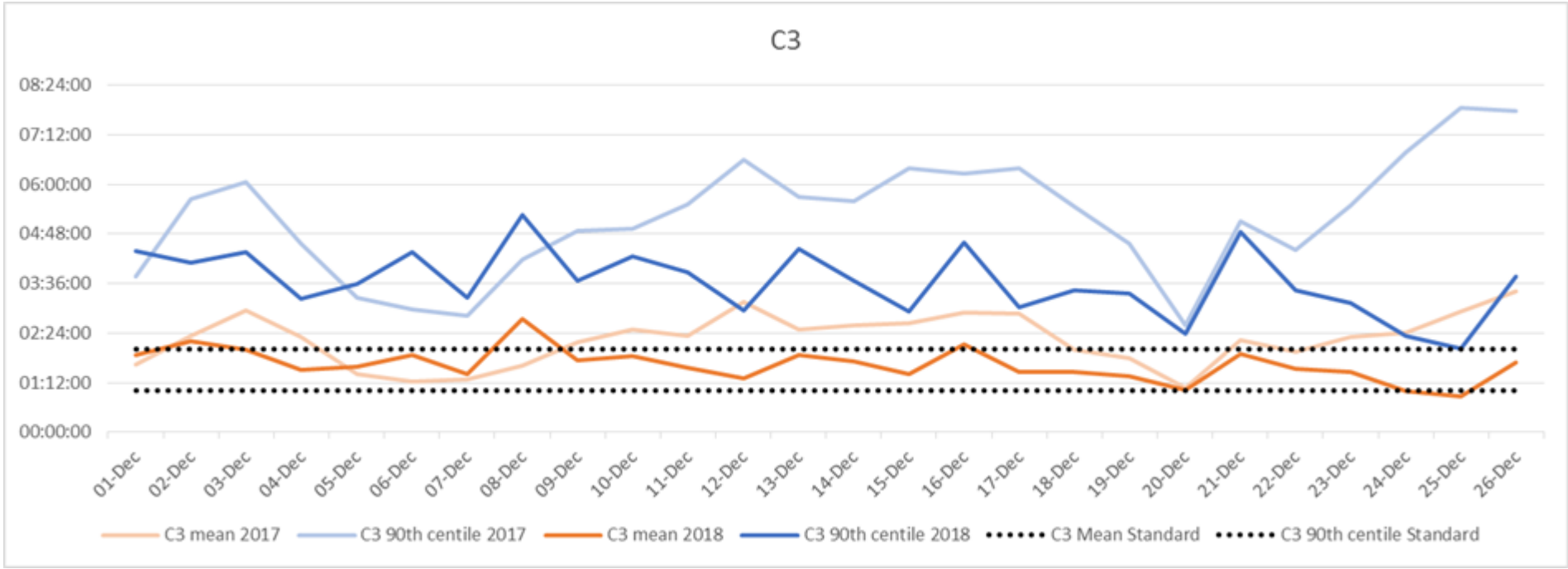
Comparison with last December

Category 2 performance in December 2017 and 2018



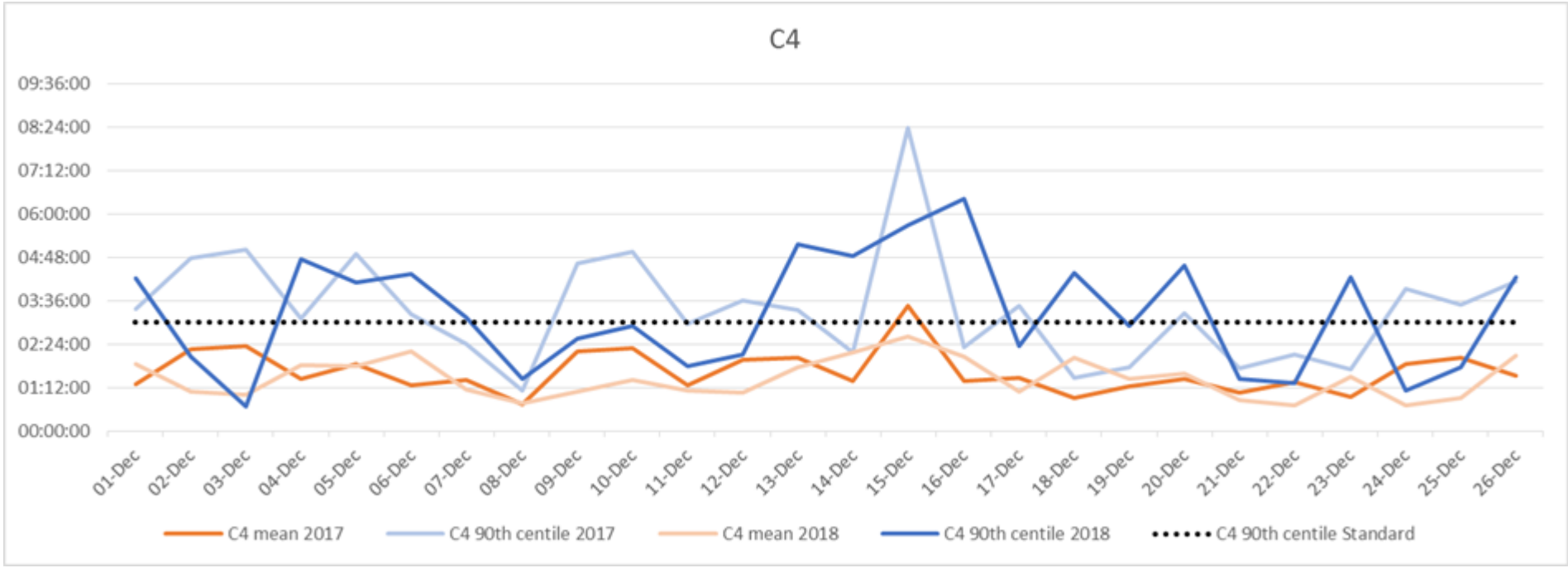
Comparison with last December

Category 3 performance in December 2017 and 2018



Comparison with last December

Category 4 performance in December 2017 and 2018



Capacity and Demand Review

Achieving the new ambulance standards

The aim of the review was to determine the underlying capacity required to deliver ambulance response time performance across the North East Ambulance operational area, designed to meet the new national ambulance targets

Scope of the review

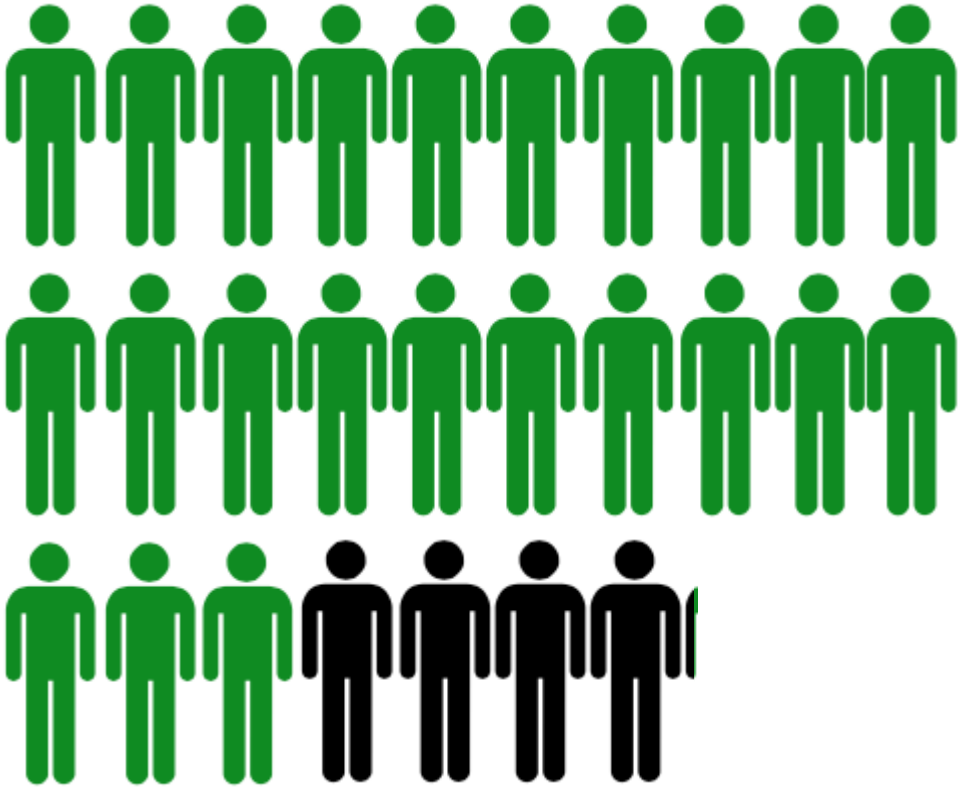
- Demand predictions to 2021
- Model performance to 2021 with current resourcing
- Identify potential efficiencies
- Model performance impact of each potential efficiency
- Model resource needs to bridge any performance shortfall

Bridging the Gap

Based on 2017-18 resources

272 additional paramedics are required to meet response performance standards

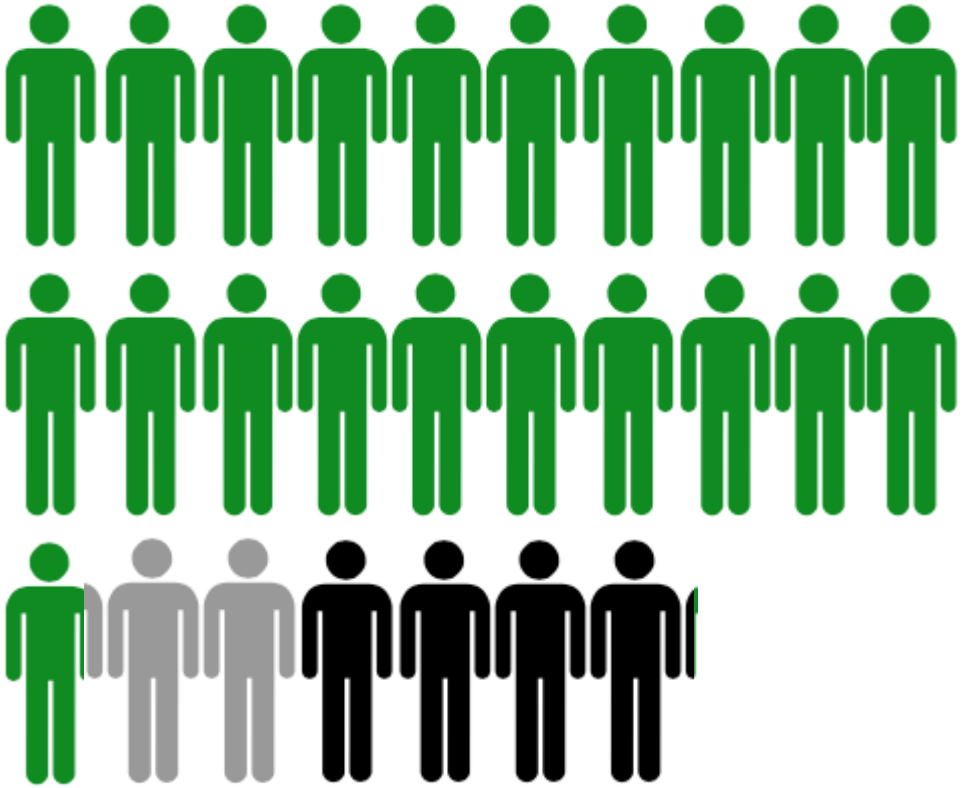
Bridging the Gap



272 additional paramedics are required to meet response performance standards

42 have been funded through additional investment in 2017/18 (in post)

