Special Adults, Wellbeing and Health Overview and Scrutiny Committee

Date	**Friday 7 September 2018**
Time	**9.30 am**
Venue	**Committee Room 2 - County Hall, Durham**

Business

Part A

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

1. Apologies
2. Substitute Members
3. Declarations of Interest, if any
4. Any Items from Co-opted Members or Interested Parties
5. Community Hospitals Update - Report of the Director of Integration (Pages 3 - 16)
6. Shotley Bridge Hospital Update - Report of the Director of Corporate Programmes, Delivery and Operations, North Durham Clinical Commissioning Group (Pages 17 - 28)
7. NHS England Review of Specialised Vascular Services - Report of the Director of Transformation and Partnerships and presentation by representatives of NHS England's Specialised Commissioning Team, County Durham and Darlington NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust and North East Commissioning Support (Pages 29 - 40)
8. Review of Urgent Care Hubs across Durham Dales, Easington and Sedgefield CCG - Joint Report of the Director of Transformation and Partnerships, Durham County Council and Sarah Burns, Director of Commissioning, DDES CCG and presentation by representatives of DDES CCG and North East Commissioning Support (Pages 41 - 106)

9. HealthWatch County Durham Annual Report - To consider the report of the Director of Transformation and Partnerships and a presentation by HealthWatch County Durham. (Pages 107 - 136)

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
30 August 2018

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

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

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

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

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

Special Adults Wellbeing and Health Overview and Scrutiny Committee

7 September 2018

Community Hospitals in County Durham - Update

Report of Lesley Jeavons - Director of Integrated Community Services.

Introduction and Purpose of the Report

1. In April 2017 the Financial Recovery Group (FRG), a meeting of senior officers from County Durham and Darlington Foundation Trust (CDDFT) and North Durham and Durham, Dales, Easington and Sedgefield (DDES) Clinical Commissioning Groups (CCG), requested that consideration be given to the role and function of part of the community hospital offer across County Durham with a view to recommending options for service delivery over a medium to long term.

2. This report references key issues that have been considered to date with the purpose of informing AWH OSC on strategic intent.

Background

3. The community hospital estate across County Durham is as follows:

Community Hospital	Bed Compliment
North Durham	
Shotley Bridge	8
Chester-le-Street Community Hospital	16 - 23
DDES	
Peterlee Community Hospital	Owned by NT&H FT and Barchester 0 beds other than IS
Sedgefield	16
Weardale	16
Richardson	16
Bishop Auckland	24 step down (ward 6)

4. All three CCGs, North Durham, DDES and Darlington, commission activity within Community Hospitals in County Durham. Darlington CCG currently commission 971k level of activity, across all 3 DDES sites although more recently their rate of admission to the Richardson Hospital has fallen, with alternative provision being commissioned from the independent sector. Work is needed to clarify their position going forward.

5. A previous review had been undertaken which considered the activity within the community hospitals in Durham, Dales, Easington and Sedgefield (DDES) locality only, which are:

- Sedgefield Community Hospital
- Weardale Community Hospital and
- Richardson Community Hospital

6. The review was led by the Director of Commissioning, DDES and was initiated as a result of falling demand and occupancy levels across the three hospitals with associated revenue cost pressures identified by CCDFT. The review recommended a number of short-term actions resulting in bed reductions across two of the hospitals i.e. Sedgefield and Richardson and an additional reduction in length of stay across all three. Previous bed modelling activity undertaken by County Durham and Darlington Foundation Trust (CDDFT) had identified the potential to reduce the bed profile across the DDES community hospitals (other than Peterlee CH) to 48.

7. The review also identified a need to update the specification for Community Hospitals and this work will be undertaken as part of the community contract mobilisation process.

8. It is also relevant to note that the funding of the three DDES Hospitals is via a block contract whereas prior to April 2018, the funding of the two North Durham hospitals and Bishop Auckland Hospital was funded via a payment per admission. This is relevant as prior to April 2018, CDDFT were funded via activity and bed take up as opposed to receiving a block amount of funding regardless of activity. Furthermore Chester le Street is subject to a PFI agreement, held by CDDFT.

9. As reported to OSC previously, a dedicated programme of work has been underway for some time in relation to the role, function and future of Shotley Bridge Hospital and this is subject to a separate update.

Review Context

10. Following the request from FRG, the objectives outlined below were to be considered further:

- Clarity on the bed take up and activity delivered from the DDES sites following the reduction outlined above
- Consideration of the effectiveness of the community hospital offer generally and
- Clarity on lease agreements and impact of any change to these.

Review Findings

Existing Bed Function

11. The bed compliment and service offer differs across all of the hospitals although as referenced above the DDES hospitals were reconciled to 16 beds each in September 2017.

12. At the time of review Chester-le-Street hospital has a maximum of 23 beds with Shotley Bridge hospital operating with 8.

13. The main function of the inpatient beds in the hospitals is to provide a rehabilitation and step-down facility. Only two, Weardale and Richardson, offer 14 Intermediate Care (IC) beds with other localities across the county utilising the independent sector for this service with wrap around community services provided by CDDFT. This forms part of the community contract with additional funding from the Better Care Fund.

14. The Local Authority leads the existing commissioning arrangement of independent sector beds delivering a mix of block and spot contracts, totalling 73 beds across the county.

15. Community Hospital bed utilisation had fallen intermittently between 2016/2017 across Sedgefield, Weardale and Richardson and this information was used as rationale for the reduction in beds from 24 to 16 in September 2017. Up to date information on occupancy is featured at appendix 2 of this report.

16. From the work undertaken to date it is clear that beds continue to be utilised to facilitate discharge from acute sites, whether or not the patient is felt to be eligible for IC or rehabilitation. This depends on pressure within the system and beds are sometimes required as part of system-wide escalation plans to facilitate patient flow. Whilst helpful in this regard, it can also result in patients experiencing two discharges prior to returning home. Community hospital staff reported occasions where they believe this has been to the detriment of patients who could have returned home in the first instance. The discharge to a community hospital being considered a speedier discharge than home. This practice has been confirmed by the Discharge Management Group and work is underway at an operational level to address this issue and to manage admissions and discharges from the community hospitals more effectively.

17. The majority of Intermediate Care beds exist within the independent sector. The Local Authority leads the existing commissioning arrangement delivering a mix of block and spot contracts, totalling 73 beds across the county. Wrap around therapeutic services are provided by CDDFT and this forms part of the community contract with additional funding from the Better Care Fund.

18. Independent sector IC bed take-up is relatively high but it is rare that beds are fully occupied. Difficulties do occur however in terms of choice and location of beds; particularly in Chester-le-Street and the Dales locality where block contract IC bed provision is low. The review of the intermediate care bed model carried

out by Durham County Council prior to recommissioning in 2016, identified some quality issues that have been addressed through the larger block provisions. There are concerns however regarding the local national impact of nurse recruitment with a number of homes deregistering their nursing provision.

Estate

19. There are different arrangements in place in relation to capital recharge for community hospital buildings. Where agreements have a significant period to run i.e. 13 years in the case of Richardson and Sedgefield, this remains a cost pressure on the whole of the NHS.

Current Position in Relation to Service Delivery

Staffing (non-medical):

20. Whilst providing nursing staff is no longer an issue across the community hospitals, should it become so in the future CDDFT would flex beds to ensure a safe, responsive service was in place across all of the Community Hospital estate.

Medical Cover:

21. This is delivered by local GPs for Weardale, Sedgefield and Richardson Hospitals via annual SLAs between CDDFT and the identified GP practices. This has been difficult to secure at times and at times has provided a variable model of cover in each hospital. It is generally telephone access Mon to Fri 0900 to 1800 and one to two ward round visits per week. Out of Hours cover is provided via the local Out of Hours Services accessed via 111 or 999. There will be opportunities going forward to look at how medical cover can be provided in new innovative ways.

22. Medical cover is provided directly by CDDFT at Chester-le-Street and the adjacent GP practice to Shotley Bridge Hospital has been commissioned by CDDFT to provide cover there. Whilst not referred to as formal medical cover, the utilisation of specialists in geriatric medicine and GPs with Special Interest remains relevant to the community offer for the frail elderly. Recent discussions have taken place with the Care Group Medical Director and his colleagues regarding opportunities to offer specific sessions in North Durham to Teams Around Patients (TAPs) whilst continuing to offer a Rapid Access Service in under-utilised clinics within hospital bases. This is an important service development opportunity as is shifts the emphasis away from acute hospital environments to a service offer closer to a patient's home.

23. The Care Group Director of CDDFT's Integrated Care Group would like to enhance the level of Consultant oversight and intervention across the service. It is his view that where consultants and GPs work together, the throughput and follow-up for patients is more positive.

Therapy

24. The availability of sufficient therapy continues to be an issue. It is widely agreed that there should be a greater therapeutic emphasis within the existing community hospital offer. CDDFT have experienced difficulties with recruitment and retention across all sites and this will require further consideration. This will be addressed through the implementation of the new community contract.

Day Hospital Function

25. All community hospitals operate a day hospital service within a clinic based model.

26. This provides specific therapeutic input and is delivered in line with models of rehabilitation elsewhere in the country. It is important that a community hospital resource maintains its emphasis on rehabilitation and reablement. However it should be noted that this is dependent on the successful investment and recruitment/retention of therapy staff.

Delayed Transfers of Care (DToC)

27. Work has been undertaken to understand the nature of DToC activity across County Durham. The information considered does not identify a significant problem with DToC although work to reduce the length of stay will be of benefit to patients.

Other Services Delivered from Community Hospitals

28. Community Hospitals provide more than beds and in-patient units. Examples of the additional services provided across all Community Hospital sites are listed below:

- Secondary care outpatient clinics.
- Community rehabilitation.
- Podiatry.
- Falls clinics
- Mainstream physiotherapy and occupational therapy.
- Diagnostics.

Strategic Landscape

29. In 2015 the Health and Wellbeing Board in County Durham tasked Chief Officers from the NHS and Local Government with identifying an enhanced integrated service offer for County Durham. This resulted in work being undertaken to outline a new model of care that placed the patient at the centre of services, within their own communities. This included the support of multi-disciplinary teams, to be delivered with primary care at the centre of activity and ensuring effective pathways led to services being provided in local communities. Elected

members will be familiar with this initiative which is referred to as Teams Around Patients (TAPs).

30. This model has been widely accepted and primary/secondary care and Durham County Council have been fully engaged in its development.

31. Through recent informal discussions GPs have expressed a view that Community Hospitals have an important function in that place based service provision.

32. There has been significant interest regarding the perceived loss of local services from members of the public and their elected representatives. Elected members have made very clear how much they and the electorate value local community hospitals and are supportive in relation to their retention. A reference group has been established in respect of the Richardson Hospital and similarly a senior officer/member reference group is in place in relation to Shotley Bridge Hospital. Experience has shown that local communities, including those affected by any major change to services benefit from ongoing engagement and consultation. In relation to the reference group aligned to The Richardson Hospital, the engagement of members of the local community has proven to be hugely beneficial in helping to best utilise void space and to influence key communications with the public

33. The issue of rurality and access to services including availability of transport is of critical importance to local people as is the availability of alternative bed based services in their locality.

Potential Alternative Use of the Estate to Offset Void Costs

Use for office accommodation

34. Work has been underway across the NHS and partner organisations to utilise space where it exists and consequently resultant void costs to the CCG follow.

35. As referenced above local people have been involved as part of the Richardson reference group to publicise the potential to utilise room for meetings and VCS activity. A proposal to utilise the empty ward at the Richardson for the Dales locality team comprised of nurses and social workers is also being considered by CDDFT and DCC.

36. At Sedgefield Community Hospital the CCGs have recently utilised a significant amount of void space for North Durham CCG staff so making savings on rental costs elsewhere.

Alternative use for other bed based services

37. The CCGs currently purchase 73 IC+ beds across the Independent Sector at a cost of £1.551million.

38. Based on existing bed numbers there is currently a significant cost differential between a community hospital bed and that which is provided by the independent

sector in respect of intermediate care. However, this is a complex service landscape and provision must not be predicated on cost alone. In the future partners may wish to consider the future nature of bed-based provision across the system including the type of interventions as well as where it should be delivered.

39. The potential need for hospice provision has been explored. Commissioners have no indication that the existing hospice offer is inadequate.

40. The direction of travel previously outlined is that of enhancing services to enable people to say at home. It is well documented that lengthy stays in hospital beds has a detrimental effect on people, particularly older people who are frail. The Integrated Care Partnership in County Durham is determined to enhance services that prevent the need for bed based services and provide care and support at home.

Conclusion

41. This paper summarises the work undertaken to date in relation to understanding the nature of the Community Hospital offer in County Durham and the use of beds across part of the estate

42. Since reducing the bed base in September 2017 across three of the hospitals it is clear that utilisation of the remaining beds is operating at a level which indicates the resource is being used effectively (see appendix 2). Furthermore CDDFT have the flexibility to open additional beds in times of surge and increased activity. This did occur during this winter and proved beneficial in managing demand across the system.

43. The link with a place based service offer also needs to be considered and as referenced in para 41, as TAPs develop further and community services are delivered within localities, it would appear that a locality based community hospital function as part of a menu of services, will be a valuable asset.

44. AWH OSC were advised on 2/05/2018 that in considering the issues outlined in this paper, that Chief Officers had received a recommendation from the then Director of Integration, that no change other than the work that is underway in respect of Shotley Bridge Hospital should be made to the Community Hospital estate. Furthermore whilst the continuing financial pressure across the NHS and social care economy must be recognised, it should be balanced against the reality of ongoing lease agreements and associated costs to both commissioners and providers should a premises close, as well as the availability of alternative services, the need for dispositions for patients from acute sites and the transport concerns of local people.

45. This does not however, negate the need for internal efficiencies to be explored and CDDFT are keen to carry out additional work in this regard.

46. There may be changes to the clinic activity carried out in community hospitals over time. This may relate to a range of factors, such as changes to commissioning pathways or clinical guidelines.

47. The previous bed reductions across the DDES Community Hospital estate will continue to be monitored and information gathered to inform whether the bed base is being utilised effectively. It should be noted that as more services are delivered in a community setting, activity and demand may reduce further, so requiring consideration to be given to further reductions in the future.

Recommendations and reasons

48. The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:

    a. Receive this update report for information.
    b. Note the work underway to utilise space across the estate.
    c. Receive a separate report in relation to Shotley Bridge Hospital.

Contact: Lesley Jeavons Director of Integration.

Appendix 1: Implications

Finance – financial commitment in relation to buildings will continue as per established agreements.

Staffing – challenges with recruitment exist across the NHS may continue. Situation monitored. Workforce planning in place within CDDFT.

Risk

Equality and Diversity / Public Sector Equality Duty

Accommodation – Community Hospital build arrangements differ across the county.

Crime and Disorder – N/A

Human Rights – N/A

Consultation – N/A

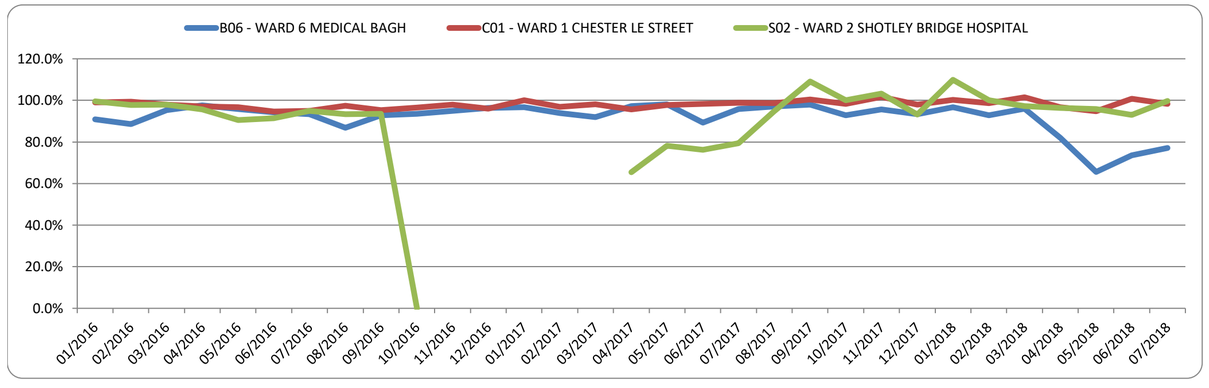
Procurement – N/A

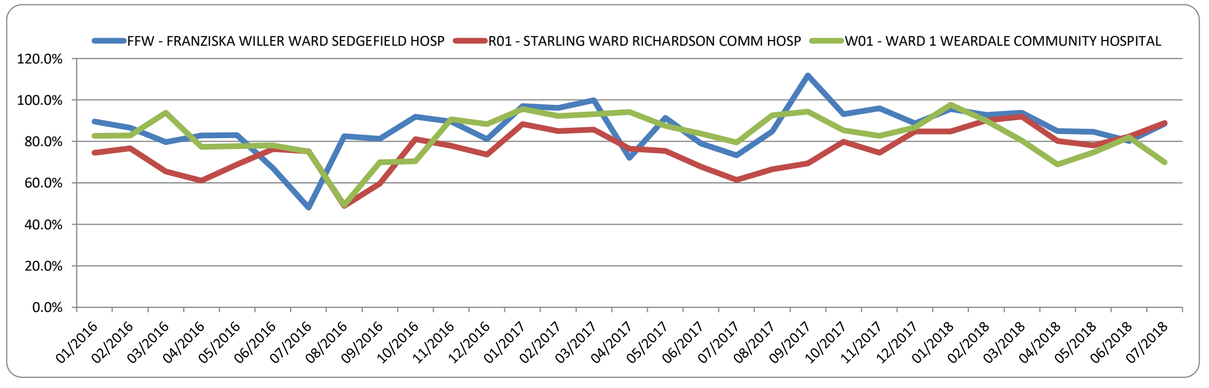
Disability Issues – Community Hospitals offer a range of services to older people and these with long term conditions.