Bridging the Gap



272 additional paramedics are required to meet response performance standards

42 have been funded through additional investment in 2017/18

22 to be delivered through reducing average turnaround to 30 mins (11 in year 1)

Bridging the Gap

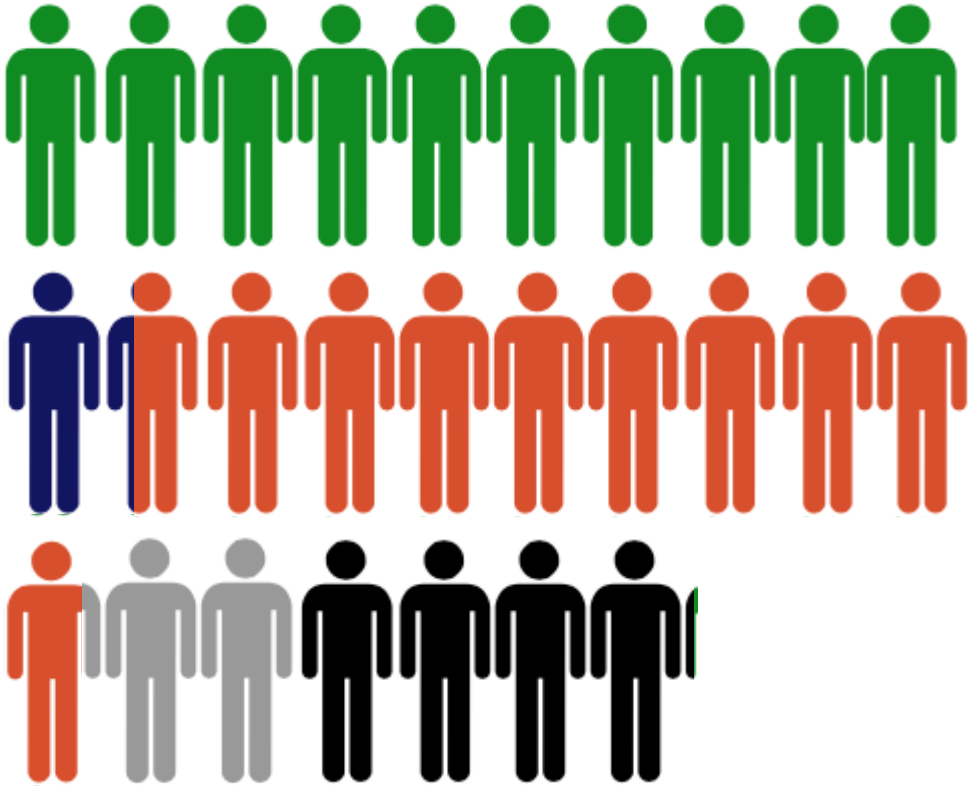
272 additional paramedics are required to meet response performance standards

42 have been funded through additional investment in 2017/18

22 to be delivered through reducing average turnaround to 30 mins

95 to be delivered through reducing abstractions (32 in year 1)

Bridging the Gap



272 additional paramedics are required to meet response performance standards

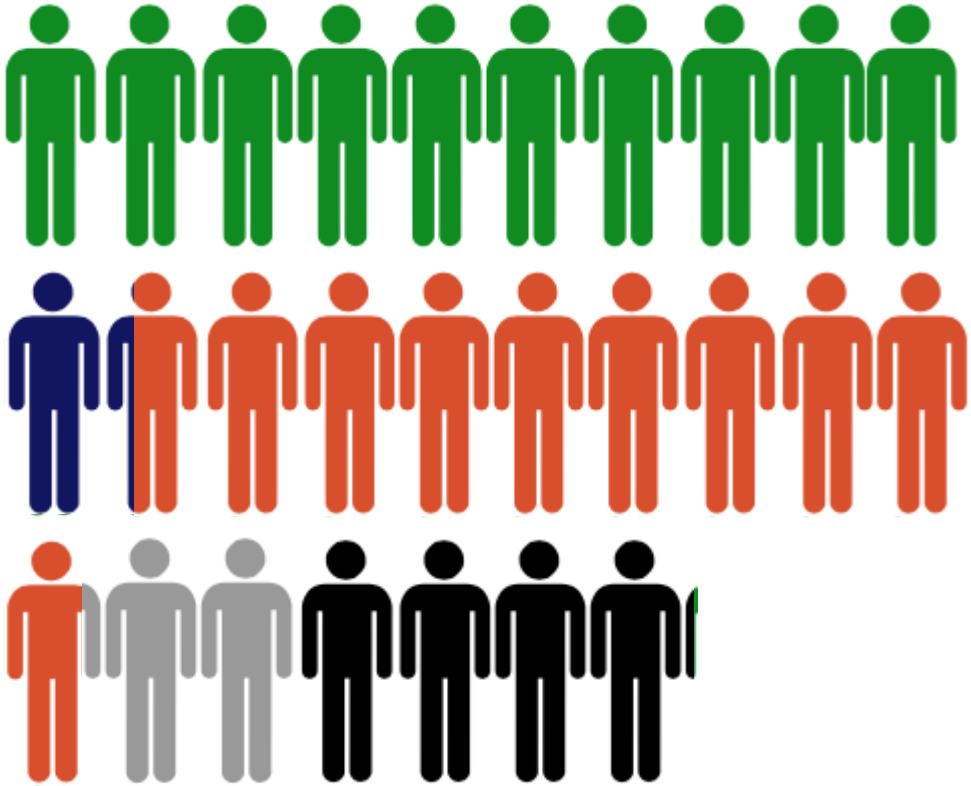
42 have been funded through additional investment in 2017/18

22 to be delivered through reducing average turnaround to 30 mins

95 to be delivered through reducing abstractions

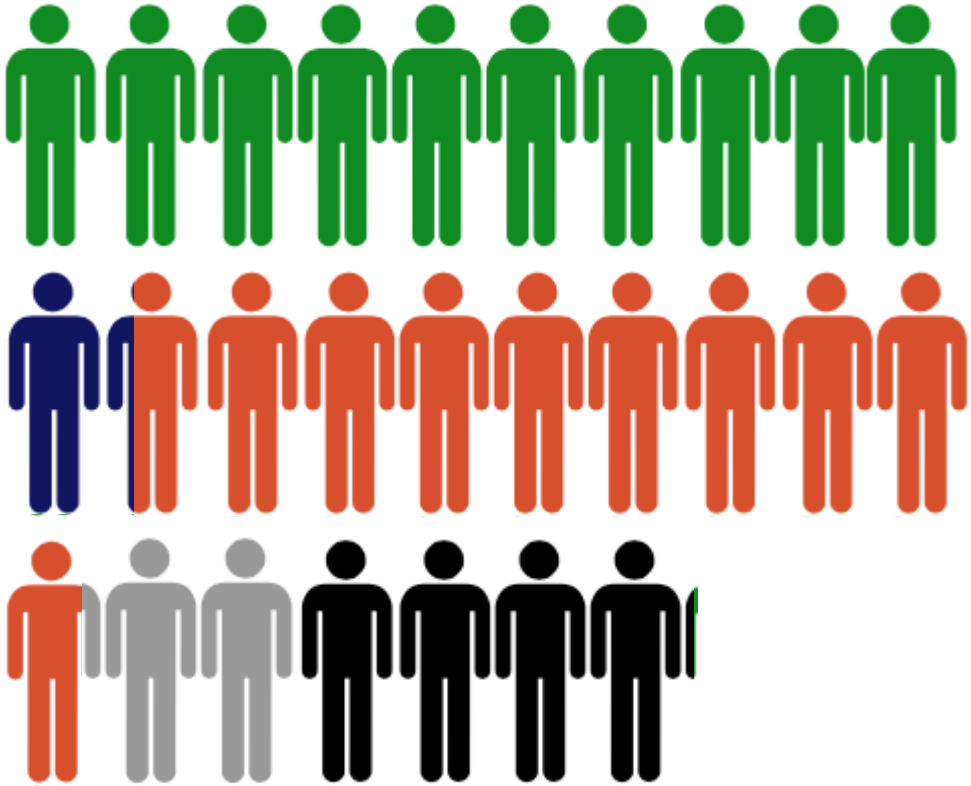
13 to be delivered through 8 hour shift re-roster (13 in year 1)

Bridging the Gap



This reduces the gap in paramedic establishment to 100

Bridging the Gap

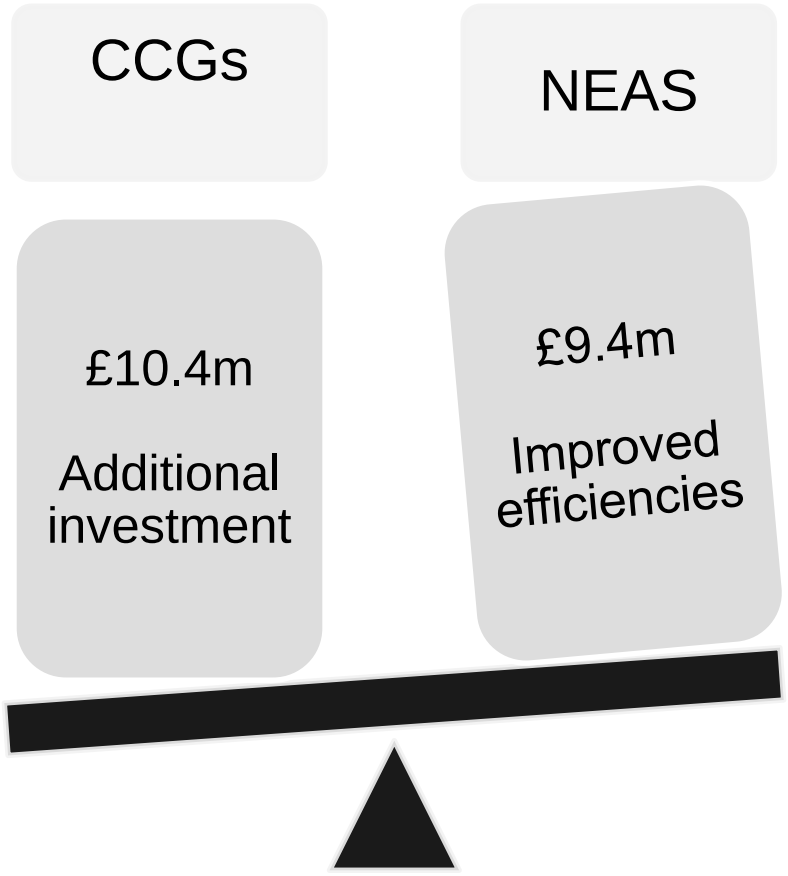


Our contribution through delivering these efficiencies will save almost £9.4 million:

- £1.7m from reducing turnaround
- £6.9m from reducing abstractions
- £0.8m from 8-hour shift

Balance of responsibilities and accountability

Funding the changes to achieve the new standards

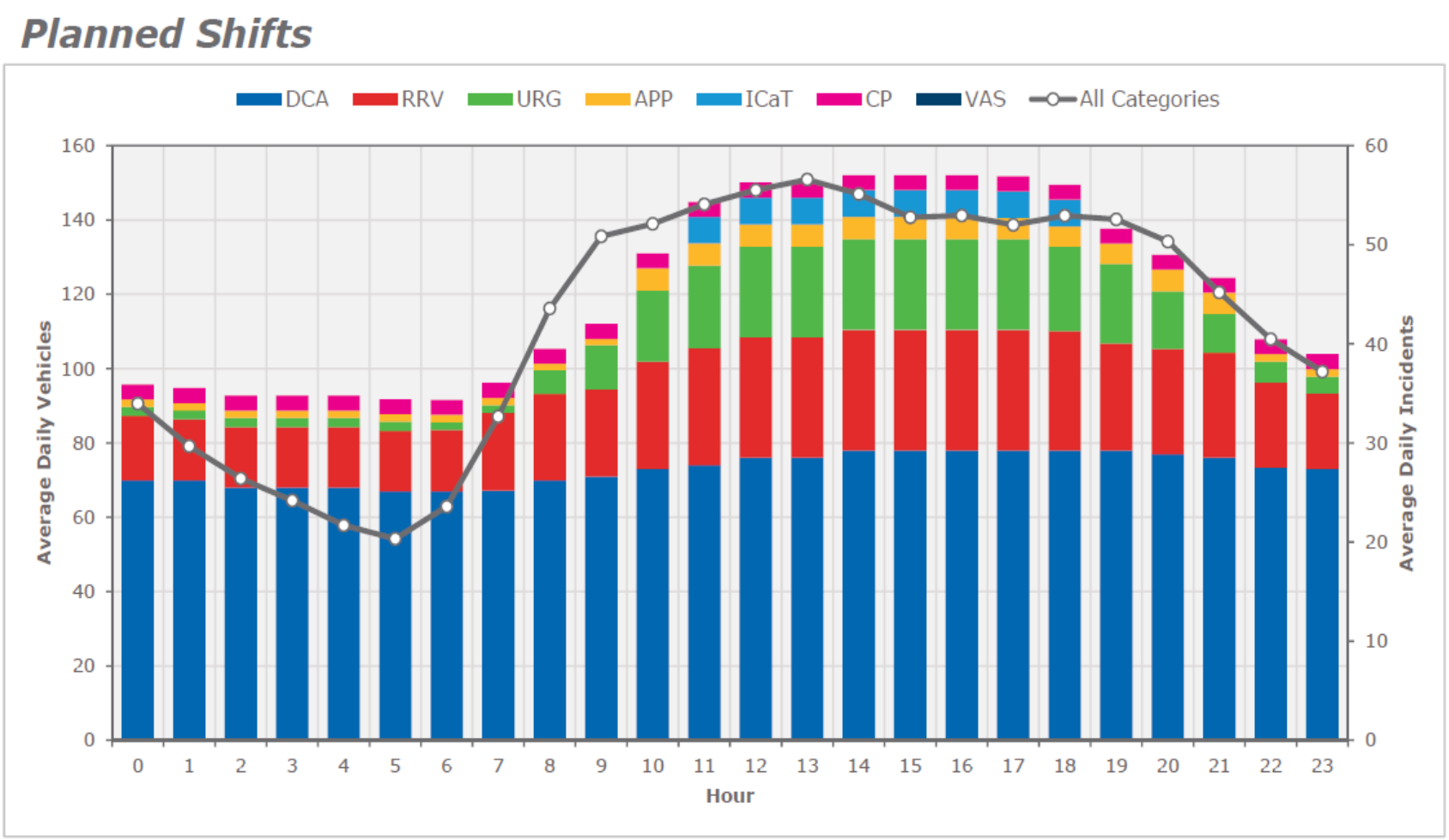


Ambulance future resourcing

	CURRENT VEHICLES			FUTURE VEHICLES			CHANGE IN VEHICLE NUMBERS		
	Rapid Response	Two-crew vehicles	Inter tier	Rapid Response	Two-crew vehicles	Inter tier	Rapid Response	Two-crew vehicles	Inter tier
VEHICLE TOTALS	38	74	27	18	112	18	-20	+38	-9
	CURRENT STAFFING			**FUTURE STAFFING**			**CHANGE IN STAFFING**		
	Para	CCA	ECT	Para	CCA	ECT	Para	CCA	ECT
OVERALL STAFFING	540	450	70	646	544	47	+107	+94	-23

Current shifts with existing resources

DCA= double-crew ambulance; **RRV**= rapid response car; **URG**= urgent care; **APP**= advanced practitioner; **ICaT**= intermediate tier vehicle; **CP**= community paramedic; **VAS**= voluntary ambulance service



Ambulance resources across North of Tyne

DCA= double-crew ambulance; **RRV** =rapid response car; **ITV**= intermediate tier vehicle

Local authority area	Future resources	Net changes
Northumberland	20 x DCA, 4 x RRV, 3 x ITV	+ 6 DCA -2 RRV (24 to 12 hours) -2 ITV (24 to 12 hours)
North Tyneside	7 x DCA, 2 x RRV, 1 x ITV	+3 DCA -1 ITV
Newcastle	9 x DCA, 1 x RRV, 2 x ITV	+4 DCA -1 DCA (0200h – 0600h) -3 RRV

Ambulance resources across South of Tyne

DCA= double-crew ambulance; **RRV** =rapid response car; **ITV**= intermediate tier vehicle

Local authority area	Future resources	Net changes
Gateshead	4 x DCA, 1 x RRV	-
South Tyneside	7 x DCA, 1 x RRV,	+3 DCA
Sunderland	9 x DCA, 1 x RRV, 1 x ITV	+5 DCA -1 DCA (0000h-0800h) -3 RRV (24 & 12 hours) -3 ITV
Durham	31 x DCA, 5 x RRV, 2 x ITV	+14 DCA -2 DCA (0200h-0700h) -1 RRV

Ambulance resources across Tees Valley

DCA= double-crew ambulance; **RRV** =rapid response car; **ITV**= intermediate tier vehicle

Local authority area	Future resources	Net changes
Darlington	2x DCA, 1 x RRV	-1 RRV (24 to 12 hours)
Hartlepool	6 x DCA, 1 x RRV, 2x ITV	+3 DCA -2 RRV (24 to 12 hours) -2 ITV
Stockton on Tees	3 x DCA, 1 x RRV, 1x ITV	+1 ITV
Middlesbrough	8 x DCA, 2 x RRV, 2 x ITV	+3 DCA -1 DCA (0200h-0700h) -1 ITV -1 RRV
Redcar & Cleveland	6 x DCA	+2 DCA -2 RRV

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Adults, Wellbeing and Health Srutiny Committee

7 March 2019

Durham Health and Wellbeing System Plan 2019/20 – Part A Adults

Report of Stewart Findlay, Chief Officer – Durham Dales, Easington & Sedgefield, and North Durham Clinical Commissioning Groups (CCGs) & Chair of the County Durham Integrated Care Board

Purpose of the Report

1. The purpose of this report is to present the Durham Health and Wellbeing System Plan 2019/20 and outline an approach to the development of a longer term five-year Durham plan which considers the recently published NHS Long Term Plan (https://www.longtermplan.nhs.uk/).

Executive Summary

2. As part of the County Durham Health and Care Plan partners of the Integrated Care Board agreed to work collaboratively to develop a 2019/20 Durham Health and Wellbeing System Plan.

3. The plan is attached at appendix 2 is part A and focuses predominantly on adults. It identifies a number of key operational delivery priorities across partners for 2019/20. It sets out a number of shared agenda areas related to quality, finance, workforce, performance and estates. An outline timetable of public engagement and or consultation associated with the plan for 2019/20 is identified. In respect of these detailed reports and business cases will be shared more widely as part of the process.

4. Part b, children's is being developed under the leadership of the Integrated Steering Group for Children and will be finalised and presented in May 2019. It will focus on some of the following key areas:

   - Children and Young people Strategy
   - The integrated Steering Group governance and work programme
   - Integrated commissioning approach for children's and the priorities linked to the inspection regimes in children's services.
   - Therapy services review
   - Development of place based 0-19 services

5. In relation to the development of the long term plan the Chair of the Health and Wellbeing Board and Chair of the Adults, Wellbeing and Health Scrutiny Committee have agreed to hold a joint development session in June or July 2019. The development session will provide an opportunity to explore the operating environment for health, social care and prevention and the priorities that need to be set out in a longer term plan. This will take account of the draft County Durham Vision and Strategy 2035, NHS Long Term Plan and other national strategies and policies.

6. A planning group, reporting to the Integrated Care Board and Integrated Steering Group for Children has been established comprising senior officer leads from each partner organisation. The role of the planning group will be to support the coordination and development of the County Durham Health and Wellbeing Long Term System Plan. This will include agreement of an outline timetable for developing a final draft long term plan by autumn 2019 and a programme of public and stakeholder engagement including Area Action Partnerships.

Recommendation(s)

7. Members of the Adults, Wellbeing and Health Scrutiny Committee are recommended to:

- Receive the report and plan attached at appendix 2.
- Note the approach to the development of the long term Durham System Health and Wellbeing Plan outlined in the report.
- Note that a Durham System Plan for Children's will be presented in May 2019.

Contacts:	Jon Quine, Commissioning Delivery Manager North of England Commissioning Support	07899 086357 jon.quine1@nhs.net

Appendix 1: Implications

Legal Implications
From an NHS perspective the plan makes reference to the NHS Constitutional Standards and steps to achieve these, which are support in law; all NHS Organisations are therefore obliged to adhere to these. There are also changes and implications for NHS Standard Contracts, again subject to the appropriate law in this regard.