Legal Implication

CDDFT - Community Hospitals - Midnight Bed Occupancy

Measure	Ward Name	01/2016	02/2016	03/2016	04/2016	05/2016	06/2016	07/2016	08/2016	09/2016	10/2016	11/2016	12/2016	01/2017	02/2017	03/2017	04/2017	05/2017	06/2017	07/2017	08/2017	09/2017	10/2017	11/2017	12/2017	01/2018	02/2018	03/2018	04/2018	05/2018	06/2018	07/2018
Available	B06 - WARD 6 MEDICAL BAGH	744	696	744	720	744	720	744	744	720	744	720	744	744	672	744	720	744	720	744	744	720	744	720	744	744	672	744	720	744	816	840
	C01 - WARD 1 CHESTER LE STREET	713	667	713	690	713	690	713	713	690	713	690	713	531	448	496	480	496	480	496	496	480	496	480	555	552	496	544	543	554	650	690
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	682	638	682	660	682	660	682	682	660	682	660	682	682	616	682	660	682	660	682	682	540	496	480	558	534	448	528	480	496	480	480
	R01 - STARLING WARD RICHARDSON COMM HOSP	744	696	744	720	744	720	744	744	720	744	720	744	744	672	744	720	744	720	744	744	672	496	480	558	518	448	499	480	496	480	480
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	496	464	496	480	496	480	496	496	480	CLOSED						104	248	240	248	248	240	248	240	310	293	277	296	308	308	298	300
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	620	580	620	600	620	600	620	620	600	620	480	496	496	448	496	480	496	480	496	496	480	496	480	546	523	448	504	480	496	480	480
	Total available beds	**3,999**	**3,741**	**3,999**	**3,870**	**3,999**	**3,870**	**3,999**	**3,999**	**3,870**	**3,503**	**3,270**	**3,379**	**3,197**	**2,856**	**3,162**	**3,164**	**3,410**	**3,300**	**3,410**	**3,410**	**3,132**	**2,976**	**2,880**	**3,271**	**3,164**	**2,789**	**3,115**	**3,011**	**3,094**	**3,204**	**3,270**
Occupied	B06 - WARD 6 MEDICAL BAGH	676	617	709	703	713	678	695	646	668	696	683	717	720	631	684	700	730	643	713	722	705	690	689	695	719	624	714	591	488	601	648
	C01 - WARD 1 CHESTER LE STREET	706	663	698	670	690	653	677	695	657	688	676	685	531	434	487	459	485	472	490	489	482	488	488	544	553	489	552	525	525	655	678
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	611	553	544	547	566	443	328	563	536	627	591	553	662	592	681	476	623	521	500	578	604	462	461	495	511	416	496	408	420	385	425
	R01 - STARLING WARD RICHARDSON COMM HOSP	555	534	488	440	512	549	560	364	430	603	561	548	658	571	638	551	561	488	457	496	467	396	358	473	439	404	459	385	387	395	427
	Non IC Plus Patients	*555*	*534*	*488*	*440*	*512*	*549*	*560*	*364*	*430*	*603*	*427*	*390*	*559*	*517*	*523*	*472*	*501*	*451*	*412*	*365*	*442*	*303*	*311*	*454*	*432*	*348*	*380*	*311*	*302*	*376*	*367*
	IC Plus Patients	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*134*	*158*	*99*	*54*	*115*	*79*	*60*	*37*	*45*	*131*	*25*	*93*	*47*	*19*	*7*	*56*	*79*	*74*	*85*	*19*	*60*
	IC Plus as % of Richardson Occupancy	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*23.9%*	*28.8%*	*15.0%*	*9.5%*	*18.0%*	*14.3%*	*10.7%*	*7.6%*	*9.8%*	*26.4%*	*5.4%*	*23.5%*	*13.1%*	*4.0%*	*1.6%*	*13.9%*	*17.2%*	*19.2%*	*22.0%*	*4.8%*	*14.1%*
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	494	454	486	459	449	439	471	463	449	CLOSED						68	194	183	197	235	262	248	248	289	322	277	288	297	295	277	299
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	513	481	582	464	482	469	466	306	420	437	435	438	474	413	462	452	434	402	394	459	453	423	397	474	511	403	405	331	371	394	336
	Non IC Plus Patients	*513*	*481*	*582*	*464*	*482*	*469*	*466*	*306*	*420*	*437*	*316*	*302*	*365*	*345*	*402*	*401*	*408*	*383*	*365*	*330*	*401*	*332*	*377*	*427*	*444*	*330*	*377*	*283*	*297*	*339*	*252*
	IC Plus Patients	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*119*	*136*	*109*	*68*	*60*	*51*	*26*	*19*	*29*	*129*	*52*	*91*	*20*	*47*	*67*	*73*	*28*	*48*	*74*	*55*	*84*
	IC Plus as % of Weardale Occupancy	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*27.4%*	*31.1%*	*23.0%*	*16.5%*	*13.0%*	*11.3%*	*6.0%*	*4.7%*	*7.4%*	*28.1%*	*11.5%*	*21.5%*	*5.0%*	*9.9%*	*13.1%*	*18.1%*	*6.9%*	*14.5%*	*19.9%*	*14.0%*	*25.0%*
	Total occupied beds	**4,110**	**3,836**	**3,995**	**3,723**	**3,924**	**3,780**	**3,757**	**3,401**	**3,590**	**3,654**	**3,507**	**3,489**	**3,703**	**3,212**	**3,590**	**3,257**	**3,588**	**3,197**	**3,208**	**3,475**	**3,440**	**3,103**	**2,999**	**3,443**	**3,494**	**3,017**	**3,373**	**2,922**	**2,873**	**3,102**	**3,240**
% Occupied	B06 - WARD 6 MEDICAL BAGH	90.9%	88.6%	95.3%	97.6%	95.8%	94.2%	93.4%	86.8%	92.8%	93.5%	94.9%	96.4%	96.8%	93.9%	91.9%	97.2%	98.1%	89.3%	95.8%	97.0%	97.9%	92.7%	95.7%	93.4%	96.6%	92.9%	96.0%	82.1%	65.6%	73.7%	77.1%
	C01 - WARD 1 CHESTER LE STREET	99.0%	99.4%	97.9%	97.1%	96.8%	94.6%	95.0%	97.5%	95.2%	96.5%	98.0%	96.1%	100.0%	96.9%	98.2%	95.6%	97.8%	98.3%	98.8%	98.6%	100.4%	98.4%	101.7%	98.0%	100.2%	98.6%	101.5%	96.7%	94.8%	100.8%	98.3%
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	89.6%	86.7%	79.8%	82.9%	83.0%	67.1%	48.1%	82.6%	81.2%	91.9%	89.5%	81.1%	97.1%	96.1%	99.9%	72.1%	91.3%	78.9%	73.3%	84.8%	111.9%	93.1%	96.0%	88.7%	95.7%	92.9%	93.9%	85.0%	84.7%	80.2%	88.5%
	R01 - STARLING WARD RICHARDSON COMM HOSP	74.6%	76.7%	65.6%	61.1%	68.8%	76.3%	75.3%	48.9%	59.7%	81.0%	77.9%	73.7%	88.4%	85.0%	85.8%	76.5%	75.4%	67.8%	61.4%	66.7%	69.5%	79.8%	74.6%	84.8%	84.7%	90.2%	92.0%	80.2%	78.0%	82.3%	89.0%
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	99.6%	97.8%	98.0%	95.6%	90.5%	91.5%	95.0%	93.3%	93.5%	CLOSED						65.4%	78.2%	76.3%	79.4%	94.8%	109.2%	100.0%	103.3%	93.2%	109.9%	100.0%	97.3%	96.4%	95.8%	93.0%	99.7%
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	82.7%	82.9%	93.9%	77.3%	77.7%	78.2%	75.2%	49.4%	70.0%	70.5%	90.6%	88.3%	95.6%	92.2%	93.1%	94.2%	87.5%	83.8%	79.4%	92.5%	94.4%	85.3%	82.7%	86.8%	97.7%	90.0%	80.4%	69.0%	74.8%	82.1%	70.0%
	Total rate of occupancy	**102.8%**	**102.5%**	**99.9%**	**96.2%**	**98.1%**	**97.7%**	**93.9%**	**85.0%**	**92.8%**	**104.3%**	**107.3%**	**103.3%**	**115.8%**	**112.5%**	**113.5%**	**102.9%**	**105.2%**	**96.9%**	**94.1%**	**101.9%**	**109.8%**	**104.3%**	**104.1%**	**105.3%**	**110.4%**	**108.2%**	**108.3%**	**97.1%**	**92.9%**	**96.8%**	**99.1%**





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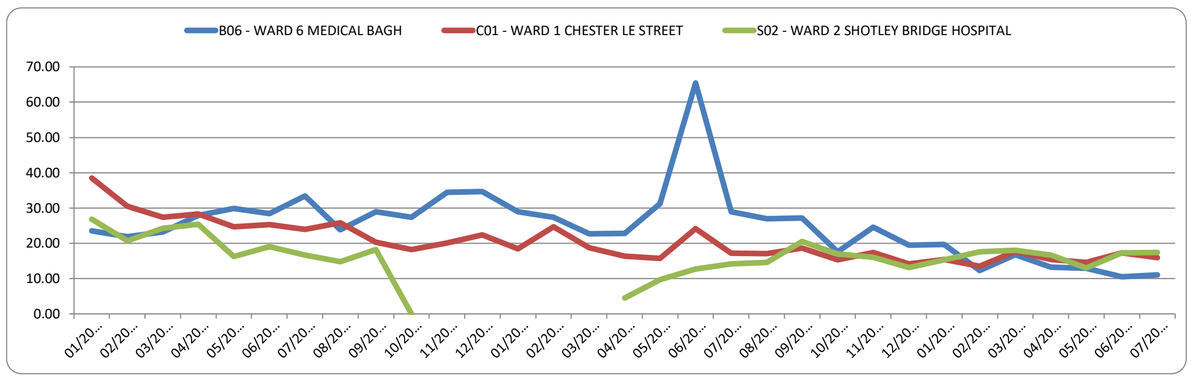
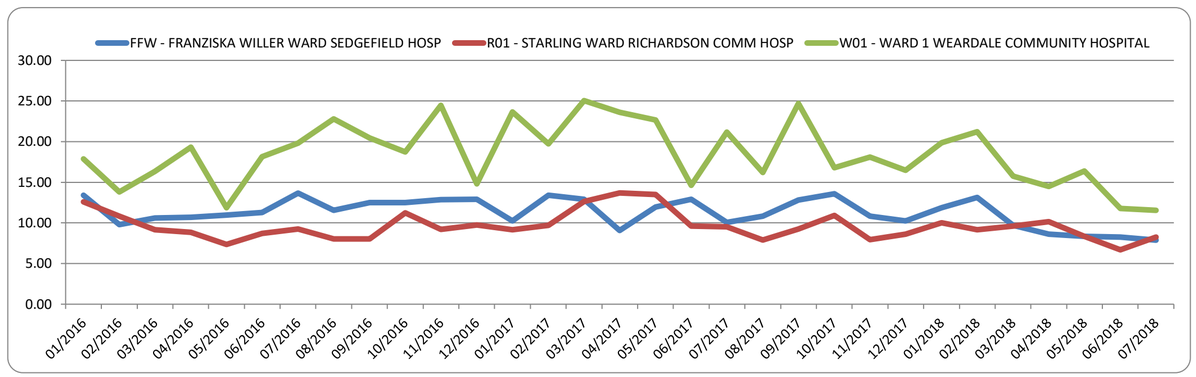
CDDFT - Community Hospitals - Average Length of Stay

Measure	Ward Name	01/2016	02/2016	03/2016	04/2016	05/2016	06/2016	07/2016	08/2016	09/2016	10/2016	11/2016	12/2016	01/2017	02/2017	03/2017	04/2017	05/2017	06/2017	07/2017	08/2017	09/2017	10/2017	11/2017	12/2017	01/2018	02/2018	03/2018	04/2018	05/2018	06/2018	07/2018
Average Length of Stay	B06 - WARD 6 MEDICAL BAGH	23.54	21.92	23.23	27.92	29.89	28.45	33.47	23.82	28.95	27.42	34.47	34.64	28.95	27.35	22.69	22.82	31.22	65.45	28.90	26.92	27.16	17.61	24.58	19.51	19.66	12.26	16.75	13.24	12.92	10.52	11.07
	C01 - WARD 1 CHESTER LE STREET	38.50	30.55	27.35	28.30	24.73	25.26	24.00	25.86	20.28	18.26	20.15	22.42	18.40	24.69	18.76	16.39	15.70	24.14	17.15	17.04	18.66	15.37	17.38	14.20	15.44	13.51	17.72	15.45	14.57	17.32	15.94
	FFW - FRANZISKA WILLER WARD SEDGEFIELD HOSP	13.42	9.79	10.60	10.71	10.95	11.30	13.67	11.57	12.50	12.49	12.87	12.92	10.24	13.40	12.91	9.06	11.97	12.92	10.06	10.81	12.81	13.57	10.82	10.23	11.85	13.13	9.70	8.61	8.36	8.25	7.88
	R01 - STARLING WARD RICHARDSON COMM HOSP	12.59	10.83	9.17	8.84	7.37	8.69	9.27	8.01	8.05	11.22	9.22	9.75	9.17	9.69	12.62	13.69	13.50	9.63	9.52	7.89	9.27	10.94	7.95	8.62	10.01	9.16	9.60	10.14	8.36	6.69	8.24
	S02 - WARD 2 SHOTLEY BRIDGE HOSPITAL	26.83	20.72	24.30	25.45	16.24	19.04	16.65	14.81	18.19	CLOSED						4.50	9.75	12.76	14.14	14.59	20.57	17.00	16.00	13.11	15.34	17.63	18.00	16.63	13.00	17.26	17.37
	W01 - WARD 1 WEARDALE COMMUNITY HOSPITAL	17.87	13.80	16.33	19.32	11.88	18.16	19.83	22.78	20.43	18.72	24.47	14.80	23.64	19.75	25.05	23.61	22.66	14.64	21.17	16.22	24.69	16.77	18.09	16.46	19.86	21.22	15.76	14.50	16.39	11.79	11.55
	Total rate of occupancy	**19.64**	**15.36**	**16.42**	**17.30**	**14.33**	**16.09**	**17.41**	**15.82**	**16.60**	**16.12**	**16.84**	**16.24**	**14.47**	**16.49**	**16.87**	**15.04**	**15.77**	**23.81**	**15.59**	**13.57**	**17.09**	**14.77**	**14.69**	**13.11**	**14.88**	**13.24**	**13.65**	**12.38**	**11.47**	**10.97**	**11.07**





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Special Adults Wellbeing and Health Overview and Scrutiny Committee

7 September 2018

Update – Shotley Bridge Hospital Project

Report of Mike Brierley – Director of Corporate Programmes, Delivery and Operations, North Durham Clinical Commissioning Group & Durham Dales, Easington and Sedgefield Clinical Commissioning Group.

Purpose of the Report

1. The purpose of this briefing note is to offer a further update in relation to the CCG's work concerning Shotley Bridge Hospital. This briefing note will outline:

    - The background to the project
    - The Functional case for change
    - The Strategic case for change
    - The Economic Case
    - The Financial Case
    - The Clinical case for change
    - Stakeholder briefing sessions (2017)
    - Progress made since last briefing (6th March 2018)
    - Issues to be resolved/possible outcomes
    - Decision making in healthcare – notes/guidance
    - Next steps and timescales

Background

2. Shotley Bridge Community Hospital (SBCH) is a NHS Property Services (NHSPS) freehold site comprising a medium sized hospital building circa 10,500 m2 gross internal area (GIA), which formed part of a larger hospital site, the majority of which has been demolished.
3. The buildings on the site consist of a six storey tower with basement containing wards, offices and various day services including a day theatre, outpatient's areas and various one and two storey extensions to the tower buildings containing ancillary services, outpatients, a restaurant and offices.
4. The main tower was constructed in 1969 with a two storey tower and basement with corridor link in circa 1950. A rear extension was added in circa 1990 with further extensions in 2001.
5. The associated building infrastructure services to the older blocks have not been replaced since their original installation and as such have exceeded the expected operational lifespan, leading to a number of operational risks.

6. North Durham CCG have been working alongside NHS Property Services to look at the area, the existing services being provided out of Shotley Bridge Hospital site and what future service delivery options may look like.

7. To support what will ultimately be an outline business case; discussions have taken place with our stakeholders from an early stage to look at options and possibilities for how future services may be delivered. North Durham CCG will continue talking with stakeholders to encourage openness and transparency.

The Functional Case for Change

8. Shotley Bridge Hospital's functionality and condition is not fit for the future. It no longer provides a clinically appropriate environment to meet the health needs of local patients. The configuration of the building limits what services can be delivered and does not support the delivery of proposed new models of care as outlined in the CCG's Commissioning Plan.

9. A 6 Facet Survey was carried out in 2009 and updated in 2015 which highlighted circa £2m (excluding VAT) of backlog maintenance being required over the next 5 years.

10. The operational costs to run Shotley Bridge are circa £1.8m per annum (exc. VAT).

The Strategic Case for Change

11. The NHS nationally and locally in North Durham, Durham Dales Easington and Sedgefield (DDES) and Darlington requires real planning to meet the needs of a population in which most of the disease is attributed to chronic diseases. We need to look carefully at how this can be delivered if the NHS is to be sustainable for the next generation.

12. The driver for change is the current state of the building. By reviewing the actual health needs in the area now (and looking at future need) gives us an opportunity to align our strategy to provide more care closer to home.

13. The ageing population in West Derwentside and surrounding areas, as well as an increased prevalence of chronic illnesses requires a move away from hospital care. To truly improve the health of the population, a move towards self-care and enabling the patient is needed. This requires more consistent provision of primary care, care that is well coordinated, planned and integrated but most of all, care that is delivered as close to a patient's home as possible.

14. Our aim is to improve the quality of community services by focusing on the frail elderly population and to ensure that we provide a modern, supportive environment for delivering high quality and integrated care in line with national objectives that we are expected to meet as an organisation.

The Economic Case for Change

15. As a CCG we pay void costs on any vacant clinical or non-clinical space. Over the years, it has been well documented that the cost of empty public space to taxpayers is millions and millions of pounds. This includes all public estate, not just health estate. There is a national drive for rationalisation of the estate, as well as release of poor or inadequate estate that is no longer fit for modern day healthcare. There is also some national interest in public sector organisations working more closely together when delivering their services through the 'One Public Estate' vision.

16. It is critical that any decisions we make as an organisation about future provision in the area not only meet the national and regional direction of travel in terms of estate costs, but that these also satisfy likely future clinical need. This future need may only be predicted based on the information we have available to us now. This includes information we have about current local service, future changes that are likely to impact the development, our own strategies such as Estates and our Teams Around Patients work and also information relating to our providers and how able they are going to be, to deliver services from a new development in future.

17. Aside from these challenges we need to ensure that we do not leave the CCG (and so ultimately the taxpayer) with avoidable estates costs in future through lack of use.

Financial Case for Change

18. Regional Estates strategies suggest that the eradication of backlog maintenance is a priority, as is the release of older buildings that are no longer fit for purpose. Such estate is expensive and unsustainable for the local health economy. Shotley Bridge hospital falls into this category.