Finance
The plan sets out the shared financial landscape and how partners will work together.

Consultation
The plan outlines a programme of engagement and consultation in relation to key programmes across the system in 2019/20. Public engagement and / or consultation will be undertaken in accordance with standard practice and legal requirements.

Equality and Diversity / Public Sector Equality Duty
All schemes / projects detailed in the CCGs Operational Plan are subject to Equality and Diversity Risk Assessment, Quality Impact Assessment, and Data Protection Impact Assessments. These are to ensure that any service reform does not negatively impact on any one part of our community.

Human Rights
The Human Rights Act (2000) ensures that all public authorities in the UK, including NHS organisations, have a positive obligation to respect and promote peoples' human rights. These are underpinned by the core values of Fairness, Respect, Equality, Dignity and Autonomy for all. These values are at the heart of high quality health and social care, and continue to be upheld through the NHS Long Term Plan and Planning Guidance.

Crime and Disorder
There are no implications within either the Long Term Plan or Guidance in this regard.

Staffing
Workforce is reflected in the plan; including the development of new roles and the recruitment of additional staff to fulfil the outcomes are stated. Detailed workforce plans are to be developed in 2019/20.

Accommodation
Specific changes to accommodation requirements are detailed in the plan under the estates section. Such changes will be subject to appropriate engagement and consultation processes on an individual basis.

Risk
Failure to deliver on the plan would increase the risks of poorer outcomes for our community, and the risk of direct intervention in relation to NHS partners from NHS England / NHS Improvement.

Procurement
There are no implications for procurement within this report at this point.

Appendix 2

Durham Health and Wellbeing System Plan 2019-2020 Part A - Adults

Adults and Children's System Plans

This is Part A of a system plan which predominantly focuses on adults.

Part B – children's is being developed under the leadership of the Integrated Steering Group for Children and will be finalised and presented in May 2019. It will focus on some of the following key areas:

- Children and Young People's Strategy
- The Integrated Steering Group for Children governance and work programme
- Integrated commissioning approach for children's and the priorities linked to the inspection regimes in children's services.
- SEND
- Therapy services review
- Development of place based 0-19 services
- Maternity services
- Children's mental health
- Joint Autism Strategy

Partners within the Durham System Plan

- City Hospitals Sunderland NHS Foundation Trust - CHS
- County Durham and Darlington NHS Foundation Trust – CDDFT
- Durham County Council – DCC
- Durham Dales, Easington and Sedgefield Clinical Commissioning Group – DDES CCG
- North Durham Clinical Commissioning Group – ND CCG
- North East Ambulance Service – NEAS
- North Tees and Hartlepool NHS Foundation Trust - NTFT
- Tees, Esk and Wear Valleys NHS Foundation Trust – TEWV

County Durham Integrated community care partnership

NHS North Tees and Hartlepool NHS Foundation Trust

City Hospitals Sunderland NHS Foundation Trust

Durham County Council

NHS County Durham and Darlington NHS Foundation Trust

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS North Durham Clinical Commissioning Group

Better health for the people of North Durham

NHS North East Ambulance Service NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust

Durham Village

If County Durham CCGs were a village of 100 people

6	x	Diabetes
5	x	Heart Disease
17	x	Raised Blood Pressure
3	x	Cancer
1	x	Dementia
1	x	Severe Mental Illness
7	x	Asthma
2	x	Stroke
22	x	Long Term Illness
27	x	Living in 'Most Deprived' Quintile

£1,477
Annual Cost Per Capita

1 Long Term Unemployed

24
Weekly Binge Drinkers

17 Smokers

14
Obese Adults

2
Persons (65+) Receiving Self Directed Support

7.7 years
Difference in Life Expectancy at Birth

7.1 years
Difference in Life Expectancy at Birth

Population Age Breakdown

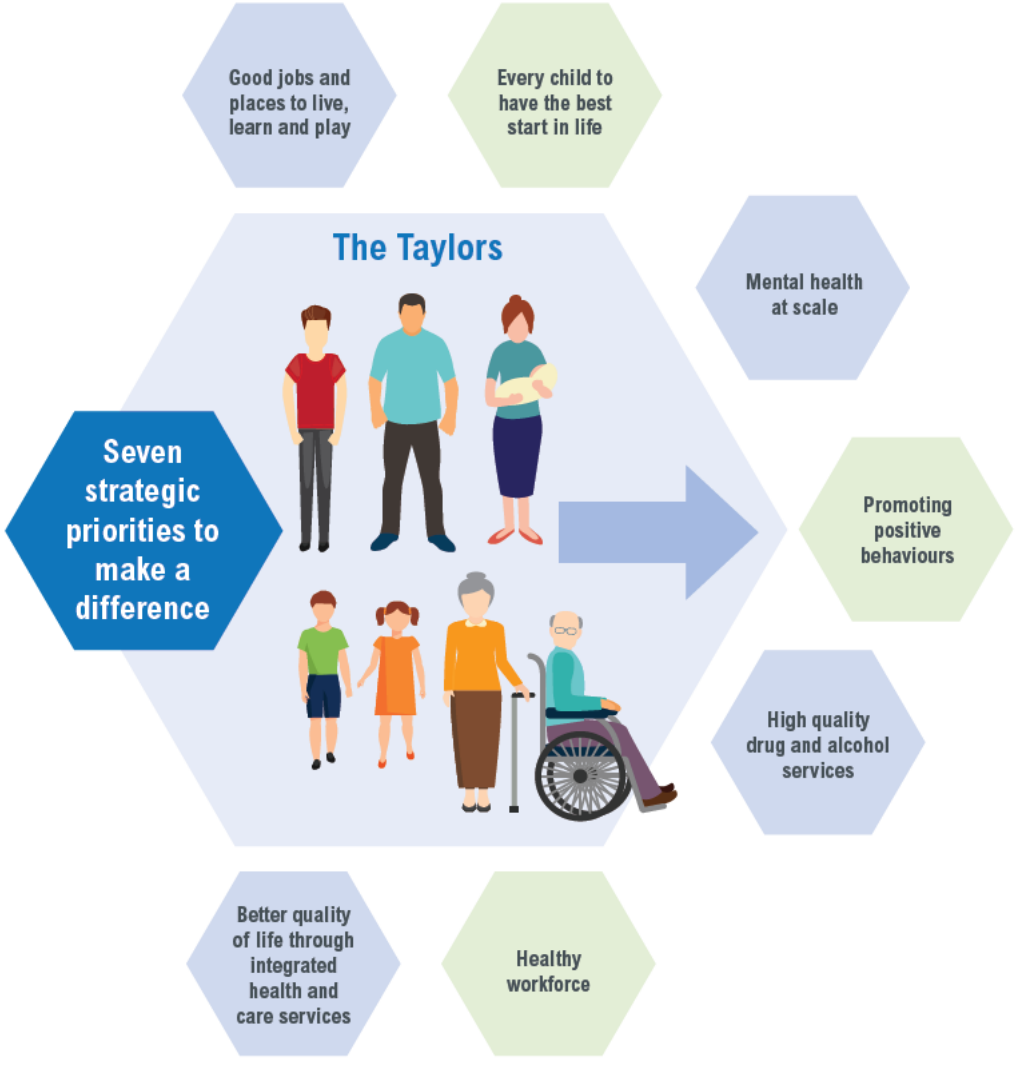
Under 5s
5 - 18 years
19 - 65 years
66 - 80 years
81+ years

Actual Population: 547,163

Introducing the Taylor family

This is a fictional County Durham family – the Taylor family. However, they face some of the key challenges that a lot of our local communities face.

Supporting and working with the Taylor family to improve health and wellbeing in County Durham are a plethora of organisations. The County Durham Partnership is made up of key public, private and voluntary sector organisations that work together to improve the quality of life for the people of County Durham. The County Durham Partnership is made up of five thematic groups, altogether wealthier, altogether better for children and young people, altogether healthier, altogether safer and altogether greener. These groups work collectively in a range of partnerships including the County Durham Health and Wellbeing Board, the Safer Durham Partnership, County Durham Children and Families Partnership and the Area Action Partnerships. Improving the public's health can only happen by working with other partnerships in County Durham which are a key asset.


Good jobs and places to live, learn and play
Every child to have the best start in life
The Taylors
Mental health at scale
Seven strategic priorities to make a difference
Promoting positive behaviours
High quality drug and alcohol services
Better quality of life through integrated health and care services
Healthy workforce

Introduction

The County Durham Integrated Care Board (ICB) brings together partners in Health and Social Care commissioning and delivery. This forum was established as health and social care partners recognise the need to collaborate to achieve improved outcomes for the population within existing resources. This forum has been proven to be effective in co-ordinating commissioning and delivery activities across the County.

Historically each organisation has had their own delivery plan in line with their governance and assurance requirements. The organisations that are part of the ICB have separate local, regional and national policies, politics, regulators and stakeholders. However these policies and plans impact on the same people and communities in County Durham.

It is recognised by partners that our individual plans are interlinked and that the actions of one organisation will have an impact across the wider health and social care system. For the first time we are bringing together the key components of the separate organisational plans into a single County Durham Health and Wellbeing Plan. This will enable greater involvement from partners and greater oversight as we work to deliver our priorities in County Durham. The ICB doesn't replace governance arrangements within individual organisations, but allows us to have a common view of the issues and priorities across County Durham and ensure that we are joined up as we work to deliver improvements.

The development of a County Durham Health and Wellbeing Plan follows a strong track record of joint working and collaboration between health and social care. The development of a shared plan will strengthen that joint working, but also allow us to demonstrate how effective collaboration is in County Durham.

This plan sets out the key activities that we will be working on together across the next twelve months. The plan aims to set out the context that individual organisations are working in and how this effects that the areas that we need to work on in Durham. We recognise that the landscape in health and social care is rapidly changing and this plan will be need to be reviewed after six months and updated to reflect any emerging priorities.

Work is ongoing to develop a longer term plan that sets out to deliver the requirements of the Care Act, the NHS Long Term Plan and other relevant policy documents. This plan will demonstrate the journey towards greater system thinking in commissioning, delivery, performance monitoring, driving efficiency and improving outcomes for the people of County Durham.

The plan explains the key projects that we are working on together and should be read alongside individual organisational plans and also national policy which is covered later in this report. The plan also sets our how we will engage and consult where appropriate with the public and stakeholders if there are changes to services proposed.

There will be an opportunity in the summer to meet with the Overview and Scrutiny Committee and the Health and Wellbeing Board to examine the operating environment and the priorities set out in this and future plans in more depth.

National & Local Context

There is a wealth of national and local information that we use to form our plans

Many of the key deliverables are set out in national policy documents or in statute

Department of Health & Social Care

Prevention is better than cure

Our vision to help you live well for longer

Care Act 2014

NHS

The NHS Long Term Plan

County Durham Joint Health and Wellbeing Strategy

Director of Public Health Annual Report 2018

A new vision for 'The Taylors' Improving health in County Durham

NHS Operational Planning and Contracting Guidance 2019/20

County Durham Joint Strategic Needs Assessment

Durham Context

We recognise our place boundaries with others in the Integrated Care Partnership and the wider Integrated Care System of Cumbria and the North East, however our Health and Care plan relates to the place of County Durham. This plan helps us meet head on the challenge set for the Health and Wellbeing Board to be a more integrated system to protect the services for the people of Durham; we have strong foundations on which to build in the next 12 months.

The JSNA contains a range of information to help us understand the major health and wellbeing issues of importance locally. This information, when placed in context and linked to evidence, can provide intelligence and insight which, if communicated in the right way and to the right people can better inform decisions. It helps to inform the planning and improvement of local services, and guides us to make the best use of the funding. Durham Insight is an integral part of Durham County Council's Integrated Needs Assessment approach with the main aim of informing and supporting our joint Strategic Needs Assessment, and other assessments and strategies managed by the authority and its partners. Locally it has provided the evidence base for the JHWS and underpinned the development of the 7 priorities that have emerged from this that are reflected in the Taylor family.

Overall health and wellbeing has improved significantly in County Durham but it still remains worse than the England average. In addition, large health inequalities still remain across County Durham, especially with regards to breastfeeding, babies born to mothers who smoke, childhood obesity and premature deaths. The impact of this becomes obvious when looking at life expectancy; a child born today in the most deprived areas of County Durham could expect to live between 7 and 8 years less than one born in the least deprived areas.

Our ambition as a whole system is to work differently and collaboratively with partners across organisational boundaries to best meet the needs of the local population. We recognise there is still more to do, but great progress has been made in recent times with some specific examples below:

- A re-procured Community Services contract is now in place which has helped re-define service delivery and enable greater collaboration in particular to support integration and joint working between health and social care. The new structure reflects the arrangements of the CCGs and primary and social care being built up from the local TAPs (Teams around Patients), to locality and then countywide services. The NHS long term Plan has demonstrated Durham is ahead of the game with place based care

Durham Context

- Durham, Darlington and Teesside NHS mental health and learning disability partnership (formerly accountable care partnership) is now in place and is about improving outcomes for service users through partnership working. It makes sure funding set aside for mental health and learning disability services remains within those services and through the partnership we can provide a more streamlined system.
- We have worked closely with our Ambulance Service (NEAS) and acute provider Trust (CDDFT) to improve access to Urgent and Emergency care and Acute services.
- Work on the Troubled Families project, which encompasses a whole system, whole family approach to improve outcomes for children has achieved to the point where it has been given earned autonomy for the next funding allocation giving more freedom to innovate in this important area of work
- Based on the Blackpool model The Positive Lives initiative delivered through the DCC support and recovery team , funded by the CCGs works with the high intensity users of emergency services and is impacting on the demand on these services

Work is also now underway to develop an Integrated Commissioning approach with the Council and the CCGs to help us get the best quality services for our people through the most efficient use of resources available. Through stakeholder engagement we have started some transformation conversations and feedback from people across the system is they value the opportunities presented to work collectively in the future.

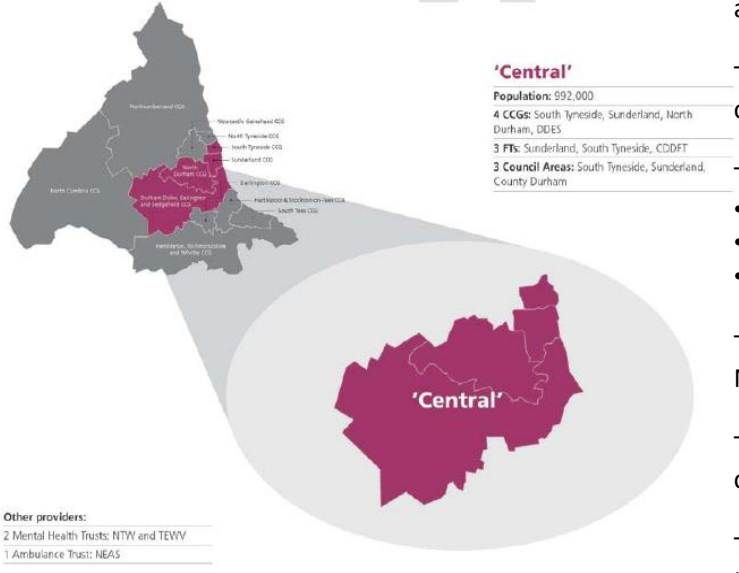
We recognise there is still more to do; we are on a journey and looking to the future, we will be having conversations with our stakeholders with workshops to further develop our thinking.

Boundary Relationships

County Durham sits in the centre of the North East and has relationships with a number of surrounding H&SC commissioners and providers. County Durham is part of the North East and North Cumbria Integrated Care System and is part of the 'Central' Integrated Care Partnership as shown in the diagram.

The NHS commission services based on their registered population i.e. those registered with one of the member GP practices whereas the LA commissions/provides services for the resident population. For people that live at the boundaries of the county this can sometimes cause complexities for H&SC services.

Changes to public health commissioning have meant that pathways have had to be in place for some patients living near the borders or perhaps attending a school in another county.



DCC commissions a number of services collaboratively with other North East local authorities as appropriate.

The two Durham CCGs work collaboratively with the Tees and Darlington CCGs to commission health services for the population.

The majority of County Durham residents receive acute care from three providers:

- County Durham & Darlington FT
- City Hospitals Sunderland FT
- North Tees & Hartlepool FT

There are also contracts in place with four other acute trusts including Gateshead, Northumberland, Newcastle and South Tees.

The majority of mental health care is delivered by Tees Esk Valleys NHS FT with some care provided by Northumberland Tyne and Wear FT.

These complexities can be challenging, but there are arrangements in place to ensure that dialogue takes place with neighbouring mental health and physical health providers, neighbouring local authorities and neighbouring commissioning organisations to ensure that pathway are smooth and effective.

Public Engagement and Consultations

Partners are committed to working together when engaging/consulting with the public and stakeholders in future wherever possible and we aim to develop a system plan that joins up engagement and consultation activities across County Durham.

The plan will focus on broad ongoing engagement activities for some of our key project areas such as access to services, improving care for frail and elderly care , primary care, outpatient care as opposed to issue specific engagement. We feel that this approach will help the public and stakeholders to have a greater understanding of the need for service development and improvement across the NHS and Local Authority.

This will not replace any of our formal duties to inform, engage or consult with stakeholders and the public, but will ensure that a broader range of patients views can be considered.

We will inform:

- When there is a temporary change that would only affect current users and they wouldn't be aware of the change i.e. short term/temporary change in hours of opening for a service

We will engage:

- When we are considering changing the way a service is delivered or when we want to develop alternative options for service delivery. We need to secure input before we develop the options to understand what users/carers/staff think about the services

- Where substantial development or variation changes are proposed

We will seek views of Health Overview and Scrutiny and ensure appropriate communication takes place in all circumstances

Public Engagement and Consultations

Quarter 1

- Learning disability commissioning Strategy
- Shotley Bridge Hospital - engagement
- Urgent treatment centre staffing model – engagement
- Stroke rehabilitation – engagement
- Ward 6 inpatient Services - engagement
- Pre consultation engagement Sunderland and South Tyneside Path to Excellence Phase 2
- Clinical Strategy – Hospital Services, South Integrated Care Partnership – engagement

Quarter 2

- Stroke rehabilitation
- Ward 6 inpatient Services
- Pre consultation engagement Sunderland and South Tyneside Path to Excellence Phase 2

Quarter 3

- Mental health rehabilitation and recovery services – engagement
- Shotley Bridge Hospital - consultation
- Sunderland and South Tyneside Path to Excellence Phase 2 - consultation

Quarter 4

- Mental health rehabilitation and recovery services – engagement

Shared Agenda

Finance

- The financial landscape across health, social care and public health is challenging with all partners experiencing increased costs and the need to ensure more effective and effective allocation of budgets through greater efficiencies.
- Some examples that contribute to this are:
  - Continued impact of austerity
  - Potential cut to the public health grant circa £19 million
  - Above inflation pay awards in the health sector
  - Efficiency targets set nationally for the NHS
  - Growing demand for services to meet the needs of the population, particularly in hospitals
- Partners are careful not to shunt costs to on another and work to achieve better outcomes from the County Durham health and social care £.
- Some examples of work programmes to support this are:
  - Ensuring the sustainability of hospital based services
  - Transforming community services around the health and social care needs of patients and to support the effective use of hospital services.
  - Reforming the out patient system to ensure a focus on clinical outcomes and improved
  - A focus on prevention and the longer term aim to improve outcomes
- A finance sub group of the Integrated Care Board is established to support a greater understanding of financial planning across health and social care.

Workforce

- There are significant workforce challenges across health and social care in Durham and across the country. There are shortages of GPs, social care staff, nursing, therapies and a number of medical specialities.

- Some key programmes are already in place to address some of the challenges:
  - GP and practice nurse career start scheme
  - Regional international GP recruitment scheme
  - Social care academy
  - Bid for a work programme to support organisational development across community health and social care
  - Mental health time to change workforce group.

- There is more to do regarding workforce. Partners are establishing a group in 2019/20 to ensure an even greater focus on plans to address shortages and the capacity and skills needed to support the long term plan and service transformation.

- In relation to NHS workforce planning Health Education North East is working with partners in County Durham to support plans regarding medical, nursing and therapy shortages.

Shared Agenda

Digital and Technology

- Digital and technology are key enablers to support delivery of the plan and longer term service transformation.