19. CCGs are expecting a 20%-25% reduction in their Running Cost Allowance (RCA) in the next year or so. Premises costs including void costs are funded from the CCG RCA, it is essential where possible that any savings that can be made are made through an improved use of estate.

20. This will ultimately allow more money to be made available to improve health services for our population.

Clinical Case for Change

21. This is a functional case for change however; at the same time it is sensible to review clinical activity in the area while aligning this to what we are likely to need in the future. In doing this we also need to consider national and regional changes in delivery of care to patients.

22. The GP Five Year Forward view sets out a number of priority areas to develop primary care services. These are mainly to bring them closer to a patient's own

home using new models of delivery and bringing multiple specialties together. Nationally, it is a priority to develop community services that can be flexible in delivering care to meet individual patient needs.

23. GP services are developing rapidly, as are relationships between health and social care. It is a priority going forward that health and social care services work closer together than ever before in delivering appropriate care. This means sharing resources and facilities where it is appropriate to do so. Our work on Teams Around Patients is evidence of this shift in care delivery.

24. This project is an opportunity to look at what we are doing now, look at national guidance/expectations and see how we may be able to improve the experiences of our patients by keeping them closer to home and in appropriate accommodation for their needs.

Current and Planned Arrangements

Stakeholder briefing sessions (2017)

25. A series of workshops took place with representatives from different organisations and these workshops were broken down into three key groups.

26. Workshop No. 1 - Its purpose was to brief the North Durham CCG Executive of the approach being taken to prepare the Outline Business Case (OBC) for the re-provision of services out of SBCH, and to specifically discuss the strategic case and its requirements.

27. Workshop No. 2 - The purpose was to review the OBC methodology, review the status of Shotley Bridge Community Hospital including the services being delivered and current levels of utilisation. Review strategic drivers including local and national policies, discuss the future service needs of Shotley Bridge/West Derwentside and agree on a high level vision – strategic case, review the options to deliver the vision.

28. *Workshop No. 3* - The purpose was to facilitate a similar discussion to Workshop No.2 but with a wider audience including the local MP Laura Pidcock, council members, members of the 'Friends of Shotley Bridge Community Hospital', representatives from the NHS providers who deliver services from SBCH and key officers from Durham County Council, Karbon Homes and North Durham CCG.

Steering Group Establishment

29. A steering group was established in November 2017 which meets monthly. The purpose of the Shotley Bridge Steering Group is to:

- Consider information and data relevant to the need for healthcare provision in Derwentside.
- Consider options for the future Shotley Bridge Hospital estate.

- Act as the overall control group and receive and consider reports on detailed proposals.
- Steer implementation of the final model once agreed.

Project Group Establishment

30. A project group was also established in November 2017 to develop a functional case for change and clinical options for future service delivery. This group will also support the development of an Outline Business Case and may evolve into overseeing the activities that support the implementation of service changes.

Progress made to date

31. We have briefed elected members regularly on all of the work undertaken and how the work had enabled more accurate activity data in relation to the services currently running out of the hospital. This has since been shared with an independent healthcare planner.

32. We said at the last report that options may include the transfer of stand-alone clinics to other sites (clinics that don't require additional facilities such as diagnostics) or indeed clinics which have low levels of activity.

33. The Healthcare planner has set out the space requirements for a new build based on current activity with a 10% allowance for population growth. The figure also assumes a 75% occupancy rate across clinics which we are advised is high. Throughout the process potential solutions have emerged which also consider use of existing space where there may be equipment that is currently underutilised. For example we know that we have space at Stanley Primary Care Centre and we know that we also have unused audiology suites, as well as radiology equipment there.

34. A summary at Appendix A outlines the options that have been derived from this work. We have further work to do with our colleagues at NHS property Services around the costings but hope to conclude this by autumn and work through some affordability modelling. These options assume that low level paediatric outpatient clinics would move into Stanley Primary Care Centre but this has not yet been decided.

35. Postcode travel analysis is being undertaken to understand the distances between locality postcodes and other health facilities. To fully understand all factors a Northerly, Southerly, Easterly, Westerly and central postcode will be used from the Stanley and Consett areas to get an appropriate average. This will help us build a consistent picture to determine what can be considered a fair travel distance for users of health services, taking into account public transportation.

Issues for Resolution and Possible Outcomes

Beds

36. Current activity data suggests that there is a clinical need for patient beds in the Consett area. We know that a high proportion of patients from the area go to Weardale Hospital and we are doing some further analysis to understand what their health needs are so we can consider what might be better offered closer to home. The CCG have no control over which patients are directed to which hospital and decision making by our main provider CDDFT is based on clinical need and available beds at that point in time.

37. We know that as part of our community contract with CDDFT they are looking at reducing the patient length of stay which is expected to have an impact on the number of beds required across the whole health estate for that provider. We are meeting with them to get a better understanding of this work to help inform our decision making on beds.

38. The Healthcare planning process has indicated that anything less than a 24-bedded ward is not cost effective in the longer term due to the additional services required to support the facilities. This was confirmed by our independent healthcare planner. The Carter Review, which looked at achieving cost efficiencies across healthcare, concluded that 16 beds was the minimum possible bed number to achieve efficiency. This project would be unable to support either of these numbers because the need is not there.

39. An 8-bedded ward is being considered however, this would go against both sets of advice and guidance around cost effective hospitals and would leave us with uncertainty about the future sustainability of this facility. Current evidence would suggest that an 8-bedded ward is not cost effective or sustainable.

40. We are looking at alternative options for bed provision with the independent sector in the area, as well as with the Willowburn Hospice to get a fuller understanding of what is available and what we may be able to do differently in future.

Theatres

41. Darlington and UHND – CDDFT have confirmed that they are not supportive of delivering surgical services (including endoscopy) at locations other than their main sites for patient safety reasons. The Trust feel that they need the appropriate back up services in place on the same site as the surgery that is taking place. This means that delivering surgery from Shotley Bridge/Consett in future is unlikely.

42. At this stage and with this knowledge in mind, the CCG would not be able to support the building of a new theatre suite for it to stand empty due to the Trust's future clinical plans. This would not be value for money for the taxpayer.

43. It would be inappropriate for the CCG to proceed to build theatres knowing that their main provider had no use for it clinically and no intention of using it. The ultimate result of doing this would be further cost to the taxpayer for expensive, empty space.

44. Aside from these issues, the activity data for these services is low and potentially not large enough to warrant its own facility in any event.

Chemotherapy

45. We are aware that the Trust has plans to refurbish their chemotherapy ward so that it can provide a better patient environment. The Trust also has the option to extend their beds so that the current activity at Shotley Bridge can be absorbed to the main site. We know that these plans rely heavily on Macmillan funding.

46. The CCG have met with Macmillan, who confirmed one of their strategic priorities is care closer to home and that our plans for Consett may impact their thoughts around what they fund within UHND. Both the CCG and Macmillan will separately meet with the Trust's service manager to establish whether or not there is any merit in approaching this jointly and so we can better understand the Trust's plans for chemotherapy in future.

47. Again, if the Trust were intending on absorbing activity from Shotley Bridge into their main site, it would not represent value for the taxpayer if the CCG were then to build a new unit, for it to be unstaffed by the main service provider and standing empty.

Urgent Care

48. A recent review of urgent care has recommended between the hours of 1200 midnight and 0800am there is very little activity through any of North Durham's urgent care centres.

49. As such it is recommended that if an urgent care facility was provided in future, it would open only during the hours of 0800am and 1200 midnight.

Outpatients

50. The options developed suggest there is enough activity to support the continued delivery of some community outpatient services from the Consett area.

Stanley

51. We are working with the General Manager for Paediatrics at CDDFT. They and the Paediatricians from the Trust are keen on Stanley as a children's services centre having delivered from the site before.

52. Stanley's proximity to Consett means that patients from both Consett and Stanley would not be at a disadvantage from this move travel wise. The service manager was keen in particular for disabled children in the area to have good access to facilities which Stanley can provide for well. This would also make better use of the currently unused audiology suite at Stanley and negate the need for the CCG to build a new one, which would be expensive.

53. Activity levels for these services are low and as they do not depend on being located next to other services, can be safely moved.

54. This opens up the possibility for additional paediatric services to work out of Stanley in future, through further discussion between the Trust and the CCG. This would also bring the facility back into its intended original use and reduce some of the CCG's void costs there.

55. We are also running a 12 month Children's Autism Diagnostic service pilot with Tees, Esk and Wear Valleys (TEWV) Mental Health Foundation Trust.

Other Public Services

56. An initial meeting has taken place between the CCG and representatives at Durham County Council who are leading on the One Public Estate agenda. This looks at the potential for co-locating health and social care services and sharing of facilities.

57. Durham County Council (DCC) have the service data from Shotley Bridge and are working with their social care teams to establish whether or not any services have the potential to be co-located well together out of any potential new building. DCC reps will also explore possible interest from the ambulance service, fire service and others as part of this exploratory work.

58. If any of this were likely to be developed within project timescales it would have the potential to offer some income to the project and make it health and social care funded – benefitting both public sector organisations.

59. DCC are also looking at potential income for health from the Genesis project at the old steelworks in Consett.

Mental Health

60. TEWV plans outline a significant requirement for administration space within the healthcare planner's space calculation which moves the project away from being a healthcare setting and more of an administration/office space.

61. It is unlikely therefore that the CCG would pursue this as part of the project as there is other empty space that could be used within the estate for this purpose. It would not be cost effective to invest in building more property for administrative services.

Procurement Issues

62. To date the CCG have worked alongside NHS Property services with their healthcare planner and surveyor to establish space requirements and outline costs.

63. The CCG do have the opportunity to work with an alternative developer for this project however; this would require a full procurement exercise to establish a preferred bidder.

64. We are in the process of working through the benefits and disadvantages of working with NHS Property Services or an alternative provider and will need to make a decision soon on which offers the best value for money and poses the least risk to the CCG.

Where to Build

65. The existing hospital is being built around with houses and does not represent the best site accessibility wise for patients and the public.

66. We will look at current and other sites as part of our work to establish what is most accessible and most affordable. These locations may form part of our options for public engagement.

Decision Making in Health Care – Notes and Guidance

67. The NHS Constitution in England gives CCGs the power to make decisions about the commissioning of health care services. GPs and other local health professionals (such as those within a CCG) commission most NHS services and are responsible for ensuring that all health services delivered meet clinical need (NHS Constitution).

68. Upper tier and unitary local authorities in England have, by law, powers to review and scrutinise any matter relating to the planning, provision and operation of the health service (including public health) in its area. This enables scrutiny of the quality of services provided locally, and the CCG fulfil this obligation by ensuring that any CCG decisions to change services are taken through the Health Overview and Scrutiny Committee at appropriate stages for their views (NHS Constitution).

69. The CCG are also obliged by the NHS Constitution to involve people early in the service change process and we have done this by engaging with stakeholders through a series of workshops and then subsequently setting up steering and project groups which include patient representatives, public representatives (local councillors), providers of services and CCG managerial staff.

70. The CCG will continue to be open and transparent throughout the project and will continue to involve these parties.

71. It is important to clarify that no decisions have been made about the future delivery of services within Shotley Bridge and that the project is in its early stages, assessing clinical need so that options for future delivery of care can be properly evaluated.

72. Ultimately the CCG decides whether or not changes to services are required and what they may look like in future but thorough decision making principles are

applied including the involvement of key stakeholders and the use of clinical data and information to ascertain clinical need. Any service changes also must be 'future-proofed' and in order for this to be successful, we need to work across the healthcare system with our providers so that our efforts are aligned to their strategic direction and regional/national expectations around the future provision of health and social care services.

73. If NHS Property Services were to sell the site and redevelop elsewhere, the funds from the sale would return to the Department of Health to recycle into the NHS via the standard business case approval processes. There is no commitment to reuse the funds locally. This is current DoH policy and has been consistent since 2013. In its response to the Naylor Report DoH have confirmed this position.

Next Steps

74.

- Outline business case to NHS England end 2018
- Public consultation early 2019
- Full business case Spring-Summer 2019
- Construction later 2019

All timescales are approximate and subject to change.

Recommendations

75. The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to accept this report for information.

Appendix A – Healthcare Planner Options

- Do nothing
- Close and do not replace
- Do minimum – provide at other sites
- Outpatients facility for chronic and continuing care
- Outpatients facility for chronic and continuing care, urgent care and imaging
- Outpatients facility for chronic and continuing care, urgent care, imaging and chemotherapy
- Outpatients facility for chronic and continuing care, urgent care, imaging, chemotherapy, surgery and endoscopy
- Outpatients facility for chronic and continuing care, urgent care, imaging, chemotherapy, surgery, endoscopy and inpatient ward

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Special Adults Wellbeing and Health Overview and Scrutiny Committee

7 September 2018

NHS England Review of Specialised Vascular Services

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

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with further information in respect of proposals to reconfigure specialised and some non-specialised vascular services in the North East England.

2 A presentation will also be given to members by representatives of NHS England's North Region Specialised Commissioning Team setting out further detailed information gathered by NHS England in response to the Committee's recommendations at its special meeting held on 1 June 2018.

Background

3 Under Section 244 of the NHS Act 2006, local NHS bodies have a duty to consult local Overview and Scrutiny Committees on proposals for any substantial development of the health service or substantial variation in the provision in their areas. Scrutiny Committees are also required to consider the extent of consultation undertaken.

4 At a meeting of the North East Joint Health Scrutiny Committee held on 15 February 2018, representatives of NHS England's North Region Specialised Commissioning Team presented a report and gave a presentation in respect of proposals to review specialised and some non-vascular services across the North East. The presentation set out the services affected and the case for change, by the Northern England Strategic Clinical Network, and an independent clinical review, carried out by the Vascular Society of Great Britain and Ireland, which recommended that full vascular services should be delivered from the three vascular centres, located in Middlesbrough, Newcastle and Sunderland – rather than four.

5 At the North East Joint Health Scrutiny Committee, members noted that the major impact of the recommendations of the independent clinical review was upon residents of County Durham with the loss of some vascular services from University Hospital North Durham. Due to the absence of the County Councillor Robinson from the meeting due to illness, the Joint Committee resolved that the discussions be noted and the proposals reconsidered by the Joint Committee after consideration by Durham County Council's health scrutiny committee and provision of the consultation responses and business case to the joint Committee.

6 The issue was considered by the Committee at its special meeting held on 1 June 2018 when representatives of NHS England North Region specialised Commissioning team attended along with vascular service clinicians to provide members with information detailing the rationale for the review; the current activity in respect of specialised vascular services and the proposed communication and engagement activities that will be undertaken in informing the local community about the review and what is being proposed and how they can input into the review process.

7 Members considered carefully the proposals and agreed to recommend to the North East Regional Joint Health Overview and Scrutiny Committee that:-

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

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

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

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

8 In response to the recommendations submitted by Durham County Council to the North East Joint Health Scrutiny Committee meeting on the 21 June 2018, the Committee :-

(i) Accepted the clinical case for the reduction from 4 to 3 specialised vascular services centres in the North East.

(ii) Recognised the variation in impact, in terms of the detail of the proposals across each North East local authority area, and agreed that it would not be possible for the Joint Committee to submit a co-ordinated response to NHS England.

(iii) Referred the formulation, and submission, of a response to NHS England to each Local Authority.

9 Following this Committee's recommendations to the North East Joint Health Scrutiny Committee, NHS England responded with a series of follow up work which aimed to address the concerns expressed by this Committee, specifically:-

(i) NHS England have asked both Organisations to undertake a rapid self-assessment of how they would become the third merged arterial centre in the region; considering infrastructure, finance and workforce requirements.

(ii) NHS England will further explore the concerns raised by members around travel and access times for the Durham, Darlington Easington and Sedgefield population and present back to the Durham Overview and Scrutiny Committee at the earliest opportunity.

(iii) NHS England in collaboration with CCG's have started early planning discussions with NEAS around travel impact. NEAS have agreed to undertake a rapid impact/modelling assessment and present back to commissioners on outcomes.

(iv) NHS England agreed to formally present back the outcomes in response to the recommendation to the Durham Overview and Scrutiny Committee at the earliest opportunity and hope that they are accepted which will enable the patient and public engagement activities to commence without further delay.

10 The intention of NHS England to commission this further work was reported back to this Committee on 6 July 2018 when the Committee agreed that the information be brought back to a special meeting of the Committee in September 2018.

Latest position

11 Representatives of NHS England, County Durham and Darlington NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust will be in attendance to present the additional information requested above. An updated briefing paper prepared by NHS England is attached to this report (Appendix 2).

Recommendation

12 The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to:-

1. receive this report;

2. note and comment on this report and the presentation provided by NHS England's North Region Specialised Commissioning Team in respect of the proposals to reconfigure specialised and some non-specialised vascular services in the North East and the associated communications and engagement plans.

Background papers

North East Joint Health Scrutiny Committee Agenda and papers – 15 February 2018 and 21 June 2018

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee agenda and papers – 13 April 2018

Durham County Council Special Adults Wellbeing and Health Overview and Scrutiny Committee agenda and papers – 1 June 2018

Durham County Council Adults Wellbeing and Health Overview and Scrutiny Committee agenda and papers – 6 July 2018

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

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder - None

Human Rights - None

Consultation – The consultation, communications and engagement plan for the proposed review will be developed by NHS England's North Region specialised commissioning team and reported to the Committee.

Procurement - None

Disability Issues - None

Legal Implications – None

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Updated briefing – Durham OSC – 7 September 2018

PROPOSED RECONFIGURATION OF VASCULAR SERVICES

What are vascular services

NHS England commissions adult specialised vascular services, including surgery and interventional radiology. Clinical Commissioning Groups commission non-specialised vascular services.

Vascular services manage the treatment and care of patients with disorders of arteries and veins.

Specialised vascular surgery is done to reconstruct, unblock or bypass arteries to restore blood flow to organs. These procedures reduce the risk of sudden death, prevent stroke and reduce the risk of amputation.

Interventional radiology uses a range of minimally invasive treatments that diagnose or treat vascular diseases, for example, the use of stents. A large proportion of vascular surgical procedures are now carried out using such non-invasive techniques, which significantly reduces risks for patients and means a shorter stay in hospital and speedier recovery.

An example of a non-specialised vascular procedure is the treatment of varicose veins.

Where are vascular services provided from

Vascular services are currently provided from four sites in the North East - James Cook University Hospital, in Middlesbrough, the Freeman Hospital, in Newcastle, Sunderland Royal Hospital and University Hospital of North Durham.

Regardless of where patients live, they are able to choose where they have their planned vascular surgery. In an emergency situation, the patient would always be taken to the nearest vascular centre.

Vascular services are provided by highly specialised clinicians including vascular surgeons, interventional radiologists, anaesthetists, nurses, physiotherapists and rehabilitation specialists.

Case for change and independent review

In June 2014 the Northern England Strategic Clinical Network, who provides targeted health system support to improve health outcomes and reduce unwarranted variation of patient care, published ‘North East Vascular Services - Case for Change’. This strategic review concludes that, based on substantial clinical evidence, the North East vascular service should be re-configured to a maximum of

three vascular ‘hubs’ – centres that provide a full, high quality vascular service. This case for change was prompted by a number of clinical drivers which include:

- improved health outcomes for patients - increasing evidence of link between surgical volumes and improved patient outcomes for complex arterial surgery, especially abdominal aortic aneurysms;
- advances in technology and shift towards non-invasive treatment methods for vascular patients (for example, the use of balloon catheters and stents) which means there is an increased reliance upon specialist interventional radiology or dual-trained surgeons;
- advances in treatment have greatly improved patient outcomes, however this requires the ready availability (24/7) of consultant radiologists who have expert and highly specialised skills, working alongside vascular surgeons;
- a general increase in pressure on services and on the AAA screening programme.

In addition to the strong clinical case for change, the proposed reconfiguration will also improve the overall sustainability of the service in the region and aid recruitment, while minimising any potential gaps in rotas and fragility within a service which is under increasing pressure.

James Cook University Hospital, in Middlesbrough, and Freeman Hospital, in Newcastle, are major trauma centres so must continue to provide a full vascular service.

The third vascular centre in the North East is therefore a choice between Sunderland Royal Hospital and University Hospital of North Durham.

County Durham and Darlington NHS Foundation Trust and City Hospitals Sunderland NHS Foundation Trust requested an independent clinical review, which was carried out by the Vascular Society of Great Britain and Ireland in 2015/16.

This clinical review also advises that there is a strong case to remodel vascular services in the North East and that there is only sufficient specialised vascular activity and vascular clinicians to support three centres.

It recommends that full vascular services should be delivered from three centres - in Middlesbrough, Newcastle and Sunderland.
Sunderland Royal Hospital is recommended as the third vascular centre:

- it is also geographically located in the centre of the region in between the two major trauma centres in Newcastle and Middlesbrough;
- it has the physical infrastructure already in place for it to become the third vascular centre with a new emergency department, state-of-the-art imaging hub (key for interventional radiology) and an intensive care unit with sufficient bed capacity;
- there are more consultant interventional radiologists working at Sunderland Royal Hospital, which is a critical part of the vascular services workforce and adds greater resilience for a centralised service;

- it provides a number of related speciality services and has established cross-speciality working in cardiology (care dealing with disorders of the heart and parts of the circulatory system), renal (care dealing with kidney disorders), stroke and care of the elderly – services which can form part of the care needed by vascular patients;
- some services, such as renal, depend on an on-site vascular service.

The reviewers also recommended that each of the three vascular centres (hubs) in the region 'network' with hospitals that don't provide specialised and other types of vascular surgery (spoke sites). Clinical teams at the 'hub and spoke' sites will develop close working relationships to ensure that patients are correctly signposted to specialised clinicians, when needed, and receive the appropriate diagnosis and referrals.

- Sunderland Royal Hospital will network with University Hospital of North Durham and South Tyneside District Hospital
- James Cook University Hospital, in Middlesbrough, will network with University Hospital North Durham and Darlington Memorial Hospital
- Freeman Hospital, in Newcastle, will network with the Queen Elizabeth Hospital in Gateshead

Delivering a sustainable and safe service with best outcomes for patients

After extensive discussions between NHS England, County Durham and Darlington NHS Foundation Trust, City Hospitals Sunderland NHS Foundation Trust and the Vascular Advisory Group (the regional network of vascular surgeons) – and taking into consideration the case for change report and review mentioned earlier in this document - a consensus has been reached that the third vascular centre should be at Sunderland Royal Hospital.

- NHS England has accepted the independent reviewers' recommendation that the third arterial centre should be developed at Sunderland Royal Hospital.
- County Durham and Darlington NHS Foundation Trust agrees with the independent reviewers' recommendation - that City Hospitals Sunderland NHS Foundation Trust is best placed to develop the third arterial centre.
- The Vascular Advisory Group has also endorsed the independent reviewers' recommendation.

The proposed reconfiguration will result in all specialised and non-specialised vascular surgery - with the exception of some minor vein procedures, for example the treatment of varicose veins - being transferred from University Hospital of North Durham to Sunderland Royal Hospital. Treatment of varicose veins will still be done in Durham at the Durham Treatment Centre.

Specialised and a large majority of non-specialised vascular surgery need to be co-located due to their interdependencies.

Additional clinical drivers for the proposed reconfiguration of services include:

- larger surgical teams and a full range of facilities enables an increased choice of treatments for patients;
- more specialised clinicians in centralised locations will result in an increased consistency of treatment provided to patients and adequate critical care support;
- enable compliant and sustainable vascular surgical and interventional radiology on-call rotas;
- professional and clinical development of clinicians;
- improved post-graduate training and research opportunities;
- meeting NHS England's key requirements for a fully compliant vascular centre, which include:
    - a minimum population of 800,000;
    - a minimum of six vascular surgeons to ensure comprehensive out of hours cover;
    - a minimum of six interventional radiologists to ensure comprehensive out of hours cover;
    - a minimum of 60 abdominal aortic aneurysm repairs per year (ten per surgeon);
    - leg amputations should only be undertaken in arterial centres;
    - a minimum of 50 carotid artery intervention procedures per unit per year (these procedures help to prevent strokes by removing 'furring' or hardening from arteries that carry blood to the brain).

Who is affected by the proposed service change

Based on current patient data, this proposed service reconfiguration will potentially affect around 676 patients per year – 12 patients per week.

Around ten patients a week would have their vascular surgery at Sunderland Royal Hospital instead of University Hospital of North Durham.

It is estimated that around two patients a week, who live in Darlington, would more than likely choose to go to James Cook University Hospital for their vascular surgery, due to living closer to Middlesbrough than Sunderland.

While considering the impact of this proposed vascular service reconfiguration on patients and their family, carers and friends, current data shows that a large majority of patients who have vascular surgery, and need to stay in hospital, remain in hospital a relatively short time – up to three or four nights.

University Hospital of North Durham will continue to provide vascular services

University Hospital of North Durham would continue to provide vascular services including 3,600 vascular outpatient appointments a year, which will include diagnostics.

Patients that don't have their vascular surgery in Durham will still be able to access local rehabilitation services.

Day-case surgery, which includes the treatment of varicose veins, would also remain in Durham and be done at the Durham Treatment Centre.

Communications and engagement approach

Discussions between NHS organisations in relation to the proposed service reconfiguration are on-going.

It is hoped that the proposed reconfiguration will be implemented after agreement by the relevant health scrutiny committees and after carrying out planned patient, staff and stakeholder communications and engagement.

A key element of the communications and engagement activity is to identify patients who have accessed/are accessing these vascular services and to speak to them about the proposed reconfiguration so they have an opportunity to feedback about the potential impacts the changes may have.

Key community and voluntary groups will also be targeted to ensure we reach and speak to as many patients and stakeholders as we can – this will be informed by an equality impact assessment. A travel impact assessment has also been carried out to help inform these discussions. Engagement activity is likely to include survey work, face to face interviews and focus groups.

A feedback report will be prepared and will include themed analysis and insights which will be used to inform the development of the proposed service reconfiguration and, in particular, mitigate any impacts on patients.

As part of this activity we will also brief and arrange face-to-face discussions with key stakeholders.

We will, of course, keep you updated on progress.

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Special Adults Wellbeing and Health Overview & Scrutiny Committee

7 September 2018

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

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

Purpose

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

Background

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

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

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

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

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

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

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

Latest Position

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

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

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

8. Representatives of Durham Dales, Easington and Sedgefield CCG attended the Committee's meeting held on 6 July 2018 and gave a presentation to members detailing the proposed revision of urgent care hub provision across DDES CCG, the stakeholder engagement undertaken to date and the proposals for consultation on the revisions.

9. At the meeting, the Committee "**Resolved that** report and presentation be noted and that the Committee recommend to DDES CCG that the proposed review of Primary Care Support Services and the associated communications and engagement activity be paused for a period of 9 months to allow for more robust patient/stakeholder engagement activity to be undertaken along with a review of the referral practices being adopted by NHS 111 service to ensure that local residents are able to access urgent appointments in primary care services within their locality and that these services are being actively promoted by the CCG."

10. Representatives of Durham Dales, Easington and Sedgefield CCG have asked to attend the meeting to provide an update in respect of the proposals for members' consideration, to answer some of the members concerns expressed at that meeting and to provide greater clarity on the rationale for the proposals. An updated report by the CCG is attached to this report (Appendix 2).

Recommendation

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

Background Papers

Report and Minutes of the Adults Wellbeing and Health Overview and Scrutiny Committee on 9 October 2015, 1 March 2016, 24 May 2016 and 1 September 2016, 9 November 2017 and 6 July 2018.

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

Appendix 1: Implications

Finance – None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder – None

Human Rights - None

Consultation – None

Procurement - None

Disability Issues – None

Legal Implications – None

Durham Dales, Easington and Sedgefield Clinical Commissioning Group

APPENDIX 2

Primary Care Service Consultation, Communication and Engagement Plan

Tina Balbach
Engagement Lead, DDES CCG
Clair White
Head of Commissioning DDES CCG

This document can be made available in different languages and formats on request
Please contact the Engagement Team on 0191-3713222

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SECTION ONE - CONTEXT

1.1 Introduction

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group (DDES CCG) is reviewing their primary care, same day need services to ensure patients are treated in the right place at the right time and by the right health care professional wherever possible. The CCG has an overarching Engagement Strategy but it recognises that certain transformation projects require bespoke communications/engagement plans to be in place. The aim of this communications and engagement plan is to inform the development of Primary Care Services in the DDES area that will appropriately meet the needs of the population now and into the future.

The CCG comprises three localities, all with specific and varying needs. DDES is one organisation, but the locality focus has enabled specific input from communities to inform the options that have been designed for the public to consult on. All options can be flexible to meet the needs of each community.

1.2 Background

In spring 2016, DDES CCG undertook a public consultation in relation to urgent care services.

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

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

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

During the consultation, the CCG also engaged with the public on the locations of the extended and enhanced GP opening times. As a result nine hubs were developed in the following

locations, with each providing appointments up to 8pm on week nights and 8am -1pm on Saturday and Sunday.

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

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

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

There is a high prevalence of long term conditions with a history of poor health outcomes for the population of DDES. The design of any future urgent care service must ensure that we have the best services that enable the best treatment of our patients. We feel that this should start and stay, wherever possible, in primary care where treatment is proactive, holistic, preventative and patient-centred. *We also need to develop services that are financially sustainable*

A key change was that services would be accessible via appointment rather than as a 'walk in' service.

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

1.3 Setting the context of the project

The CCG engages extensively and regularly through Patient Reference Groups (PRGs), Health Networks, Area Action Partnerships (AAPs) and various community groups. The Health and Wellbeing Board and Adults Overview and Scrutiny are also regularly kept up to date. This is important as it engages on its commissioning priorities and the CCG's strong beliefs and commitment to put local communities at the heart of everything they do.

An initial period of pre-engagement was conducted to help the CCG to understand the experience of people using Primary Care Services.

More detailed information about the engagement carried out around Primary Care Services can be found in Appendix one of this document.

These engagement activities helped to inform the development of a number of possible Primary Care Service 'options'. These options are ideas on how services could be further developed or delivered differently to best meet the needs of local people.

Importantly, throughout the pre-engagement, and changes to the models to deliver Primary Care Service, an on-going dialogue was maintained with the local health Overview and Scrutiny Committee (OSC).

In particular, the rationale for the proposed changes to Primary Care Services were presented at a meeting on 6th July 2018, and a full consultation plan (including Communications and Engagement Plan and briefing documents) will be shared and discussed at the OSC meeting on 7th September 2018.

To give some context; during the urgent care consultation the public stated a preference for nine delivery sites. Data would suggest that this has created too much provision across too many sites. The service review as documented in the next section evidences this.

1.4 The case for change

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

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

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

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

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

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

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

The CCG confirmed its intention to OSC to carry out further engagement with patients to gain insight into the new services to help to identify why services were not being utilised as expected. Feedback has been gathered from patients using PCS and also patients using out of area services. Additional targeted work was carried out with identified patient groups such as the Gypsy Romany Traveller (GRT) community.

The business case covers specific sections in more detail, noting this has already been presented and sets the case for change and evidence to support.

This document will focus on what is next to include all engagement and consultation plans and our key messages

SECTION TWO – PRE ENGAGEMENT

2.1 Aims and methodology

The pre-engagement activity took place over a nine week period from the middle of December 2017 to the end of February 2018. However this is ongoing at the request of the local Overview and Scrutiny Committee.

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

There was a requirement to do some further data analysis and patient engagement to understand whether the way the service is current set up is giving patients the best service. We engaged with patients and stakeholders to find out about their experiences of using the Primary Care Services but also to aim to reach those who have not. If they are not using the PCS, then where are they going? What services are they using?

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

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

All of the pre-engagement activity has been recorded and is shown in the evidence log – see appendix one.

The Engagement Team, supported by the CCG Commissioning Team, attended each Primary Care Service (the nine hubs, three in each locality), and spoke to patients about their experiences of the services and completed questionnaires.

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

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

2.2 Who was engaged?

This pre engagement has now been extended and will continue throughout August to give a greater sample size. However, please note this pre-engagement is not the only driver for change, the main driver is from the conclusion of the robust review.

We have extensively engaged the public and patients / carers from a variety of different backgrounds, experiences, groups and communities over the two years of reviewing and implementing new services. We also worked with groups who included those from the nine protected characteristic groups.

We worked with extensively with Clinicians, GP Practices, GP Federations and Commissioners to truly understand the service need the need to change services and their feedback and recommendations are covered in detail in the following section.
We spoke to patients using the primary care services and also those who were accessing care from outside the DDES area, with the aim to find out why they weren't using their local services. In addition to this the Commissioners have been working with the out of hours providers to ensure our patients are redirected back to their own services to support patient education and behavioural change.

In addition to this the Commissioners have been working with the out of hours providers to ensure our patients are redirected back to their own services to support patient educations and behaviour change.

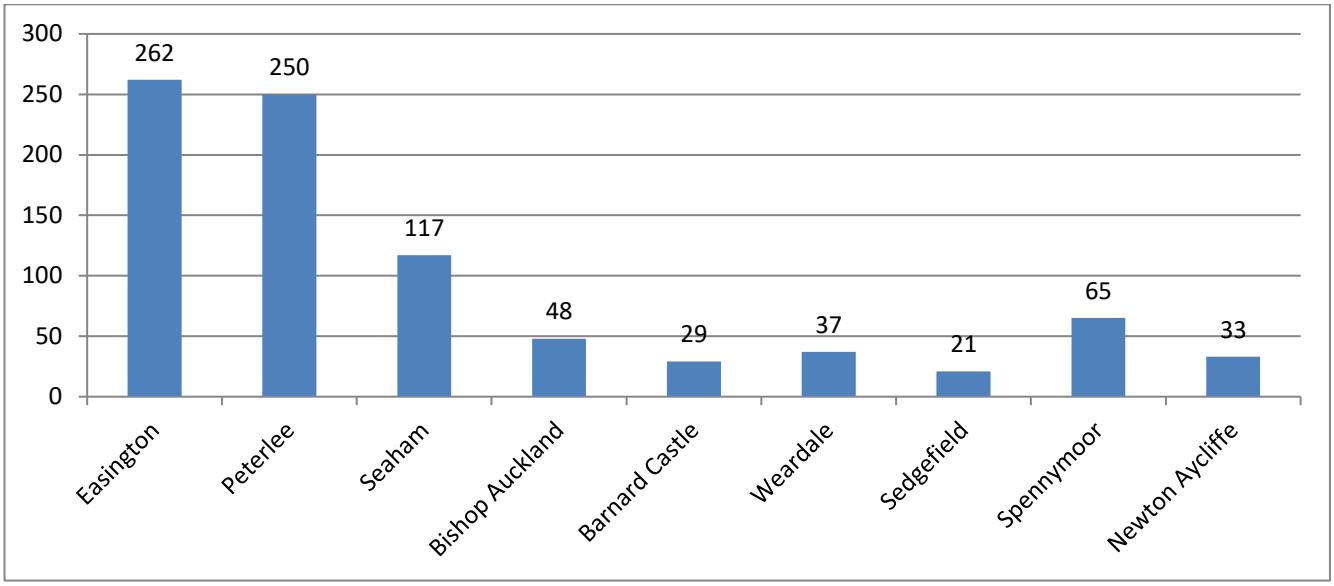
All of the engagement activity has been recorded and is shown in the evidence log, which can be found at appendix one.

2.3 Summary of key findings

Summary of key findings from the survey results around the service model. Over 862 patients from across the Durham Dales, Easington and Sedgefield (DDES) CCG were engaged over the period; the responses were recorded through an on line survey.

The sites which received the most patient feedback were Easington with 30% and Peterlee with 29% of the 862 patients who completed a survey.

The actual number of surveys returned from each hub site is detailed below; this will be update as new feedback is received.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29
37
21
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33
Easington
Peterlee
Seaham
Bishop Auckland
Barnard Castle
Weardale
Sedgefield
Spennymoor
Newton Aycliffe

SECTION 3 CONSULTATION

3.1 Options Development

Following the review of Primary Care Services, the next stage was to develop some options that would address all of the concerns and issues raised from the finding.

This process was robust and included the input from the Director of Commissioning, Commissioning Managers, a lead clinician/GP from every GP practice across DDES, every Practice Manager and our patient reference groups across all localities, this includes our Locality Clinical Chairs, Rushi Mudalagiri, Dilys Waller and Winny Jose.

A business case paper was prepared on the options for the service review and potential changes were presented to the DDES CCG Confidential Executive Meeting. The Executive Team who supported the commissioners to move to the next stage. The next stage was to engage with the practices and our patients groups initially.

To aid the discussion, the Commissioning Team put forward a range of potential options to the Primary Care Home (PCH) GP Practice Groups in April, however it was highlighted these were not exhaustive. The Clinical Chairs led on this piece of work and facilitated the session with their own locality practices, to ensure recommendations were built on clinical need.

The Primary Care Home membership consists of one GP lead from each practice and their practice manager. These members are at the meetings representing their GP practice, partners and their own registered patients.