- Some examples of key schemes for 2019/20 across partners include:
  - Expansion of the digital programme in care homes to enable access to records by primary care and social workers, support for prescribing and remote monitoring of people with long term conditions.
  - Continued access through the roll out of the great north care record.
  - Roll out of e-consultations in primary care
  - Development of the replacement to the SIDD system
  - Development of the electronic patient record system business case for acute services
  - Liquid logic
  - Proposed re-procurement of the health record system in acute services

Estates

- An estates group has been established with all partners across health and social care. The purpose of the work is:
  - shared planning of estate utilisation
  - Ensuring effective use of current estate and reducing costs for all partners
  - Ensuing estate plans support the transformation of community and primary care services
- Continue to explore shared use estate developments, key examples implemented:
  - the Lavender Centre in Pelton
  - Lanchester Medical Centre
  - Care coordination centre
- In relation to the estate plan in 2019/20 some key projects include:
  - Engagement in early 2019 and consultation later in 2019 on options for Shortly Bridge Hospital
  - Planned closure of Crook Health Centre
  - Proposed closure of Kepier Clinic
  - Relocation of clinical services from Dr Piper House in Darlington for Darlington Memorial Hospital
  - Business case for UHND Emergency Care Centre

Shared Agenda

Quality

Quality and effectiveness of primary, community and secondary care in collaboration with our partners focussed on remains at the forefront of our priorities:

- Learning and sharing across the Durham System to support improvement
- Reducing the incidence of avoidable harm across the system
- Working with partners to achieve the best clinical outcomes for our population (for example, working with Local Authorities to support effective, efficient and high quality Continuing Health Care outcomes, supporting the implementation of the Enhanced Care in Care Homes strategy and reducing rates of Healthcare Acquired Infection (HCAI) across all provision
- Ensuring the best patient experience, supporting the implementation of patient experience forum
- Supporting the population in promoting patients to become actively involved in their own care and treatment

System Performance

As a system we will continue to focus on delivery of the constitutional targets and improve the health outcomes, against key standards, for our population.

There are some priority areas that we are focused on but not limited to as partners identified below:

- Cancer 62 day - will require a collaborative approach as the standard has not been consistently achieved by all provider organisations.
- Permanent admissions of older people (aged 65 years+) to residential/nursing care homes per 100,000 population.
- Non-Elective admissions/100,000 population
- Percentage of older people (aged 65yrs+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Delayed Transfers of Care (DToC) delayed days per 100,000 population
- Improving access to physiological therapies
- Improving mental wellbeing for people of all ages, including suicide prevention and reducing loneliness
- A&E 4 hour standard
- Ambulance performance standards

Key schemes across County Durham

Prevention

Promoting positive behaviours

Name of scheme: Embedding A Wellbeing Approach **Partner(s):** Whole system **Scheme dates:** January 2019 onwards

Need for the scheme: Taking a whole-system approach to population wellbeing reflects the need for coordinated collaborative delivery across a wide variety of sectors to create an environment that is consistent, interdependent and responsive to individual need; recognising people's life circumstances are not static and their support needs are often not singular or linear. This approach ensures provision is underpinned by population needs and not defined by service criteria, reflecting that key pillars of wellbeing such as self-efficacy, autonomy and health are not equally distributed across society.

Aim and benefits of scheme: The development of our wellbeing model will be guided by a set of principles. These will inform the review of relevant wellbeing services. They include the following:

1. Based on need, assets and evidence based interventions
2. Building empowerment, resilience and capital through community led and co-produced solutions
3. Reducing health inequalities through a life course approach that considers prevention and early intervention at every opportunity
4. Building on our successes
5. A Whole System Approach to population wellbeing
6. Value for money and collaborative commissioning
7. Aligned to our local health and wellbeing strategies.

Name of scheme: Children's mental health and resilience **Partner(s):** Whole system **Scheme dates:** April 2020

Need for the scheme: The County Durham CYP MH local transformation plan (LTP) takes a Thrive approach which ensures we start at the point of promoting good mental health and developing protective factors such as building resilience in children and families. There are currently good programmes of work in place across County Durham operating at an early help stage such as parent peer support and children's bereavement support but these are short term funded. Young people who experience a complex bereavement are known to be at greater risk of self harm and suicide. By ensuring effective bereavement support is in place for young people who are more vulnerable they can build their coping mechanism's to consider alternative coping strategies to self harm and can avoid suicidal ideation. If these lower level mental health support services are not in place the risk is that parents are less able to manage young people's mental health issues at home and needs are escalated to acute treatment services such as Child and adolescent mental health services . The LTP seeks sustainable funding for these two short term contracts. In addition to this County Durham will be submitting a wave two EOI for trailblazer funding when the call is announced which would provide additional investment for young people wrapped around school and FE settings..

Aim and benefits of scheme: Maintaining children's mental wellbeing, intervening early through evidence based interventions known to work, young people reporting improved wellbeing, fewer young people attempting to take their own lives

Prevention

Promoting positive behaviours

Name of scheme: Smoking in pregnancy **Partners**: Whole system **Scheme dates:** April 2020

Need for the scheme: At 18.4% across Durham we have higher than national numbers of women still smoking at time of delivery. This is unevenly distributed across County Durham with more women in deprived communities still smoking demonstrating significant inequalities. There has been great efforts made to reduce this % and the trend line is going in the right direction. However to achieve the national ambition of less that 6% of women still smoking at time of delivery by 2022 there is a significant amount of work to do across all partner agencies. County Durham has established a multi disciplinary steering group to drive an action plan forward to tackle the inequalities – working under the regional local maternity system (LMS). Work this next year includes improving ownership of the issue in maternity services, changing the narrative to a one of addiction and treatment, workforce development and better capturing of data to drive improvement.

The stop smoking services will also be reviewed during 2019/20 to ensure it reflects local need.

Aim and benefits of scheme: Fewer still births; fewer neonatal deaths; fewer low birth weight babies; better outcomes for mum

Name of scheme: Obesity / healthy weight **Partner(s):** Whole system **Scheme dates**: April 2020

Need for the scheme: County Durham has 23.7% reception age children and 36.2% of year 6 children with excess weight; at present these % are not reducing. We also have over two thirds of the adult population estimated to be overweight. The whole system healthy weight action plan sets out the work to be achieved which for the next year includes a focus and commitment to preventing children from becoming overweight in the first place through dedicated work during maternity and early years. Significant work is underway and must continue on changing the lived environment such as work on fast food takeaways, workplaces through health at work scheme, active travel and extensive work in schools such as the promotion of Active 10,20,30 (daily mile). Work is also linked to the County Durham child poverty plan and supporting out of school activities to include healthy food. Work with culture and sport is critical and aligning with the wellbeing approach and social prescribing will happen over the next year.

Aim and benefits of scheme: Excess weight and obesity have both short and long term impacts on the health and wellbeing of people but also impacts upon the economic outcomes of the County due to the known link between increased levels of absenteeism and obesity related ill health. Reducing obesity will in turn reduce the risk of type two diabetes, risk of cancer, risk of CVD and also risk of poor mental health as there is a strong association between obesity and depression.

Mental Health

Mental health at scale

Name of scheme: Recovery Approach **Partner(s)**: TEWV **Scheme dates**: April onwards

Need for the scheme: This is a TEWV-wide priority to change our processes and culture to support a personalised, well-being focussed approach to care. It will help service users find connectedness, hope, identify, meaning and empowerment. There is a need for this because traditional service delivery did not always focus on individual service user's goals were, or what would best sustainably support their wellbeing. We have also identified that care planning has in some cases become a bureaucratic exercise which is not assisting service user recovery nor informing the treatment and support offered by staff.

Aim and benefits of scheme: Outputs are continued increase in courses available at the Durham Recovery College and Recovery College Online, and service users become students at both of these. Increase in number of "expert by experience" roles in the Trust and peer workers. Delivery of a new way of developing and recording care plans. These outputs should lead to benefits such as an increase in patient satisfaction and improved clinical outcomes.

Name of scheme: Right Staffing **Partner(s)**: TEWV, Sunderland and Teesside Universities **Scheme dates**: April onwards

Need for the scheme: The NHS Long Term Plan will require an increase in the mental health workforce. However workforce supply is currently constricted and many mental health staff are reaching an age at which they can retire. Therefore we need to improve training, recruitment and retention while also improving the way we plan and roster to ensure the right number of staff, with the right skills are available at the right time in wards and community teams

Aim and benefits of scheme: Outputs include: Increased numbers of mental health and learning disability clinicians (including through increased places at Sunderland and Teesside universities); investment into apprenticeships, including degree apprenticeships to reduce liability for the Apprentice Levy; improvement in establishment and rostering practice, development of more varied clinical career pathways leading to improved staff retention. The aim is to be able to deliver high quality services that contribute to improving people's mental health and wellbeing by having the right staff in the right place with the right skills. Benefits will be consistency of staffing, safe levels of staffing, reduction in use of agency staffing, able to offer full range of therapeutic interventions to more people.

Mental Health

Mental health at scale

Name of scheme: Crisis Hub **Partner(s):** TEWV **Scheme dates**: 19/20 Q1 – Q3

Need for the scheme: Commissioner review and feedback from service users / stakeholders (including Durham Overview and Scrutiny) identified that the current crisis service offer is not consistent across the county, and there can be difficulties for service users regarding access. The existing Crisis House in Shildon does not clearly offer value for money or accessibility to all County Durham residents and the potential for a safe haven model will be explored.

Aim and benefits of scheme: Develop a single crisis team that works across the County, with more consistent quality and improved access arrangements for service uses. Benefits will be improved service user experience and reduced waiting time to access the service.

Name of scheme: Children & Young People (CYP) Neurodevelopmental pathway **Partner(s):** TEWV **Scheme dates:** 19/20 Q1 – Q3

Need for the scheme: To provide streamlined pathways for Children and Young People with autism, and / or with a learning disability to ensure they receive the right support promptly.

Aim and benefits of the Scheme: The output will be to complete an improvement event utilising TEWV's Quality Improvement Methodology to review current pathways and to agree streamlined processes to ensure children and young people receive the right support the first time. The benefits should be reduced waiting time for children and young people with autism or a learning disability to receive an assessment and signposting to appropriate post-assessment treatment or support.

Learning Disabilities

Name of scheme: Review of integrated community service **Partner(s):** Durham County Council **Scheme dates:** Q1-Q3

Need for the scheme: The changes to Learning Disability provision in line with the national Transforming Care agenda has achieved a reduced reliance on inpatient services. This is supported by investment in an enhanced community service and improvements to case management already developed across Durham, Darlington and Tees. A formal review of the integrated community team will be completed to identify any improvements to ensure the service model remains responsive to need..

Aim and benefits of scheme: To undertake a review of the integrated service in Durham to ensure it remains fit for purpose to meet current and future needs.

Name of scheme: Joint LD commissioning Strategy **Partner(s)**: whole system **Scheme dates**: Q1

Need for the scheme: The health and quality of lives of people with learning disability are often worse than other citizens. Therefore, it is often necessary to provide paid public support to address the inequalities people with learning disability experience.

Aim and benefits of scheme: Our shared vision is for all people with learning disability to have a good life in their community with the right support from the right people at the right time. We remain committed to driving up quality and value for money; making changes that result in positive outcomes; responding to local needs and meeting statutory requirements. For this to become a reality we must commission the right types of services from the right providers. Through effective procurement, monitoring, workforce development, partnership working and support, we must ensure that organisations that provide health and social care have sufficient capacity and high calibre staff to deliver the best outcomes for people who use these services and for their families and carers.