These potential options were discussed and included the following:

Options appraisal (Durham Dales used as an example)

Option	Advantages	Disadvantages
1. No changes to current service delivery	• Maintains status quo • Provides access equally across the area • Public support for services in rural areas	• Poor value for money • Staff morale and retention issues • Unable to have a GP on all sites due to availability/funding Public perception of value for money of service
2. Reduce to two sites (Bishop Auckland and one rural site)	• Provides more access in the rural areas • Public support for services in rural areas	• Poor value for money • Staff morale and retention issues • Unable to have a GP on all sites due to availability/funding • Public perception of value for money of services • Difficulty identifying the rural site due to geography
3. Reduce to one site (Bishop Auckland)	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours	• Distance to travel for rural patients • Difficulties with access for frail/house bound patients • Patient perception of loss of services in rural areas

	service • Provides value for money	
4. Reduce to one site (Bishop Auckland), but change/extend weekend opening hours	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Offers more patient choice	• Distance to travel for rural patients • Difficulties with access for frail/house bound patients • Patient perception of loss of services in rural areas • Duplication of service with the • Urgent Treatment Centre/Out of • Hours service
5. Reduce to one site (Bishop Auckland) with outreach services for frail/housebound patients	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Improves access for housebound patients, but is more value for money • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Provides value for money	• Distance to travel for non- house • bound rural patients • Patient perception of loss of • services in rural areas

We agreed some ground rules with the group which included:

- Not to think about or talk about money
- Not to think about current providers of services
- Start with a blank piece of paper and discuss what is now needed

We shared the 'must do's' that we are mandated to provide

An output of this service is it needs to provide GP Access, we must provide 45 minutes per 1000 patient population of extended GP/Clinical appointments, this equates to 217 hours required in additional capacity to meet the target across the full DDES area.

We also need to ensure:

- We provide planned and unplanned appointments for patients
- We meet the public's/ patient's needs around access
- We provide a service that supports the Urgent Treatment Centres (UTCs) standards.

We shared the activity per site

We shared the outcome of the engagement report for each locality specifically.
The aim was to get some options from the locality and for the CCG to record the outcomes/options agreed. This took place and encouraged some healthy debate and discussion and an outcome was put forward to the CCG on the preferred option.

As a backup and to absolutely ensure we captured all practices views. We then followed up the meeting with a practice questionnaire to ensure each practice had a voice and that and shared their view. This was sent out and collated via email communications. This included the key

questions around, how many hubs do we need to serve your locality? Where should these hubs be? What else do we need to consider moving forward with the recommendation?

The next step was for the CCG to present back at the next Primary Care Home (PCH) meeting what the practices had requested, this took place at the May PCH meeting and was agreed/ signed off this then gave the commissioner the mandate to work up and move forward with the recommendation.

In summary

- DDES executive committee have supported the model
- GP leads and clinicians from 41 GP practices have worked on the options to develop the recommendation
- Patient reference group members have supported the piece of work
- Locality and PCH Clinical leads have agreed the model.

3.2 Recommended options

Durham Dales recommendation

Recommendation	Positive impact	Potential negative impact
Reduce to one site (Bishop Auckland) with outreach services for frail/housebound patients including home visits and pre bookable appointments	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Improves access for housebound patients, but is more value for money • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Close to MIU and out of hours service • Provides value for money • Provides a pre bookable appointment system • Use of patient transport could be developed	• Distance to travel for non-house bound rural patients • Patient perception of loss of services in rural areas

Outcomes locality specific - Durham Dales

- From the information gathered via the surveys, Bishop Auckland is the busiest site with the majority of people attending on a weekend.
- The main reasons people attended was they felt they got a better service/it was easier to get an appointment, they couldn't get a GP appointment or the practice was closed. This was not unexpected as the additional service covered the period when their practice is usually closed.
- The majority of patients got an appointment via NHS 111 and had a positive experience of the service.
- Most people would be prepared to travel around 10-15 miles to a PCS service.
- The majority found that the current opening times are convenient and didn't think the service could be improved.

Activity

Averages

Per weekday 8-6pm - 0.4

Per weekday evenings 6pm-8pm - 6.4

Weekend / bank holiday 8am-1pm - 57 per weekend

Average activity Per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Durham Dales	RCH	0.01	0.6	7
	SVMC / BAGH	0.2	4.5	33
	Weardale Practice	0.0	0.4	6
	Site unknown	0.1	1	11

Sedgefield recommendation

Recommendation	**Positive impact**	**Potential negative impact**
Reduce to two sites (Spennymoor and Newton Aycliffe) during weekday evening and retain three sites at weekends, provide pre bookable appointments and offer an outreach provision	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Offers more patient choice • Provide booked appointments • Provides value for money • Offers local capacity at weekends and an alternative to hospital based services • Provides a pre bookable appointment system • Use of patient transport could be developed	• Patient perception of loss of services in a certain town or building • Distance to travel for non- house bound patients

Outcomes locality specific - Sedgefield

- Spennymoor had the highest return of surveys, with the majority of people attending after 6pm and on a weekend.
- The main reasons why patients attended was because they couldn't get an appointment with their GP / or their GP practice was closed again this is when the service is provided outside of GP practice opening times.
- The majority of patients got an appointment via NHS 111 and said their experience of the service was good or great.
- When asked about their opinion on changing the number of sites, 45% of those said that they would be happy with change as long it was somewhere convenient. 88% of patients stated they would travel 5+ miles to a PCS service, with 55% of those happy to travel 10+ miles.
- 92% of patients felt that the current opening times are convenient.
- The majority of respondents did not think there was a better way to deliver PCS

Activity

Averages

Per weekday 8-6pm - 1.2
Per weekday evenings 6pm-8pm - 6
Weekend / bank holiday 8am-1pm - 75 per weekend

Average Activity per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Sedgfield	Newton Aycliffe	0.9	3	30
	Sedgefield	0.1	0.8	14.5
	Spennymoor	0.1	2.4	26
	Site unknown	0.1	0.1	6

Easington recommendation

Recommendation	Positive impact	Potential negative impact
Reduce to two sites on a weekend (8am – 1pm) and one site during the week (12 noon – 8pm), to act as an overflow to GP Practices through the week. So if the GP Practice has no appointments then they will book patients into this service acting as an overflow. This service will provide outreach / home visiting additional service across the full locality, based on the outcome of the consultation.	• Improves staff morale and retention • GP and practitioner cover on one site creating more capacity • Access to pharmacy close by • Easier for patients to understand available services • Easier for NHS111 to signpost patients • Geographically close to MIU and out of hours service • Provides value for money • Provides access for frail and house bound pts • Provides a home visiting element • Provides a backup service for general practice • Provides a pre bookable appointment system until 8pm on an evening and on weekends • Use of patient transport could be developed	• Public perception of value for money of services • Public perception of the loss of service in their own area • Travel time to hubs

Activity

Averages
Weekday 8-6pm – **34**
Weekday evenings 6pm-8pm- **14**
Weekend / bank holiday 8am-1pm - **97** per weekend

Average activity per site

Locality of site	Site	Weekday 8am – 6pm	Weekday 6pm – 8pm	Weekends / bank holidays
Easington	Healthworks	10	4	33
	Peterlee Health Centre	19	7	43
	Seaham Primary Care Centre	5	3	21
	Site unknown	0	0	0

Easington practices will start to take all same day access activity however provide an additional overflow service for weekday activity via one central hub operating from 12 noon until 8pm (the town with the highest demand and transport links would be suggested). This reflects the fact that there has always been greater provision and therefore higher activity in the Easington area.

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

We recommend one overflow hub is in place during weekdays (12pm – 8pm) and two hubs are in place during weekends/bank holidays. It is also recommended that Further engagement is done with Easington practices and patients to understand any further outreach arrangements required.

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

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

Outcomes locality specific – Easington

- From the information gathered via the surveys, Peterlee was the busiest site with the majority of people attending between 8am and 6pm.
- The main reasons why patients attended was because they couldn't get an appointment with their GP or it was out of hours which is how this service was set up in Easington
- The majority of patients received an appointment via NHS 111 and had a positive experience of the service.
- When asked about their opinion on the sites, 41% of those that commented said they would be happy with change.
- The majority of people said that the current opening times were and convenient and they would be prepared to travel around 5-15 miles to a PCS service, with Seaham patients less willing to travel.

3.3 Consultation messages and questions

Messages

- On the 1st April 2017 DDES CCG implemented an extension of Primary Care Services based on clinical opinion and the views of the local population following a robust period of consultation. At this time there was an acknowledgment that the provision put in place was over and above the optimum level required. However it was agreed to implement and review during the subsequent six to 12 months. This was agreed by DDES Executive and OSC.
- The review of the provision currently in place has determined that services are not being fully utilised as well as they could be and in effect we are currently commissioning too much activity. DDES CCG have used robust data to evidence under utilisation but have also conducted a period of pre engagement with people who attend Primary Care Services as well as those who attend A&E and Primary Care Centres..
- Pre-engagement took place over a nine week period from December 2017 until the end of February 2018. However noting that this has been extended
- The information gathered has informed the development of a recommended service model for each locality
- Durham Dales will reduced to one site based at Bishop Auckland with outreach services for frail / house bound patients including home visits and pre-bookable appointments
- Sedgefield will reduced to two sites based at Spennymoor and Newton Aycliffe during weekday evening and retain three sites at weekends. The model will enable pre bookable appointments as well as outreach provision
- Easington will reduce to two sites on a weekend based in Peterlee and Seaham and one overflow at Peterlee throughout the week from 12 – 8pm with additional capacity and services created to include a same day and pre bookable appointment system. The model will also provide outreach service/ home visiting and anything else that is highlighted as needed as a result of the consultation process if appropriate to serve the whole of the Easington locality. We want to know where this service should be based to provide service to the Easington locality equitably and is there anything that we have missed? The above recommendation was made based on data and intelligence and would suggest the most suitable/ central and equitable option for patients and will support the best use of public money.

  DDES CCG would like to communicate to its local population the new times and locations of the primary care services model.

  DDES CCG would like to consult on the further services which may be delivered as part of this new provision and ensure equitable access to the patients across the localities.

Questions we will ask are:

- Do you understand why we are proposing the changes in your locality?
- Would these changes still allow you to have timely and convenient access for booked and same day appointments albeit, from a different location in some instances? (this depends on your clinical need)

- Do you have any suggestions that could enhance these proposals for you?

“The Four Tests” – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

NHS England expects ALL service change proposals to comply with the Department of Health’s four tests for service change (referenced in the NHS Mandate Para 3.4 and ‘Putting Patients First’) throughout the pre-consultation, consultation and post-consultation phases of a service change programme.

The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests. This has already been developed in partnership with NHS England and is attached in Appendix 7.

3.4 Consultation activity

Appendix six provides further details on the CCG's planned communications and engagement /consultation activities.

3.5 Stakeholders

A stakeholder is anyone who is effected by or can affect, the project. The CCG needs the right information to inform decisions for its community. It continually strives to maintain and strengthen its strong working relationships with its stakeholders.

In order to establish the most appropriate means of communicating with our stakeholders, further analysis is required to better understand each one in terms of:

- Their level of influence over the project
- The impact of the project on them

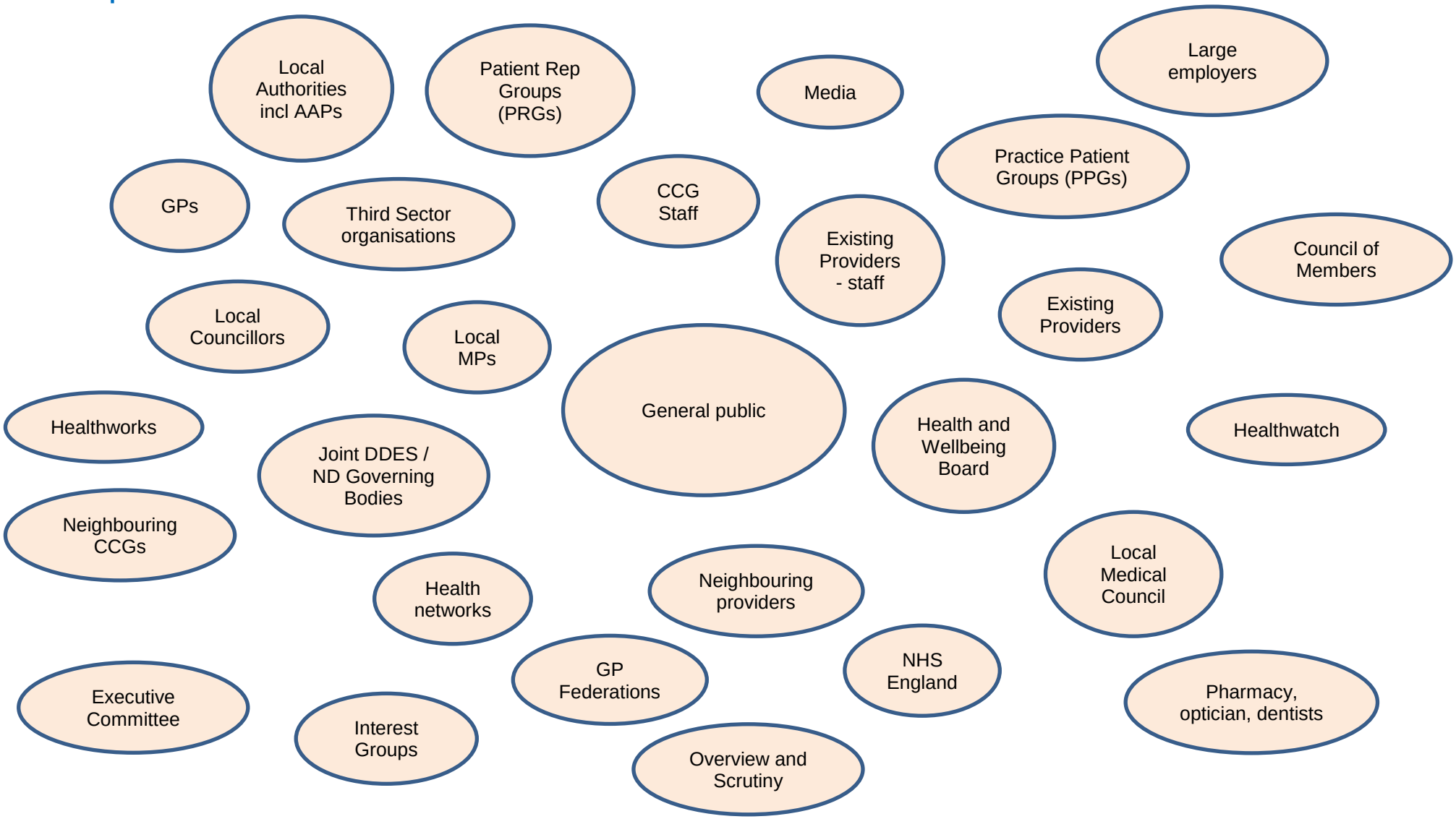
This enables the CCG to formulate a bespoke communications plan based on influence and impact, increasing the chances of the communications and engagement plan being successful.

The communications engagement process will also includes a focus on disadvantaged, marginalised and minority groups and communities, who may not always have the opportunity to have their say in decisions that affect them. This is particularly important in the DDES area due to high levels of deprivation and health inequalities, as well as the diverse make-up of the local population. The engagement team will work to establish links with these groups.

Healtwatch and Patient Reference Groups (PRGs) are onboard with this work and will support the CCG with the communications and consultation work to ensure that we simplify messages and don't use jargon and to act as critical friends throughout the process.

A stakeholder map is shown on the next page.

Stakeholder Map



3.6 Consultation briefing document

A consultation narrative document will be developed, that will detail:

- The background to the consultation
- The case for change
- The options for change
- Feedback from the public
- The rationale for the options
- How people can participate in the consultation and give their views e.g. by attending public meetings, via e-mail or via the CCG's website

Those engaged throughout the consultation dialogue period will be from a variety of backgrounds, and will have different experiences, skills and needs. For this reason, the consultation documents will be made available with different levels of detail and in different languages and formats as required. A discussion pack will be compiled to provide key messages and information to local communities in an easily digestible format. This will include the briefing document (which can be tailored according to particular audiences) and a brief, introductory video providing a context to local health services. All of this information will be available on a dedicated section of the CCG's website and will be promoted via social media channels such as Facebook, Twitter and YouTube.

Support will be offered to those who need it to ensure that they are able to understand the information contained within this document, and to ensure that all participants have enough information to give informed consideration to the options contained within the consultation narrative.

3.7 Standard formats of information

All information produced as part of the consultation will be written in language that can be understood by members of the public. Technical phrases and acronyms will be avoided, and information will be produced in other formats as required, to reflect the needs of the diverse DDES population. This may include, but is not limited to:

- Large print
- Audio
- Braille
- Different languages
- Computer disk
- Interpreters at public events
- Short animations

Suppliers will be identified as part of the development work to provide these formats of information when they are required.

3.9 Documentation and resources

Development work will include consideration of required documentation and resources. This will include, but is not limited to:

- Consultation briefing documents and questionnaires
- Posters
- Video?
- Website
- Flyers
- Leaflets (including leaflet drop)
- Stand-up banners
- Venues for public events

3.9 Generic CCG Communications and engagement objectives

Regular and consistent communications and engagement is crucial in ensuring that the CCG commissions services that are of good quality, value for money and meet the needs of local people.

For this Primary Care Service consultation, the communications and engagement objectives reflect those described in the DDES CCG Communications Strategy and the DDES CCG Engagement Strategy 2016-2018:

- Communicating clearly, effectively and honestly with local communities in order to build trust and confidence in the NHS and health professionals;
- Engaging effectively with every segment of the population in order to ensure that local people are given the opportunity to consider and comment on the options for new models of Primary Care Service in the DDES area;
- Using the comments and feedback from the local communities to inform consideration by the CCG as to how it should provide Primary Care Service to best meet the needs of the population of the DDES area;
- Inform CCG commissioning responsibilities in relation to, and the procurement of, Primary Care Services.
- Ensuring that the CCG is complying with all its legal obligations in relation to public consultations and engagement (see section 13 of this report for further details of these specific requirements).

Primary Care Services Communications and Engagement Objectives

- To communicate the recommended service model for each locality clearly and effectively with all identified stakeholders
- To consult the local population on the development of further services to be delivered as part of the provision outlined as part of the process
- To ensure that all voices are heard and that views are used to inform future service delivery
- To ensure messages from the local community are heard and used to inform decision making. Feedback will be given in a timely manner based on the ‘you said, we did’ methodology.

3.10 Risks and Mitigation

Risk and risk mitigation will be managed by the Primary Care Service task and finish group, Risks will be identified and regularly reviewed and assessed throughout the consultation development and implementation.

Risk	Mitigation
Failure to engage with relevant stakeholders and meet statutory duties / stakeholders feel they have not been fully involved	Communications engagement plan developed identifying stakeholders and partners with detailed communications activity, Ensure all stakeholders receive appropriate updates and feedback Ensure appropriate stakeholders are invited to participate in a way that is accessible to them Ensure clear communications of messages through robust communications plan, including updates on CCG website, newsletters, bulletins and through MY NHS
CCG does not engage with marginalised, disadvantaged and protected groups	Communications and Engagement plan identifies relevant groups and organisations Also work with local voluntary sector groups, community organisations and partners to access these groups and communities Targeted engagement will be undertaken where necessary e.g. potential risk was highlighted through the pre-engagement with patients from the Gypsy Roma and Traveller Communities and other BME communities in

	the area. Proposed changes to the Primary Care Service could result in these groups attending A&E if they are not aware of changes to the services.
Lack of response / “buy in”	Ensure adequate publicity and support
Accessibility of activities and appropriate feedback mechanisms to those taking part	Ensure clear contact for translations or alternative format Include appropriate feedback mechanisms in plan that are accessible to people with varying needs and abilities
Managing expectations of members of the pubic	Ensure adherence to communications plan and advise CCG of any issues
The consultation and options may be perceived by members of the public as a “cost cutting” exercise	Ensure clear rational for change is communicated within the consultation briefing document
The consultation may be subject to challenge	Appropriate governance policies/standards will be put in place to ensure correct procedure and equality analysis are maintained throughout the consultation

3.11 Legal

CCG's in England are required to ensure that they meet their legal obligations in relation to public consultations. These legal requirements are varied and are summarised by source below:

NHS Act 2006 (As Amended by Health and Social Care Act 2012)

The NHS Act 2006 (including as amended by the Health and Social Care Act 2012) sets out the range of general duties on clinical commissioning groups and NHS England.
Commissioners' general duties are largely set out at s13C to s13Q and s14P to s14Z2 of the NHS Act 2006, and also s116B of the Local Government and Public Involvement in Health Act 2007:

- Duty to promote the NHS Constitution (13C and 14P)
- Quality (13E and 14R)
- Inequality (13G and 14T)
- Promotion of patient choice (13I and 14V)
- Promotion of integration ((13K and 14Z1)
- Public involvement (13Q and 14Z2)
    - Under S14Z2 NHS Act 2006 (as amended by the Health and Social Care Act 2012) the CCG has a duty, for health services that it commissions, to make arrangements to ensure that users of these health services are involved at the different stages of the commissioning process including:
        - In planning commissioning arrangements
        - In the development and consideration of proposals for changes to services
        - In decisions which would have an impact on the way in which services are delivered or the range of services available; and
        - In decisions affecting the operation of commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

S.244 NHS Act 2006 (as amended)

The Act also updates s244 of the consolidated NHS Act 2006, which requires NHS organisations to consult relevant Local Authority Overview and Scrutiny Committees on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

S.149 Equality Act 2010

(1)A public authority must, in the exercise of its functions, have due regard to the need to—
(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
(2) A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
(3) Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
(a) Remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;
(b) Take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it;
(c) Encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.
(4) The steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.
(5) Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to—
(a) Tackle prejudice, and
(b) Promote understanding.
(6) Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.
(7) The relevant protected characteristics are—

- Age

- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

S.3a NHS Constitution

The NHS Constitution sets out a number of rights and pledges to patients. In the context of this project, the following are particularly relevant:
Right: You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

Pledge: The NHS commits to provide you with the information and support you need to influence and scrutinise the planning and delivery of NHS services.
(Section 3a of the NHS Constitution)

S.82 NHS Act 2006 - Co-operation between NHS bodies and local authorities

In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Mental Capacity Act 2005

The MCA says:

- Everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision themselves, unless it is proved otherwise through a capacity assessment.
- Individuals must be given help to make a decision themselves. This might include, for example, providing the person with information in a format that is easier for them to understand.
- Just because someone makes what those caring for them consider to be an "unwise" decision, they should not be treated as lacking the capacity to make that decision. Everyone has the right to make their own life choices, where they have the capacity to do so.
- Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The principles:

(1) The following principles apply for the purposes of this Act.
(2) A person must be assumed to have capacity unless it is established that he lacks capacity.
(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Human Rights Act 1998

The Human Rights Act places an obligation on public bodies such as local authorities and NHS bodies to work in accordance with the rights set out under the European Convention on Human Rights (‘ECHR’). This means that individuals working for public authorities, whether in the delivery or services to the public or devising policies and procedures, must ensure that they take the ECHR into account when carrying out their day to day work.

The Gunning Principles

R v London Borough of Brent ex parte Gunning [1985] proposed a set of consultation principles that were later confirmed by the Court of Appeal in 2001.

The Gunning principles are now applicable to all public consultations that take place in the UK. Failure to adhere to the Gunning principles may underpin a challenge relating to consultation process that may be considered through judicial review.

The principles are as follows:

1. When proposals are still at a formative stage
Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.

2. Sufficient reasons for proposals to permit 'intelligent consideration'
People involved in the consultation need to have enough information to make an intelligent choice and input into the process. Equality Assessments should take place at the beginning of the consultation and be published alongside the document.

3. Adequate time for consideration and response
Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?

4. Must be conscientiously taken into account
Decision-makers must take consultation responses into account to inform decision-making. The way in which this is done should also be recorded to evidence that conscientious consideration has taken place.

"The Four Tests" – NHS Mandate 2013-15 (carried forward through NHS Mandate 2015-16)

NHS England expects ALL service change proposals to comply with the Department of Health's four tests for service change (referenced in the NHS Mandate Para 3.4 and 'Putting Patients First') throughout the pre-consultation, consultation and post-consultation phases of a service change programme.

The four tests are:

- Strong public and patient engagement

- Consistency with current and prospective need for patient choice
- A clear clinical evidence base
- Support for proposals from clinical commissioners.

As a proposal is developed and refined commissioners should ensure it undergoes a rigorous self-assessment against the four tests. This has already been developed in partnership with NHS England.

Planning, Assuring and Delivering Service Change for Patients – NHS England Guidance

Guidance from NHS England sets out the required assurance process that commissioners should follow when conducting service configuration.

Section 4.4 of the guidance refers to involvement of patients and the public, stating that "*it is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service reconfiguration. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential… Early involvement will give early warning of issues likely to raise concerns in local communities and give commissioners time to work on the best solutions to meet those needs."*

Transforming Participation in Health and Care – NHS England Guidance

Transforming Participation contains guidance from NHS England to help commissioners to involve patients and carers in decisions relating to care and treatment and the public in commissioning processes and decisions.

Equality Analysis

The CCG has a duty to meet its public sector equality duty, as defined by S.149 of the Equality Act 2010. The CCG's Business Case for Primary Care Services sets out our Equality Impact Analysis and provides further information.

In summary, in the exercise of its functions, the CCG must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not

- Foster good relations between people who share a protected characteristic and those who do not

Targeted engagement has ensured that people from all groups with protected characteristics, defined within the Equalities Act (see 6.3 above), have had the opportunity to participate in the three phases of pre-engagement and the development of potential new Primary Care Service models.

To ensure that the CCG is fully meeting this duty, an equalities analysis has also been undertaken and is in the process of being validated and further informed through continuing engagement.

The equality analysis has considered potential impacts that any change to the extended Primary Care Services may have on people from groups with protected characteristics.

To validate these perceived impacts, people from these groups have been engaged and asked about their perception of how any change to service might have an impact on them, whether this be positive or negative.

The equalities analysis will be reviewed throughout the consultation process, and additional engagement will be conducted around this as required.

3.12 Data analysis

The consultation activity will result in a number of streams of quantitative and qualitative data. Due to the size and nature of the consultation, it is anticipated that the amount of data will be significant.

As the data and feedback from the public will inform the decision-making of the CCG in relation to potential changes and developments to the extended Primary Care Services, it is essential that the data and feedback is subject to robust, independent analysis.

We will be working with Healthwatch to oversee and approve our process however, in order to ensure that all public money goes into NHS services. The CCG Team will analyse the outcome and provide a report linking to the services evaluation.

3.13 Reporting and feedback

The consultation feedback will be received and reviewed by the CCG before any final decisions are made about future services. It is anticipated that the consultation feedback will enable the CCG to make informed decisions about commissioning services that reflect public need.

Following a period of consideration, the CCG will then make a decision on any changes to extended Primary Care Services. This decision will be published and communicated to stakeholders, along with the rationale for making that decision and the reasons that other options were not taken forward.

This will be assured and signed off by NHS England.

Evaluation will be on-going throughout the consultation period and beyond, overseen by the Primary Care Service Task and Finish Group.

Once the consultation has closed, a full evaluation of the consultation, including development and implementation, will be conducted.

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APPENDICES TO APPENDIX 2

Appendix 1 – Pre-engagement activity

Date	Key contact and location	Lead	Stakeholder	Action
14th November 2017	Sarah Burns, Director of Commissioning, Durham Dales, Easington and Sedgefield (DDES) CCG	Sarah Burns	Internal stakeholder	Met for an initial meeting to discuss the current situation and discuss what engagement is needed for gathering patient views
30th November 2017	Tina Balbach / Gail Linstead	Tina Balbach / Gail Linstead	Internal meeting	Planning and developing the engagement activity
18th December 2017	Meeting with DDES CCG, David Robertson and Rural Dales Councillors	Sarah Burns	Councillors	Discussed actions for engagement around the primary care services and under utilisation and how to gather views
9th January 2018	Tina Balbach / Gail Linstead	Tina Balbach / Gail Linstead	Internal meeting	Developing the engagement activity
25th January 2018	Bernie Crooks, Specialist Nurse / Health Visitor for Gypsy Romany Traveller Children and Families in County Durham	Tina Balbach	Gypsy Romany Travellers	Visited three sites: Ash Green Way, St Philips and East Howle and met with mothers with babies and young children to gather their views on primary care services. Also met with some older people and discussed their experiences and views on these services.
1st February 2018	Easington Hub	Clair White	Patients and carers	Speaking to patients who attend the extended primary care service
5th February 2018	Peterlee Hub	Clair White	Patients and carers	Speaking to patients who attend the extended primary care service
5th February 2018	Spennymoor Hub	Lyndsey Jones	Patients and carers	Speaking to patients who attend the extended primary care service
6th February 2018	Seaham Hub	Lyndsey Jones	Patients and carers	Speaking to patients who attend the extended primary care service

7th February 2018	Sedgefield Hub	Lyndsey Jones	Patients and carers	Speaking to patients who attend the extended primary care service
7th February 2018	Bishop Auckland Hub	Lyndsey Jones	Patients and carers	Speaking to patients who attend the extended primary care service
12th February 2017	PCS – Dales hubs	Clair White	Patients and carers	Speaking to patients who attend the extended primary care service
7th February 2018	Margaret Ross, Practice Manager, Marlborough Surgery	Tina Balbach	Patient Participation Group (PPG) Patient Group	Speaking to members of the PPG about the primary care services.
7th February 2018	Margaret Ross, Practice Manager, Marlborough Surgery	Tina Balbach	Patients and carers	Speaking to patients about their views and experiences on using primary care services also asking them to complete a short questionnaire
8th February 2018	Houghton Primary Care Centre, Houghton	Tina Balbach	Patients and carers	Speaking to patients about their views and experiences on using primary care services and asking why they aren't using their local services and going to this walk in service. Also asking them to complete a short questionnaire
12th February 2018	Bishop Auckland Hubs	Lyndsey Jones	Patients and carers	Speaking to patients who attend the extended primary care service
14th February 2018	Houghton Primary Care Centre, Houghton	Tina Balbach	Patients and carers	Speaking to patients about their views and experiences on using primary care services and asking why they aren't using their local services and going to this walk in service. Also asking them to complete a short questionnaire
14th February 2018	University Hospital of North Durham	Clair White / Lyndsey Jones George	Patients and carers	Speaking to patients about their views and experiences on using

				primary care services and asking why they aren't using their local services and going to Accident and Emergency. Also asking them to complete a short questionnaire
14th February 2018	Darlington Memorial Hospital	Clair White / Lyndsey Jones George	Patients and carers	Speaking to patients about their views and experiences on using primary care services and asking why they aren't using their local services and going to Accident and Emergency. Also asking them to complete a short questionnaire
16th February	Hartlepool Urgent Care Centre	Lindsay Fox	Patients and carers	Speaking to patients about their views and experiences on using primary care services and asking why they aren't using their local services and going to this walk in service. Also asking them to complete a short questionnaire
20th February 2018	Easington Patient Reference Group (PRG)	Gail Linstead	Patient Group	Explained to the group about the engagement work and asked for their support in gathering patient feedback
21st February 2018	Sedgefield Patient Reference Group (PRG)	Tina Balbach	Patient Group	Explained to the group about the engagement work and asked for their support in gathering patient feedback
25th April 2018	DDES Wide	Sarah Burns/ Clair white	DDES Practices	Presented on review of PCS Hubs
25th April 2018	Primary Care Home Meeting	Sarah Burns/Clair white	DDES Practice locality Leads and clinical leads	Presented activity of hubs and summary of engagement report and presented 3 options for opinion
4th May 2018	DDES GP Surveys	Lindsay Fox	Practice Managers	Surveys went out following presentation at DDES wide to gain

				the views from all practices
24th May 2018	DDES Wide/PCH Meeting	Sarah Burns / Lindsay Fox	DDES practice locality leads/clinical leads	Follow up discussions further to information collated from surveys sent to all practices. Discussions around options again and what they felt would work best in their localities
6th July 2018	Overview and Scrutiny Committee (OSC)	Sarah Burns/ Clair White	OSC Committee members	Presentation to the committee on review of services based on activity and engagement.
??	Easington PRG	Clair White	Patient group	
3rd August 2018	Durham Dales PRG	Clair White / Lindsay Fox	Patient group	
13th August 2018	Sedgefield PRG	Clair White / Lindsay Fox	Patient group	
21st August	Easington PRG	Clair White / Lindsay Fox	Patient group	

Appendix 2 – Engagement following advice from local health Overview and Scrutiny Committee

How we have got to where we are with the model
Business Case – signed off, decision to close all day time Urgent Care and to have GP extended access only, no walk in – done 2016-17 – approved/assured by NHS E and OSC
Coms and engagement/consultation plan that went to OSC September 2016 and was approved and commenced – that message was what to do if unwell, talk before you walk, NHS111
Decisions Log
Coms and engagement presentation demonstrating where and what we have done
Presentation from federations and practices on their messages as providers
Patients designed the resources the resources and worked with the CCG to promote these messages
Practice communication – checking in screens, banners, posters, websites, SMS sessional messages
Consulted widely on the model – spent £50,000
6 month review carried out
Findings from review
Evidence following our attendance at OCS July 2018, we have responded by:
Response to OSC official feedback
Press Release reminding of message
Posters sent to all DDES practices, pharmacies and staff
Regular social media updates
Consultation and & engagement plan for change 18/19
Consultation document
NHS England 4 tests, Quality Impact Assessment, Equality Impact Assessment - NHSE are supportive of our position
Healthwatch – supportive of our position
Invitations sent out to councillors and MPs offering to meet to discuss further
Meetings with MPs
Meetings with councillors: Cllr J Sutherland Cllr J Robinson/Cllr P Brookes/ Cllr J Grant Cllr L Maddison
Area Action Partnerships (AAPs) – Heads of Services to update on proposals
PRGs – one in each locality
Further engagement – questioners carried out for a further 4-5 weeks
National guidance £6.00 per head, must provide GP extended access (not urgent care)
UTC/Urgent Care standards are – NHS 111 is the way to signpost patients to services and must be in place by next year – we are ahead of this model

Appendix 3 - Communication Plan

Stakeholder	Type	Communication Method
MPs and Councillors	Public representative	Briefings News (stakeholder) 1-1 Meetings – if required Consultation plan
Parish Councillors	Public representative	Briefings News (stakeholder) 1-1 meetings – if required Consultation plan
Pressure Groups	Public representative	Briefings News (stakeholder) 1-1 meetings – if required Consultation plan
GP Practices	CCG members	DDES Wide GPTN Newsletter Briefings News (stakeholder) 1-1 meetings – if required Consultation plan Council of Members Locality Meetings
Federations	CCG members	DDES Wide GPTN Newsletter Briefings News (stakeholder) 1-1 meetings – if required Consultation plan
Council of Members	CCG members	Council of Members Locality Meetings
Patient Reps (PRG/PPG)	Public	PRG meetings PRG Chair Meetings Briefings News (stakeholder) Consultation plan
Media	Public (interest)	Pro-active statements Radio TV Reactive statements Briefings

Existing Providers – staff	Health service provider	Staff meetings Briefings Joint communications developed between CCG and existing provider for existing staff
Local Authority (incl. AAPs, HWBB, Public Health)	Public	Briefings News (stakeholder) Consultation plan Updates at regularly attended meetings
Executive Committee	CCG Committee	Briefings
Governing Body	CCG Committee	Briefings
Overview and Scrutiny	External committee	Briefings News (stakeholder) Consultation plan
General public/patients	Public	Consultation plan Public meetings Pre-consultation information Patient education programme
Existing providers	Health service providers	Briefings News (stakeholder) Joint communications developed between CCG and existing provider for existing staff
Extended Primary Care Access Task and Finish Group	CCG internal operational group	Meetings briefings
Third sector organisations	Public/link organisations	News (stakeholder) Briefings
CCG Staff	CCG internal group	News Briefings
Carers	Public	Briefings News (stakeholder) Public meetings
Neighboring CCGs	Health Commissioner	Briefings News (stakeholder)
Hard to Reach Groups	Public	Focus Groups – one per locality with East Durham Trust

		Briefings News (stakeholder)
NHS England		Briefings News (stakeholder) Task and finish attendance
Healthwatch		Briefings News (stakeholder)
Pharmacies		Briefings News (stakeholder)
Opticians		Briefings News (stakeholder)
Dentists		Briefings News (stakeholder)
LDC		Briefings News (stakeholder)
LMC		Briefings News (stakeholder)
LPC		Briefings News (stakeholder)

Appendix 4 – Proposed Consultation activities

An overview of proposed consultation activities are contained within the table below.