Primary Care

Better quality of life through integrated health and care services

Name of scheme: Improving Access to General Practice **Partner(s):** GP Practices, Federations, NHSE, NHS 111 (NEAS) **Scheme dates**: cont. 2019 onwards

Need for the scheme: Improving access to General Practice and Primary Medical Services is a key deliverable of the GP Forward View (2016). It is a key component due to public demand to access primary care services at a time convenient to all.
From July 2019, the Extended Access DES (not the above) requirements are to be introduced across every network, until 2021. The CCGs will support implementation. From 2021 both these access initiatives will be combined.

Aim and benefits of scheme: The aim of the service is to provide the population of County Durham with 7 day access to a GP or nurse appointment at a time and place that better suits individual need. Currently the 7 day services are being delivered from hubs in the community across both CCG areas, appointments are available with a GP, nurse or health care assistant, depending on patient need. This will also impact on the pressure of urgent and emergency care services. Following the independent report from the CCG public consultation on Improving 7 day access to Primary Care the CCG will work with partners to implement any changes identified to the current model. The Durham CCGs will continue to monitor the service to ensure utilisation rates continue to be high and agree actions with stakeholders should this change.

Name of scheme: Primary Care Networks **Partner(s)**: GP Practices, Federations, NHSE, providers **Scheme dates**: 2019 onwards

Need for the scheme: The NHS Long Term Plan describes Primary Care Networks (PCN) as the essential building blocks of an Integrated Care System. On 31 January 2019 NHSE published Investment and evolution: A five year framework for GP contract reform to implement the NHS Long Term Plan. A key component of the framework is the introduction of the Network Contract Direct Enhanced Service (DES), general practice takes the lead role in every PCN. The framework sets out clear guidance to CCGs and practices on their roles in delivering on the PCN component.

Aim and benefits of scheme: The aim of PCNs is to support sustainability for GPs and Primary Care Services and to deliver a whole system Integrated Care System. DDES CCG and North Durham CCG have been supporting practices to work in an integrated way, with community and social care providers. DDES CCG practices have developed Primary Care Homes (PCH), 8 PCH teams working across the CCG and North Durham CCG has developed Teams Around Patients (TAPs), 5 TAPs teams working across the CCG.
During 2019 the CCG will support the current PCH and TAPs to transition to PCNs in line with the requirements of the NHSE framework.

Primary Care

Better quality of life through integrated health and care services

Name of scheme: Recruitment in General Practice **Partner(s):** GP Practices, Federations, NHSE, HEE **Scheme dates**: cont. 2019 onwards

Need for the scheme: Faced with an ageing population living with increasingly complex health needs and a chronic shortage of GPs and nursing staff, primary care is experiencing an unprecedented pressure, including recruitment and retention issues. Workforce transformation based around new models of care and skill mix is developing but not without challenges.

Aim and benefits of scheme: North Durham CCG and DDES CCG have developed a 5 point plan, specifically to deal with primary care workforce challenges;

- GP Career Start scheme – an initiative aimed at attracting GPs at an early point in their career and offers additional personal development for 2 years
- Federated Salaried GPs – CCGs continually work with federations to develop a role for a salaried GP who can work into practices, long or short term
- International Recruitment – in partnership with NHSE, aims to recruit over seas GPs into local practices
- GP Resilience – aims to deliver a menu of support to help practices become more sustainable
- GP Retention Scheme – a package of financial and educational support to help doctors who might otherwise leave the profession, remain in clinical practice

The new GP five year framework addresses workforce shortfall in a number of initiatives. Initiatives include reimbursement for additional roles which include clinical pharmacists, social prescribing link worker, physiotherapists, physician associates, community paramedics. Roles will be phased in starting with clinical pharmacists and social prescribing link workers in 2019. The CCG will support the development of these roles with local PCNs.

Name of scheme: GP Resilience/Quality **Partner(s)**: GP Practices, NHSE, LA, PPI groups **Scheme dates**: 2019 onwards

Need for the scheme: To offer support to practices and NHSE in responding to requests for changes to primary care medical service contracts.
To support sustainability of general practice to ensure patients are able to access save and equitable primary care services across County Durham.

Aims and benefits of the scheme: To follow a formal governance process to ensure the public is consulted on any changes which may result in changes to services whilst supporting sustainability of GP services. In early 2019 the follow requests for contract variations have been agreed or are in the process of consultation:

- Shotton Practice and Station Road Practice to merge and become Bevan Medical Group – approved
- Skerne Medical Practice request closure of branch sites at Fishburn and Trimdon Village – Trimdon Village approved, Fishburn not approved
- Phoenix Medical Practice to merge with East Durham Medical Group – still active
- New Seaham Medical Practice to move out of the main site at St Johns and conduct all services in the Easleigh building – still active
- Bowburn Practice and Belmont and Sherburn Practice, request for change in partnership – still active

In addition the CCG support practices with a programme of resilience initiatives (in addition to recruitment above) which include, support packages for mergers, GP resilience fund applications, vulnerability/sustainability indexing, peer support register. Adults Wellbeing and Health Overview and Scrutiny are chairing a cross party group to look at the resilience issues in General Practice and how the County Durham system can support the agenda.

Community Care

Better quality of life through integrated health and care services

Name of scheme: Intermediate Care Plus Crisis Response **Partner(s)**: DCC, CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The Intermediate Care Plus (IC+) service was developed in partnership with DCC, CCGs and CDDFT. The crisis response service provides a two hour response to patients who experience a health crisis and require fast access to physical health and/or social care services to either prevent admission to hospital/a care home, to support discharge and reablement and to support a return to independence. The model operates differently across County Durham. To support the updated specification and tender process for community services it was agreed that the crisis response element of the IC+ service would be reviewed.

Aim and benefits of scheme: The expected outcomes/benefits of the review are as follows:

- Service to be delivered within a consistent model across the whole of County Durham i.e. staffing structures etc.
- Operate with standardised approach and processes
- Provide absolute clarity on pathways in out of service and the customer/patient journey.
- Recipients of service to be broadened to include palliative care and Mental Health Services for Older People
- Incorporated Trusted Assessment and discharge to assess principles.
- Have sound budget management, including management of care package costs.
- Comply with the principles of the Community Services contract i.e. promote integration and the devolvement of resources to a TAP level wherever possible

Name of scheme: Teams Around Patients Implementation **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: To improve care for frail and elderly patients and to improve coordination of health and social care services. To reduce duplication in the provision of care and to devolve resources to local populations of c30,50,000 patients .

Aim and benefits of scheme: To promote much closer working across all disciplines so ensuring an effective approach that encourages relationships which work to support people who are at risk of losing their independence through ageing and/or frailty and disability. To provide appropriate support in the community to avoid admission to hospital or long term admission to nursing/residential care and to facilitate timely discharge from hospital or care wherever possible.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: Stroke rehabilitation services **Partner(s)**: CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: There is a need to improve health outcomes for those who have had a stroke within County Durham and to ensure that the model of care is standardised and improved across the local geography. NICE Guidance and the National Clinical guidance for stroke suggest that intensive stroke rehabilitation needs to occur in the Community at the earliest opportunity with patients having as few "hand-offs" of care as possible.

Aim and benefits of scheme: Recovery and patient experience will be improved for patients. Engagement with patients has highlighted that the following are priorities for improvement:

- Communication challenges various points in the patient pathway
- Emotional wellbeing and support, particularly post discharge
- Inconsistency of community rehabilitation provision
- People would appreciate a longer period of therapy once discharged from a hospital setting

Name of scheme: Ward 6 Inpatient Rehabilitation Services **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Ward 6 is an inpatient rehabilitation ward based in Bishop Auckland Hospital. Inpatient rehabilitation is delivered in a number of different ways across the acute and community hospital sites in County Durham. The current pathways in and out of ward 6 the inpatient rehabilitation ward are currently being reviewed to ensure that patient's needs are being met in the most appropriate way.

Aim and benefits of scheme: To engage with patients and stakeholders to understand views on current service provision and to develop options for future service provision. To develop a best practice model for inpatient rehabilitation that supports recovery following acute admission.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: Musculoskeletal (MSK) Integrated Model **Partner(s)**: CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Currently, around 20% of GP referrals into orthopaedic out patients are discharged with no procedure, suggesting that these patients could have been treated or assessed within MSK services without the need to attend hospital. Historically, there were two models of MSK services delivered across the county; Tier 1 Physio Hub model (North Durham and DDES) and the Tier 2 Pathway (North Durham only), which stopped short of a fully integrated MSK model by allowing direct non-red flag GP referrals to orthopaedics under a shortened criteria agreed with CDDFT clinicians and service leads. However, there were no contractual levers put in place to manage referrals into orthopaedics and waiting times in MSK have exceeded national standards.
Aim and benefits of scheme: An integrated MSK pathway will deliver a seamless pathway of care via a high quality integrated, multidisciplinary service for patients with MSK conditions. It will ensure that the service is efficient and cost effective by appropriately managing patients at all levels of the service, and provide a single point of entry for all patients with MSK problems . The service will be the only route to specialist care outside of acute trauma and emergencies, and will provide an MDT approach in the triage, assessment and treatment of patients, involving orthopaedics, rheumatology and chronic pain. The service will prevent patients bouncing around the system (fewer avoidable cross referrals) by providing the most appropriate service before an appointment is given – right clinic, first time.

Name of scheme: RightCare Respiratory Project Group **Partner(s):** CCGs, DCC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Non-elective admissions to hospital for people with chronic lung conditions, such as COPD, are high within the county. Many admissions are avoidable if the person's condition was better managed at home and in the community through a range of measures from across the health and care system. Whilst rates of COPD are high due to legacy reasons they were still identified by NHS England as presenting an opportunity to reduce these.
Aim and benefits of scheme: A system-wide project group was established in 2017 from across Primary, Community and Secondary Care to consider what approaches could be undertaken to reduce the non-elective admissions. Since this time the group has expanded to included CDCC Public Health and British Lung Foundation patient representation. In 2019 the group will deliver a new model of diagnostic spirometry which will increase the positive diagnosis of those with COPD and reduce the likelihood of a receiving a 'false-positive' diagnosis. The group is also rolling out a smart-phone / tablet application for the self-management of COPD (MyCOPD) that promotes pulmonary rehabilitation, improved inhaler technique, and self-management through the monitoring of people's self-reported symptoms. The group is also promoting an approach to Shared Decision Making that places improved communication between health professionals and patients are the heart of decision making regarding treatment. The impact of the scheme has been a reduction in the number if non-elective admissions over 2018-19, and this is expected to continue into 2019-2020.