Consultation Activity	Overview
Locality based events	A number of local based events will be attended by relevant CCG staff to raise awareness about the start date and timeline of the consultation, provide relevant information as to how, where and when people can have a say about the proposed plans. In particular, discussion will take place at the following meetings:
Formal public events	Nine public events across the DDES area with three in each locality taking place across the consultation period. There will be a combination of weekday evening and daytime events as well as weekend daytime events in each locality. The weekday events will each be held on different days of the week to maximise the opportunity for people to attend who may be able to attend on specific weekdays due to other commitments such as work. The proposed venues may be Peterlee, Seaham, Spennymoor, Bishop Auckland, Weardale and Barnard Castle.
Existing Provider Staff Information sessions at hubs across the DDES CCG area	
Public drop-in information sessions at public venues across DDES	Libraries, leisure centres
Discussion groups	Targeted discussion groups with stakeholders with an interest in the protected characteristics defined in the Equality Act 2010. Facilitated and self-directed discussion groups with community and voluntary organisations For example this will include the following groups, amongst others:

	Investing in Children The CCG Engagement Lead will introduce the Extended Primary Care Access consultation to young people so that they can organise at least two Agenda Days ('adult-free events'). Generally, at these events the young people will discuss the consultation document and some issues that the proposed changes may pose to young people. However, the details will be discussed in a planned session to ensure that the young people's voice is included meaningfully in planning the Agenda days. This group were also involved in the pre-engagement. **Learning Disability People's Parliament -** The CCG engagement lead will have an introductory meeting with the People's Parliament in order to discuss how partnership working could be developed in the future. The Primary Care Service consultation will be discussed. In particular, there will be a discussion around holding mini-consultation sessions with the Parliament in order to provide them with a safe and non-threatening forum where they can receive information, ask questions and have a say. **Gypsy Roma Travellers (GRT) Practitioners Forum** The GRT Practitioners Forum was set up in 2015 as a means to bring together practitioners who work with the GRT community in County Durham (both on site and in housing). The purpose is for practitioners to share and disseminate information about their services and way to seek opportunity to work together on specific issues. Through this Forum, TB will try to disseminate information about the consultation, to understand the impact that the proposed changes may have and to get the GRT community's views on the consultation. This group were also involved in the pre-engagement.

	Waddington Centre The CCG engagement lead will arrange an introductory meeting with the Manager of Waddington Centre in order to discuss how partnership working could be developed in the future. The Primary Care Service consultation will be discussed. In particular, there will be a discussion around holding mini-consultation sessions with service users with mental health issues in order to provide them with a safe and non-threatening forum where they can receive information, ask questions and have a say.
Information stall and presence at local public events	Key local public events will be identified and, where possible, information stalls will be set up at events containing information about the consultation. Those attending the event will have the opportunity to participate in the consultation, or to do so later at home or online.
Engagement using social media	A programme of social media communication will be developed including mechanisms such as Facebook, Twitter, You Tube etc.
Information and consultation briefing documents / questionnaires provided online and in public places	Information and consultation documents will be available online and will also be distributed across a variety of public buildings and places in the DDES area.

Appendix 5: Media Handling Strategy

NHS Durham Dales, Easington and Sedgefield CCG

Pro-active media plan

Note: a separate media handling plan for re-active media enquiries has been added as an appendix to the Primary Care Service consultation communications and engagement strategy.

Pro-active media planning is an important part of the overall communications and engagement strategy. The aim is to inform local people about the consultation and how they can get involved through as many communication channels as possible. These are outlined below.

- **Press**

    1. Pre-launch press release – what we are going to do, why we are doing it, how we are doing it and how people can get involved.
    2. Brief to editors of local newspapers to inform them of the forthcoming proposals including key contact details and spokespeople
    3. Launch press release informing people clearly about how they can get involved (public drop in events/online questionnaire available on CCG website/how to follow us on Twitter etc.)
    4. Press release prior to each public engagement event
    5. Press release week prior to end of consultation i.e. last chance to give us your views
    6. Press release to inform public consultation has ended and next steps, signpost to further information

- **Dr Stewart Findlay's column in the Northern Echo**

    Use Dr Stewart Findlay's regular column in the Northern Echo to track progress of consultation. Dates of publication throughout the proposal are as follows:

    This column is monthly.

- **Social Media**

    Facebook and Twitter will be utilised to push key messages throughout the consultation. Highlighting events, surveys and opportunities to get involved.
    Using Facebook and Twitter effectively will allow the CCG to stay ahead of any press coverage and release messages both proactive and re-active.

The use of social media will coincide with the press plan outlined above.

- **My NHS**
  All info from press releases and links to questionnaire to be e-mailed and posted to My NHS members.

- **CCG website**
  Add branded banner to CCG website homepage for the duration of the consultation so that people (members of the public/staff/journalists/health partners etc) can easily access information about all aspects of the proposal via the CCG website.

- **Stakeholder newsletter**
  Use quarterly stakeholder newsletter to inform stakeholders about the consultation and how they can get involved.

- **Community newsletter**
  Use regular community newsletter produced by Silvia Scalabrini to inform key community contacts about the consultation and how they can get involved.

- **Communication colleagues**
  Forward all press briefings to relevant communication colleagues within the local authority and hospital Trusts.

Key contacts

Any media enquiries received by the CCG or wider project team should be directed to the NECS communications and engagement team, without comment.

NECS communications and engagement: Simon Clayton: 01642 745026 simonclayton@nhs.net

CCG project contacts: Sarah Burns: 0191 371 3217 sarahburns3@nhs.net, Clair White: 0191 371 3222 clairwhite1@nhs.net

CCG communications and engagement: Tina Balbach: 0191 371 3245 tina.balbach@nhs.net

CDDFT comms: Gillian Curry: 01642 854343; gillian.curry@cddft.nhs.uk

NHS England comms: to be entered

Appendix 6: Consultation Communications and Engagement Action Plan

Activity	Detail	Who is responsible	Timescales
Pre-engagement	Stage 1 pre-engagement activity Stage 2 pre-engagement activity	CCG CCG	
Governance	Primary Care Service Task and Finish Group • Terms of reference • Identify members • Schedule weekly meetings The group will manage and oversee consultation, as outlined in their terms of reference	Delivery team	
Stakeholder Mapping	Develop stakeholder spreadsheet - contacts Establish existing stakeholder mapping from pre-engagement Conduct additional stakeholder mapping to ensure complete stakeholder list for consultation Review and update stakeholder list throughout consultation	?? TB/SL or JM TB/East Durham Trust/PCP/Groundwork re 9 protected Characteristics TB/SL	
Supplier and Resources	Identify suppliers and obtain quotes Plan and confirm timescales and turnaround for resources and suppliers Procure required resources and suppliers with agreed deadlines and arrangements	Task & Finish Group/SC SL	

	to provide each resource		
Identify and Branding	Develop project branding and identity, share with PRGs Develop marketing material – flyers, newsletters, posters, leaflets, pull up banners, power point presentations etc	Task & Finish Group/SC	
Communications Key Messages	Development of key messages, FAQs	JMcG	
Consultation briefing document	Develop consultation briefing document Consider different languages and formats that may be required, including large print, braille, audio, easy/read etc Determine number of each type of document Have documents produced by agreed supplier within agreed timescales Consultation video	Task & Finish Group/SC/TB NECS NECS/Task and finish	
Consultation Dialogue	Plan content and format of required communications and engagement activity Develop, make arrangements for and publicise consultation activity, including Radio advertising? Press / media 9 formal public events across Durham Dales, Easington and Sedgefield	Task & Finish Group/SL/TB/SC Task & Finish/SL/TB/corporate admin TB/East Durham	

		Trust/Groundworks/PCP	
	Targeted discussion groups with stakeholders with an interest in the protected characteristics defined in the Equality Act 2010/ Facilitated and self-directed discussion groups with community and voluntary organisations	TB	
	Additional meetings - People's Parliament/ Investing in Children/Gypsy Roma Travellers	TB/SL	
	Practitioners Forum/LGBT group/Macmillan	TB/SL	
	Discussion groups in public places – libraries/surgeries	TB/SL	
	Information stall and presence at local public events	NECS/SC	
		NECS/TB	
	Consultation roadshows – supermarkets/shopping centres	CCG AAP Leads via forums	
		SL/TB	
	Online and hardcopy consultation document and survey	NECS	
	Information and surveys in		

	public places	Task and Finish/SL/TB	
Developing and supporting dialogue	Identify suitable venues for public events Visit venues to check suitability (disability access, parking, bus route, acoustics, large numbers) Arrange catering Promote events Send invites to all stakeholders, including those who took part in the pre-engagement Develop facilitator packs for facilitators at events Develop agendas and evaluation sheets for events Identify and confirm facilitators and scribes for events	SL/TB/corporate admin SL/NECS SL/Task and finish for contacts SL/NECS/NG/Corporate admin SL/NECS/NG SL/NECS/Corporate admin	
Online	Design dedicated section on CCG website Ask for partners and stakeholders to place on their websites and to cascade via their social media channels Develop content for social media	SC TB/SL/SC SC	
Public Relations and Advertising	See Appendix 6 media handling strategy		
Distribution of Consultation Materials	Develop distribution plan for flyers, posters and booklets to public places Identify and source a mailing house / distribution company	SC/NECS SC/NECS	

	to distribute all information		
Recording	Develop and maintain consultation action log	Task & Finish Group	
Analysis and Reporting	Ensure independent supplier identified and procured in good time to conduct analysis and reporting when the consultation closes	NG	
Quality and risk assurance	Provide quality and risk assurance of the engagement process	Consultation Institute NHSE	

Appendix 7 – NHS Assurance Self-Assessment – DDES CCG 5 Tests

	Key Tests	• DDES evidence
5 key tests	• Strong public and patient engagement, • Consistency with current and prospective need for patient choice • A clear clinical evidence base • Support for proposals from clinical commissioners NHSE fifth test N/A for this service change • Proposals including significantly reducing hospital bed numbers will have to meet one of the following three conditions: -Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or -Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or -Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).	• See evidence in case for change for this service review • See evidence in full case for change previously assured by NHSE. • See coms and engagement report for this service change and previous service change • Full consultation report in development for this service change going to OSC September 2018 • See recognition from OSC on our previous consultation/ engagement process undertaken on the same service implementation (noting this was the change around closing urgent care through the day and providing GP extended access only form multi sites). This was endorsed by the Consultation Institute. To note OSC also signed off our coms and engagement strategy prior to any service changes and supported the material produced and our plans in place. • Local clinical support for proposed changes as set out in the case for change document. • Support from the CCG executive committee for proposed changes • See Healthwatch recognition on the robustness of our consultation and coms strategy and their support on the new potential service change, they also support our coms and engagement strategy as they led most of the work previously and would not support the need to do any further communication. • See coms presentation that includes all communication pre and post service changes including that carried out by the provider. • An evidence log is in development to summaries all work undertaken to this point • Patient choice around what to do if you are unwell and a range of options has been one of the key messages throughout and pocket guides printed to support. NHS 111 also supports this message giving patients the options available to them based on their condition and need. • Patient satisfaction surveys are carried out as a minimum with all users of the service that attend the services that is in additional to the independent surveys carried out locally to support the case for change. • PCS service usage questionnaires carried out over 9 weeks has now been extended into September to allow for more feedback to support the recommended case • See national guidance referenced around how these services (extended access to GP services) should be commissioned and what capacity should be created in the GP5YFV, this is 45 minutes per 1000 population for the higher level. DDES are over by 100% in all areas – see business case demonstrating over-commissioning to support the population • See UTC standards referenced throughout - this identifies all activity should be signposted via NHS

		111 by the end of 2019 to all services in a coordinated way making it easier for the public. DDES CCG are already working to those standards and are recognising across the country as an example of best practice. • Received NHSE support around our model across both services as our service is way more advanced than others, as we are already promoting zero walk in services and using the NHS 111 tool • See the activity reports around site usage and zero impact on the wider health system • GP practice and clinical commissioners all signed up to service improvement via DDES wide mtg, Executive meetings , minutes available

Special Adults Wellbeing and Health Overview and Scrutiny Committee

7 September 2018

County Durham Healthwatch Annual Report 2017/18

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

Purpose of the Report

1 To provide members of the Adults Wellbeing and Health Overview and Scrutiny Committee with background information to support a presentation by representatives of Healthwatch, County Durham in respect of their Annual Report for 2017-18.

Background

2 The Health and Social Care Act 2012 established Healthwatch England as the national consumer champion in health and social care. It has significant statutory powers to ensure that the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and social care services.

3 Healthwatch County Durham is the independent, statutory champion for consumers of health and social care services in County Durham.

4 Representatives from Healthwatch County Durham will provide members with a presentation setting out the key messages from their 2017-18 Annual Report.

5 A copy of Healthwatch County Durham's 2017-18 Annual Report is attached to this report.

Recommendation

6 The Adults Wellbeing and Health Overview and Scrutiny Committee is recommended to receive this report, note and comment on the presentation by Healthwatch in respect of their Annual Report for 2017-18.

Background papers

None

Contact: Principal Overview and Scrutiny Officer Tel: 03000 268140

Appendix 1: Implications

Finance - None

Staffing - None

Risk - None

Equality and Diversity / Public Sector Equality Duty – None

Accommodation - None

Crime and Disorder - None

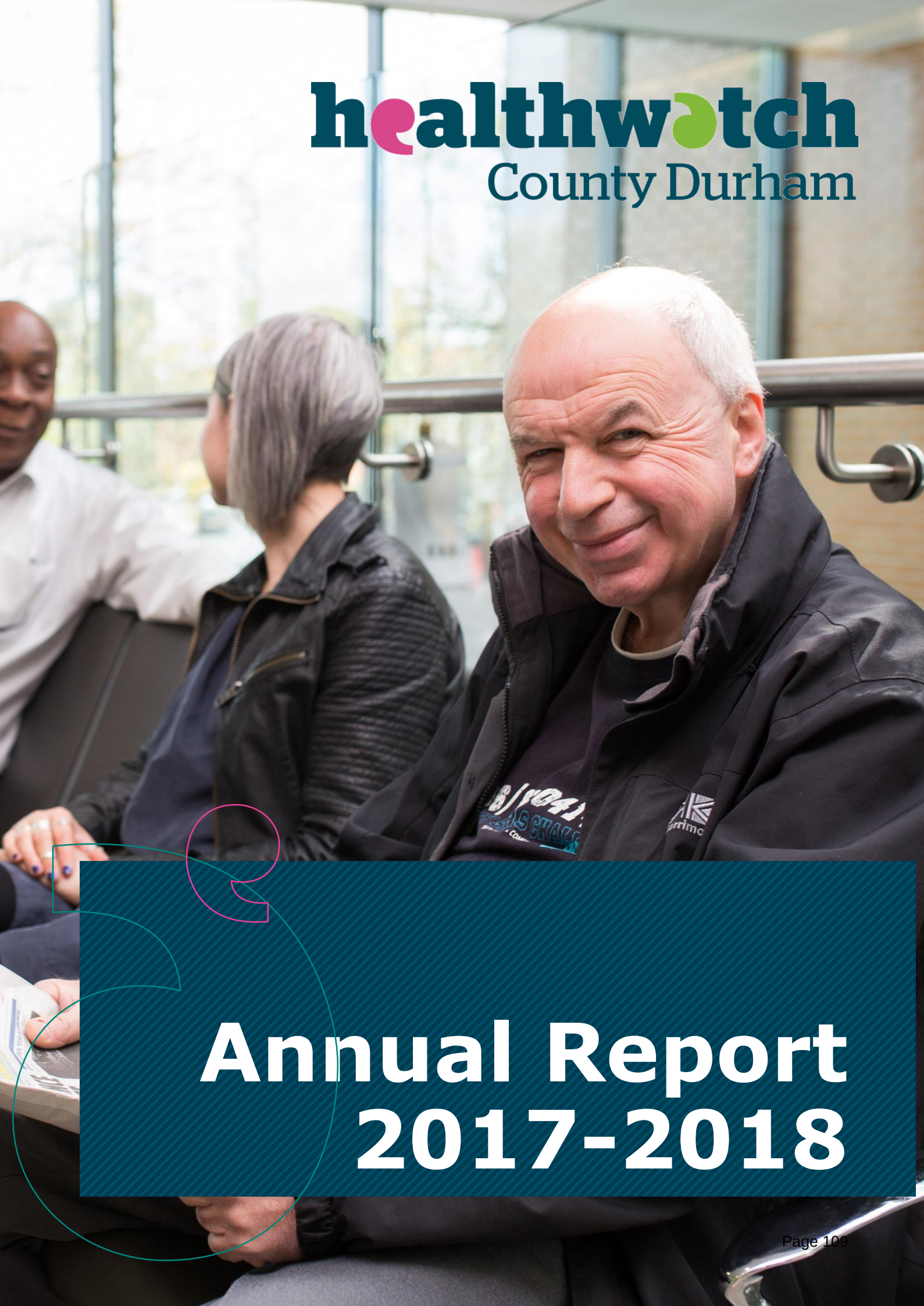
Human Rights - None

Consultation – None

Procurement - None

Disability Issues - None

Legal Implications – Healthwatch County Durham is the statutory local consumer champion for health and social care services in County Durham in accordance with the requirements of the Health and Social Care Act 2012.



healthwatch
County Durham

Annual Report 2017-2018

Contents

Message from our Chair

It has been a full and rewarding year for all at Healthwatch County Durham. This report showcases how we have made a difference by engaging with you on important health and social care issues in the county so that we can make recommendations for future improvements and change.

Our work this year has ranged across a variety of local health and social care services from pharmacies and GP surgeries to cancer screening programmes. Healthwatch County Durham is delighted to be:

+ involved in making sure stroke patients get the right support to meet their needs after an existing service was decommissioned
+ supporting the success of cancer screening programmes by finding out what is stopping people from getting screened and how these barriers might be overcome
+ delivering a programme of Enter and View visits at local GP surgeries to identify and share good practice

> **"Healthwatch County Durham is ensuring patients and service users have a voice"**

This year we have been proud to be awarded the County Durham Volunteering Kite Mark in recognition of our supportive programme for volunteers. We are also on our way to becoming a dementia friendly organisation, with all staff and volunteers offered training to become "dementia friends".

I hope you enjoy reading our report and trust you will find we have indeed tried to be the voice of the people for health and social care issues in County Durham. Be assured we share your feedback with Healthwatch England and the Care Quality Commission as well as local decision makers.

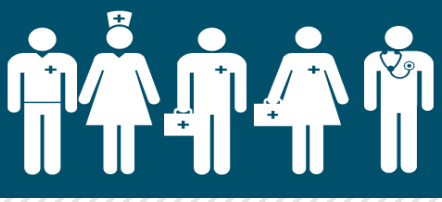
My sincere thanks to all staff, board members and volunteers for their dedication this year.