Out of Hospital Care

Better quality of life through integrated health and care services

Name of scheme: RightCare Cardiovascular Disease Project **Partner(s)**: CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Atrial Fibrillation (AF) increases the risk of ischaemic stroke, and if left untreated more so. Within County Durham there are just over 13,000 people with AF, of whom approximately 1,300 (23%) are not receiving treatment, with a predicted risk of 89 strokes occurring within this group within the next year. A further 97 stroke admissions are expected by people with no diagnosis of AF, but with multiple stroke risk factors. Variance across Primary Care in the detection and management of AF is significant, with certain practices ensuring all patients diagnosed with AF are receiving optimal treatment, with others not performing as well. There is a clear need to ensure all County Durham residents with AF are diagnosed and afforded optimal treatment to reduce their risk of stroke.

Aim and benefits of scheme: The scheme will firstly focus on the detection of previously unknown AF within the community, and apply evidence based risk assessment scoring to enhance treatment of their AF. Work will also be undertaken to educate staff within Primary Care as to the importance of detection, risk assessment and treatment of AF in the avoidance of stroke. It is envisaged that by using high quality Primary Care data areas of poor compliance with best practice can be targeted to ensure equitable access to detection and treatment for the whole population.

Urgent & Emergency Care, and non-elective admissions

Name of scheme: Urgent Care Treatment Centre Review **Partner(s):** CCGs, CDDFT **Scheme dates: April 2019 onwards**

Need for the scheme: A review and implementation of a new model of staffing across the Urgent Treatment Centres in County Durham. These centres include Bishop Auckland, Shotley Bridge, University Hospital of North Durham, and Peterlee. Both CCG's are in support of the models which will match staffing levels to demand in off peak areas and times.

Aim and benefits of scheme: The scheme will ensure that the service continues to meet the 100% breach standard to feed in to the Trust 95% standard for breaches, and ensure all patients are seen and treated within 4 hours of arrival or within allocated disposition time to maintain patient quality and satisfaction. It will implement the new staffing model in the Urgent Treatment Centres which will generate cost savings and efficient working, whilst improving home visits, speaking to dispositions, booking 111 'face to face' consultations and ensuring the full service is providing more robust GP cover in peak times and meets Urgent Treatment Centre standards.

Name of scheme: Non elective admissions/bed occupancy **Partner(s)**: CCGs, CDDFT **Scheme dates: April 2019 onwards**

Need for the scheme: This is a joint project between CDDFT, CCGs and other partner organisations to look at reducing non elective attendances, admissions and bed occupancy at Darlington Memorial Hospital, University Hospital North Durham and Bishop Auckland General Hospital.

Aim and benefits of scheme: The project aims to reduce the number of patients attending A&E, as well as improve the number of beds available on each site, to ensure improved patient flow. The four main areas of consideration are;

- System-wide A&E Attends Avoidance
- System-wide Admission Avoidance
- CDDFT Internal Processes
- System-wide Facilitation of Discharges

Planned Care, including surgery & outpatients

Name of scheme: 7-day Diabetes Nurse Specialist Team **Partner(s): CCGs,** CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The National Diabetes Inpatient Audit suggested that 1 in 6 inpatients have diabetes. These patients are at an increased risk of prolonged hospital stays due to complications associated with their condition, however most are admitted for something other than their diabetes, i.e. receiving orthopaedic or general surgical care. Currently the Diabetes Specialist Nursing Team covers 5 days, with associated Consultant cover.

Aim and benefits of scheme: The service will extend to 7-day for both Specialist Nursing and Consultant access, and will be available to all departments within the Trust, including Accident and Emergency, and Medical Admissions. It is expected that 75% of all inpatients with a diagnosis of diabetes will be reviewed by the team, with an expected reduction in the average length of stay, and a reduction in avoidable non-elective admissions.

Name of scheme: Ophthalmology Outpatients **Partner(s):** CCGs, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Within County Durham there is an over reliance upon Secondary Care for the management of non-complex ophthalmology care, most notably post routine surgery and for patients with stable conditions. There has also been a variance in the clinical pathways that people have accessed for post routine cataract removal depending upon which part of the County they live in.

Aim and benefits of scheme: Community Optometry services are able to provide high level of care for patients with non-complex needs, and therefore a redesign of the clinical pathways for stable glaucoma and post-cataract removal to access these services provides care closer to home, and reduces demand on Secondary Care services to deliver more complex care. A redesign of the post cataract removal assessment pathway will also ensure that all patients are seen in a 1-stop service, thereby eliminating the variance in experience across the County.

Planned Care, including surgery & outpatients

Name of scheme: Dermatology Outpatients **Partner(s):** CCGs, CDDFT **Scheme dates: April** Q1 and 2

Need for the scheme: Demand for Dermatology services continues to grow, with particular use of the 2 week wait referral pathway for people who's needs are found not to be as urgent as first thought. This increasing demand impacts on the ability of the service to appropriately manage both urgent and non-urgent activity. It also impacts on CDDFTs ability to meet cancer standards.

Aim and benefits of scheme: The use of tele-triage prior to an outpatient appointment enables the correct use of the clinics available. This is facilitated by the use of dermatoscopes with smartphone cameras in Primary Care, and a programme of education on what constitutes an urgent referral. There is also the development of Community Dermatology Services and enhancing Primary Care provision that will move activity from Secondary Care to the most appropriate community setting, providing care closer to home.

Name of scheme: Orthopaedic Centre of Excellence – Bishop Auckland General Hospital **Partner(s):CDDFT** **Scheme dates:** Q1

Need for the scheme: The opportunity to better utilise the upgraded theatres within the Bishop Auckland General Hospital site has been an ambition for some time with the ultimate end of creating a true centre of Excellence in Orthopaedic Surgery performed from the site in the future. This in turn would be supported by appropriate rehabilitation services both in the hospital setting and the community setting helping to improve recovery times for patients.

Aim and benefits of scheme: Substantial improvement in Referral to Treatment (RTT) performance for orthopaedic activity; Improved utilisation of theatre capacity on BAGH site.

Planned Care, including surgery & outpatients

Name of scheme: RightCare Genitourinary (GU) Project **Partner(s):** CCGs, CDC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: Non-elective admission for Urinary Tract Infection (UTI) within County Durham is higher than when compared with similar populations across the country. The reasons behind this are many with dehydration and misdiagnosis of delirium part of the picture, though any avoidable admission to hospital represents a poor patient experience and an outcome that could have been managed more appropriately. The RightCare GU project has brought together clinicians from across Primary, Community and Secondary Care to tackle this problem.
Aim and benefits of scheme: The project has multiple aspects including an education programme on the importance of hydration in care homes and by domiciliary care providers, the standardisation of catheter care across the health economy, and the appropriate assessment and treatment of delirium using the mnemonic PINCH-ME; **P**ain, **I**nfection, **N**utrition, **C**onstipation, **H**ydration, **M**edication and **E**nvironment which aims to reduce misdiagnosis and ensure optimal treatment is commenced.

Name of scheme: Operational Productivity Opportunities GIRFT / Model Hospital **Partner(s):** CCGs, CDC, CDDFT **Scheme dates:** April 2019 - onwards

Need for the scheme: The Model Hospital and Getting it Right First Time (GIRFT) are both generating Operational Productivity opportunities to improve patient pathways, for example improving the percentage of lap cholecystectomy which are performed as Day Cases instead of Inpatients.

Aim and benefits of scheme: The Model Hospital and GIRFT ambition is to identify areas of unwanted variation in clinical practice and/or divergence from the best evidence. The work will culminate in a report and set of national recommendations aimed at improving quality of care and also reducing expenditure on complications, litigation, procurement and unproven treatment.

End of Life

Name of scheme: 7 Day Community Nursing Service **Partner(s):** CDDFT **Scheme dates:** Q1-Q4

Need for the scheme: Previously the Community Palliative Care Nursing Team provided services Monday to Friday, 9-5. This meant that patients whose condition deteriorated at the weekend had very little option in terms of accessing appropriate specialist support, and often led to otherwise avoidable attendances at Accident and Emergency and subsequent non-elective admissions, in spite of patient choice not to be admitted to hospital.

Aim and benefits of scheme: By providing a 7–day service which now covers 9-5 at the weekend the Community Palliative Care Nursing Team are able to support patients at times of need, and where appropriate allow them to remain in their preferred place of residence. The result will allow for fewer unnecessary and avoidable attendance to Accident and Emergency over the weekend, and provides a significantly enhanced quality of service to patients.

Name of scheme: Six Steps for Care Homes **Partner(s):** DCC, CDDFT **Scheme dates:** TBC

Need for the scheme: Provision of training for End of Life care within residential and nursing care homes has been patchy and sporadic, and the resulting outcomes for residents has been poor. As the cohort of care home patients at End of Life grows there is a greater need for appropriately trained staff that are able to meet the needs of this patient group.

Aim and benefits of scheme: The Six Steps approach, which is a recognised best practice End of Life training programme for care homes, which has been undertaken elsewhere in the country, and is being considered by the Palliative Care Task and Finish Group. Data is currently being collated and steps are being made to resource the programme. Appropriate resourcing will allow for a consistent approach to delivery of End of Life care, which has been shown to significantly improve outcomes for care home residents. This includes improving conversations about conditions, fewer attendances at Accident and Emergency and associated avoidable non-elective admissions, and improved clinical skills in areas such as syringe driver administration.

Governance – leadership and accountability

The County Durham Integrated Care Board (ICB) works alongside the Health and Wellbeing Board. The ICB provides senior system wide leadership and accountability to support the vision and direction of travel set out in the County Durham Health and Care Plan. There is an Integrated Steering Group for Children that provides senior leadership across partners in respect of the priorities for children and young people.

There are a number of sub groups, set out in the overarching shared County Durham Partnership structure that support the work of the ICB and Integrated Steering Group for Children.

It is important to note that each partner as a statutory organisation retains accountability to its own governing body.

Within the ICB arrangements outlined, partners have agreed to plan together. A health, social care and prevention planning group has been established, reporting to IBC, with representatives from each organisation. The aim is to support the development of:

- an annual Durham Health and Wellbeing System Plan
- a long term plan taking account of Health and Wellbeing Board priorities and the recently published NHS long term plan.

Governance – delivery

To support and coordinate delivery of the Health and Wellbeing System Plan the following mechanisms have been established by partners. Their aim is to reduce duplication support partnership working:

- **Groups to support the Integrated Steering Group for Children -** with a focus on SEND and other priorities
- **System assurance group** – chief officer level responsible for assurance of delivery including performance.
- **Programme board** – oversight of the key programmes and escalation to the system assurance group.
- **System delivery group** – operational delivery and implementation of plans
- **Planning group** – supports the development of the annual Durham system plan and long term plans.
- **Local A & E delivery board** – oversight of the urgent and emergency care system for County Durham

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