Best wishes,

Brian Jackson

Highlights from our year

We've captured **2,045** people's views about health screening



We've reached **2,783** people on social media

Our volunteers have given **1,662** hours of support

We've given **234** people information and advice

We've engaged with **883** people at outreach events

We've tackled issues ranging from **pharmacies** to **stroke services** in our reports

We've engaged with **897** women on cervical screening

Our **26** volunteers have helped with everything from Enter and View visits to website design

Who we are

Healthwatch County Durham helps you and your family get the best out of health and social care services in County Durham. We share your experiences and views of services with providers to encourage them to act on what matters to you.

As well as championing your views locally, we also share your feedback with Healthwatch England, who use your voice to encourage the government to put people at the heart of national health policy.

Our team

The staff team are supported by a group of dedicated volunteers and board members and are passionate about making sure everyone's views are heard and making health and social care services the best they can be for everybody in the county.

The Pioneering Care Partnership (PCP), Durham Community Action (DCA) and Citizens Advice County Durham (CACD) are accountable for delivery of Healthwatch in County Durham.

"Healthwatch has achieved so much during 2017-18, with over 2000 views received on work plan items, volunteering hours increased by over 1000 from the previous year and the Information and Signposting service has received 37% more enquiries. Going forward we will aim to hear even more people's views so that we can continue to help shape health and social care provision effectively"

Carol Gaskarth, PCP Chief Executive

"The Board, Marianne and her team are to be congratulated. Healthwatch is now presenting the Clinical Commissioning Group (CCG) with very positive and constructive ideas about current issues in the NHS which means together we can improve services."

Feisal Jassat, Lay Chair, North Durham CCG

Meet the board

Judi Evans

Board member

"A year which has seen the volunteers deservedly recognised through their Durham Volunteer Kite Mark award. The strong sense of purpose, and in particular the focus on the voice of the patient demonstrated by all elements of Healthwatch County Durham, in no small part has contributed to its achievements. The availability of the signposting service, enabling all members of the public to contact the team directly, has shown the team's commitment to offering individual support and resolving people's issues."

Chris Shore

Board member

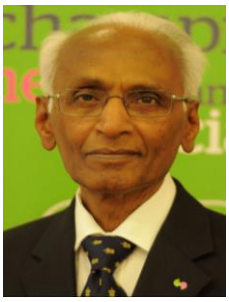
"It has been another busy year for the staff and volunteers of Healthwatch County Durham. The team's engagement work with vulnerable women has provided very useful background information about how safeguarding works, and is understood, around the county. Meanwhile, on a personal note, I have been delighted to be able to represent the organisation as a partner member on the Local Safeguarding Adults Board. "

Zena Jones

Board member

"It has been exciting to be involved in such a wide variety of projects with the team this year. In particular, the work on stroke services has stood out particularly for me. I am also keen on digital developments so it has been great to see improvements in the website and Twitter feed. Most important, however, has been the celebration of our volunteers through the Kite Mark award. We could not have the reach we do without the support they give our brilliant staff team so a very big thank you to everyone involved!"

Meet the board



Lakkur Murthy
Board member

"Using my many years experience in the NHS I have continued to support Healthwatch, ensuring that residents in County Durham have been informed about, and able to influence, changes to health services in the county. I am confident we will continue this important work over the next year."

Mary Mitchell
Board member

"As one of the long-standing board members it has been rewarding to see the difference Healthwatch is making to the county. I'm especially interested in making sure residents in more rural areas have an opportunity to share their views about the way services are delivered."

Burnard Hume
Board member

"It has been an interesting year at Healthwatch and I have enjoyed supporting the NHS Quality Improvement Board for the Foundation Trust. Healthwatch is ensuring the patient, service user and carer voice is heard. The partnerships embedded in the work we do is helping to achieve positive change."

Jim Welch
Board member

"I have been a board member for Healthwatch County Durham over the past two years. The work and projects over that time have been relevant and interesting. In particular, I have enjoyed working on the Great North Care Record project with good support from other board members and members of staff. This project helped people from a variety of backgrounds, and with differing health needs, to understand where medical records are kept and how secure they are. It should give people confidence to ask more questions about their care records, especially people with visual impairments across the county."

Your views on health and social care

Listening to people's feedback on pharmacy services

In summer 2017, we went out and about to gather people's views on local pharmacy services. Working alongside the Local Pharmaceutical Committee (LPC) and Public Health, we visited a range of pharmacies in both rural and urban locations, from large chains to independents. We also produced an online survey which we shared on our website and via a number of agencies, including Age UK and Investing in Children.

The people we spoke to were overwhelmingly positive about their local pharmacy, with almost 94% (367 out of 397 people) saying they found pharmacy staff polite and helpful. We also asked people what additional services they would like to access from their local pharmacy or GP practice dispensary and the three most requested services were:

+ extended opening hours
+ disposal of needles and sharps boxes
+ health checks, e.g. blood pressure monitoring

We made several recommendations for developing services based on people's feedback and the two that have been adopted by the LPC are:

+ to make sure all pharmacies have facilities for people to consult a pharmacist in private and also that these are clearly advertised
+ to develop a targeted strategy to encourage more young people to access pharmacy services

In addition, Public Health have confirmed that, as a direct result of our recommendations, one of the three key actions included in the ongoing action plan for pharmacy services in County Durham will be to raise awareness of the wider range of services that are available at pharmacies.

"Thank you again for working with us and community pharmacy to produce a really positive and informative account of community pharmacy services in County Durham."

Greg Burke, chief officer of the Local Pharmaceutical Committee

- 7 pharmacy visits
- 2 community groups
- 397 people

Enter and View

Part of the local Healthwatch programme is to carry out Enter and View visits where representatives visit health and social care services to find out how they are being run and make recommendations for improvements. In 2017-18 we carried out four such visits in our area at Great Lumley GP surgery in Chester-le-Street; Intrahealth Pharmacy in Chilton; John Lowe Pharmacy in Blackhill, and Bewick Pharmacy in Newton Aycliffe. We would like to thank the service providers, service users, visitors and staff for their contribution to the Enter and View programme.

"Thank you Healthwatch for visiting our practice. We hope you were able to take away information and ideas from viewing our practices and procedures that will be helpful in your future work and benefit other GP practices. Your visit has certainly helped us focus our minds not only on what we are doing well but also on areas where we knew we needed to improve. In addition, it has also highlighted further areas where we need to develop and improve our service to patients.

The whole experience, from the initial approach by Marianne [project lead] through to our involvement with Claire [volunteer support] and then the volunteers on the day, has been extremely pleasurable and informative. The staff here on the day have all been extremely complimentary of your approach and methods."

GP practice manager

Improving access to annual health checks for people with learning disabilities

Young people and adults with learning disabilities who need more health support are entitled to a free annual health check. However, accessing services isn't always easy, so we have been working with service users, the region's Clinical Commissioning Groups (CCGs) and Durham County Council to increase the number of people taking up their health check.

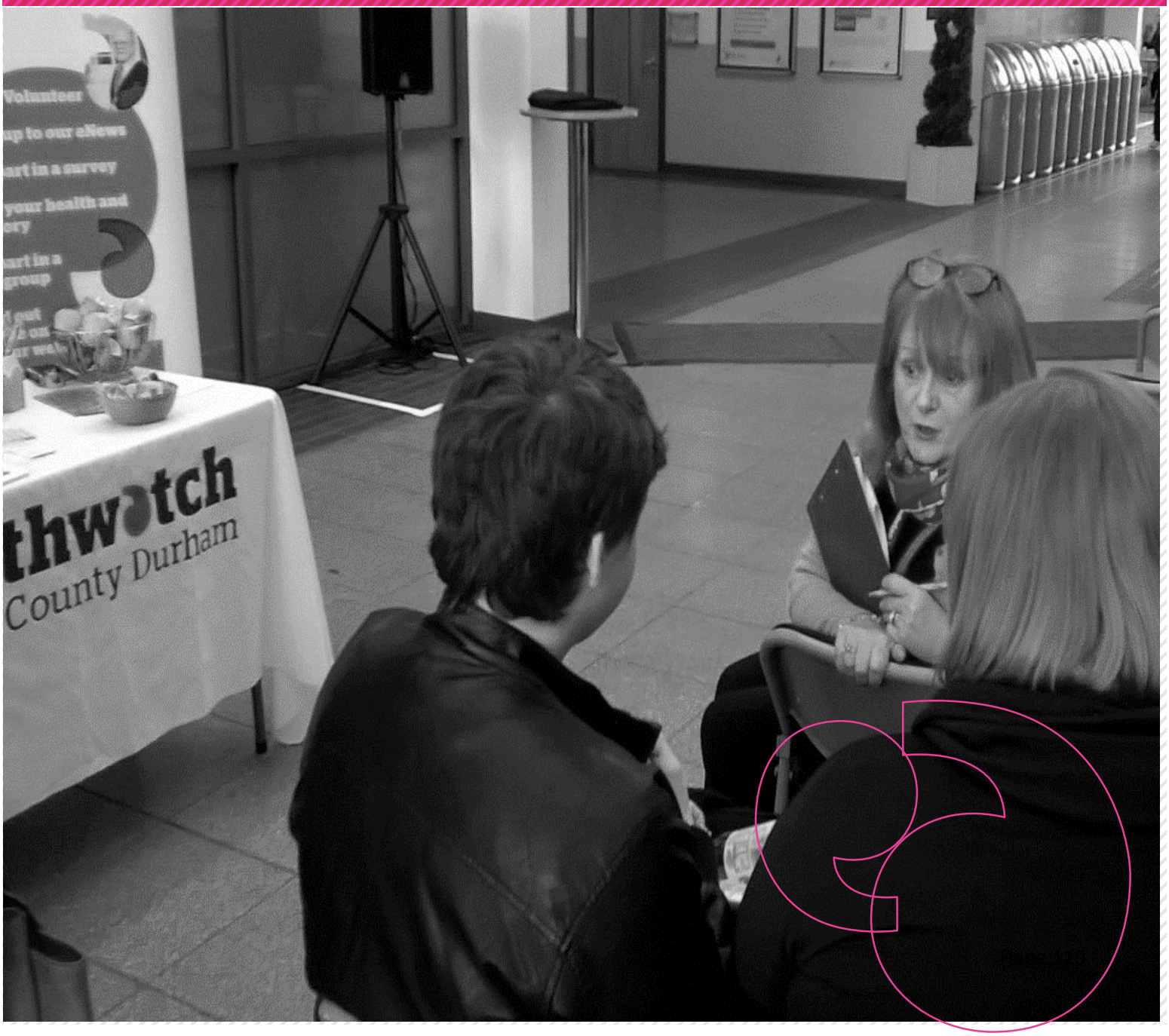
We spoke to 100 people with learning disabilities about what they felt stopped them going for their health check. Based on what they told us we recommended:

+ all eligible patients should be contacted in an appropriate and user-friendly manner to offer them a health check
+ any letters should be sent in an easy-read format
+ GPs should be encouraged to share best practice to maximise the uptake of health checks
+ GP surgeries should consider using alternative venues for health checks which may be less intimidating for people with learning disabilities
+ the use of peer groups to promote health check uptake should be encouraged

And our recommendations are already having an impact…

+ Shinwell Medical Group is running a pilot scheme offering health checks in a community setting and we are monitoring patient feedback
+ an easy-read health check letter has been developed in partnership with the CCG and Durham County Council
+ all GP practices now have access to this gold standard invite to send to their patients

Helping you find the answers



Signposting you to the health and social care support you need

Our Information and Signposting team is available Monday to Friday to help people with their health and social care queries – whether it's finding a specific service or giving advice, for example on how to complain or get the most from your GP.

In the last 12 months, the team has supported 234 people with a wide variety of questions, covering topics including:

+ how to access emergency dental services
+ GP appointment systems
+ missing medical records
+ finding appropriate nursing care placements for relatives

Case study: Helping a patient voice their concerns

We were contacted by a patient who was anxious because a prescription they needed was changing and would not be available for 48 hours. They were worried about the impact this might have on their health. We contacted the pharmacy on the patient's behalf to see if there was a solution. As a result, the pharmacy provided part of the prescription to cover the initial 48 hours with the remainder available to collect the next day. The patient was extremely happy with this outcome and the pharmacist was also pleased we had intervened as they had been unaware of the issue.

> **"Thank you for being so caring and professional. This is the first time that I've felt someone has listened to me."**
>
> *Signposting service user*

Case study: Improving awareness of dental services

Following the closure of two dental practices in the county over the last year, we have supported NHS England in signposting patients to other dentists in the area. We have also made recommendations to NHS England on how it could improve its signposting in future, based on the calls we received from concerned patients in these instances. For example, we suggested that, in future, any letters informing patients of closures should include both details of practices accessible to patients with mobility issues and details of the County Durham domiciliary dental practice. NHS England agreed these details would be included in future letters as standard. We also suggested that, in future, NHS England should inform local surgeries of any dental closures nearby so they can prepare for a likely increase in calls. NHS England said it does telephone local dental surgeries, however, it agreed that written signposting information should also be mailed to all those likely to be affected.

Finding health and social care services in County Durham

Are you having trouble finding the right health or social care service?

We have compiled a useful list of services around the county to help people find the right health support to meet their needs. **This can be found on our website.**

If you cannot access the electronic version of this document, please contact us on 0800 304 7039 and we can arrange to send you the information in an alternative format.

Keep up to date!

with local health and social care news, consultation and events, sign up to our e-bulletin at:

http://www.healthwatchcountydurham.co.uk/

Helping improve the county's online information portal for adult care and support

Locate is a website run by Durham County Council that provides information about adult care, support, and advice services in the region. Impressed by our previous work on improving local care home websites, the Locate team asked us if we would work with them to look at the effectiveness of the Locate website and how it might be improved. They felt we could help them get a realistic user's perspective on how well the website functions to meet people's needs and answer their queries.

A group of our volunteers have been working on the project for several months, using scenarios to help assess the website's effectiveness. They reported their initial findings to the Locate team in April and will be continuing to liaise with the council on this next year.

> "It was great to meet Healthwatch and the volunteers Tony and Mervyn who kindly took on this project, which must have been time-consuming. We are always looking to improve Locate so thank you. Great partnership work!"
>
> *Lesley Watson, Locate team, Durham County Council*

Making a difference together

Gathering views to improve maternity services

This year we spent time gathering views on maternity services at the request of health commissioners in North Durham and Durham Dales, Easington and Sedgefield. We looked specifically at breastfeeding and smoking during pregnancy and spoke to mothers about their experiences and choices around deciding whether or not to stop smoking and how to feed their babies. We also spoke to healthcare professionals and agencies in other areas to identify any initiatives they felt were improving outcomes for mothers and babies where they worked that could be learned from.

Our research showed that, overall, new mothers in County Durham felt supported whatever way they chose to feed their babies. However, women told us their experiences of post-natal support were not always what they had been led to expect. With regard to smoking in pregnancy, it was clear most women understood the risks to themselves and their babies if they continued to smoke, however, as with all addictions, early intervention was the key to helping them stop.

We shared our findings and recommendations from this research with commissioners and partners in County Durham who welcomed our input and fed it into their own work looking at how to improve maternity services and reduce smoking in pregnancy.

"The biggest critic was myself. I hated the fact that I smoked but when I felt guilty it made me crave more."

"Health professionals should be open to all ways of feeding."

"Too many mums are left struggling with no support and made to feel guilty for using formula."

"I was glad to receive daily telephone support from the maternity care assistants."

A range of mothers' views

"The [Healthwatch] report did highlight that 40% of women who were referred did not want to access the stop smoking service, therefore the recommendation of early intervention and Nicotine Replacement Therapy will be something we will look into."

Vince Lacey, Senior Commissioning Support Officer NECS

Working to reduce barriers to health screening

A major part of our work this year has been researching the barriers that stop people from accessing potentially life-saving cancer screening programmes. Although County Durham's uptake is slightly higher than the average for England and the North East region, we wanted to find out if anything could be done to encourage even more people to participate. Improvements in uptake could mean more cancers detected at earlier, more treatable stages.

We focused our work on breast, bowel and cervical cancer screening programmes. We wanted to hear from people from as wide a range of backgrounds as possible, so as well as using online surveys and conversations with people at widely accessed locations, we also carried out a mini "project within a project" aimed specifically at engaging women in more vulnerable positions. We used focus groups and one-to-one conversations at trusted places to capture the voices of women that otherwise might not have been heard, including:

+ women with mental health issues
+ women at risk of homelessness
+ women who are carers
+ women who have experienced domestic abuse
+ women from Gypsy, Traveller and Romany communities

Our impact

We made several key recommendations based on what people told us, including the need to better address some commonly held misconceptions about screening, such as that if someone is already being treated for one cancer they do not need to get checked for another. Our work has been well received by local CCGs and service providers and several changes to services are already being made as a result.

+ Public Health have secured funding for two new cancer awareness-raising posts and our findings and recommendations will be used in their work
+ Specialist cancer nurses in the area have also received our findings and will be working with patients to give them a better understanding of screening and the potential implications of choosing to be screened or not

"The screening detected my cancer very early and was dealt with incredibly well. It could have been so much worse had I not attended the screening."

"I am partially disabled and would only comment on the mobile unit that the steps are no good for me and some form of ramp could help"

"I am being treated for another cancer elsewhere, so I had assumed that I don't need to do this test as they will already have checked me for bowel cancer"

Working with our partners

Great North Care Record

The Great North Care Record is a programme to create a new way of sharing medical information electronically across the North East and North Cumbria – a region covering a population of approximately 3.6m people. The aim is to produce a platform to join up records in frontline care with an analytics platform that will be shared by the NHS, local authorities, universities, and other organisations relating to health and social care. It is hoped this will make the region the safest place in the world to receive care and the best place to do research.

All Healthwatch organisations within the North East and North Cumbria got involved with the programme. Our team hosted two events to help Connected Health Cities and Teesside University to engage with the public on the proposals. With these events we wanted to:

+ gather people's views on current and future models of consent for use of information
+ provide information on the constraints of current practice in information sharing at the point of care, and in planning and research, and potential issues these can cause
+ gain feedback on people's views and "tolerance levels" of how information sharing may develop in future

"The consultation was on data and information sharing for use in healthcare, including for planning and research purposes, and hence was a sensitive and (potentially) complex topic. Healthwatch worked closely with us to scope how this could be done. Our timescale was quite challenging (September to mid-December 2017) but Healthwatch managed to achieve this and we totalled 21 sessions to about 340 participants from a variety of backgrounds. Despite the logistical challenges we couldn't have envisaged the sessions going any better, and the level of participation and feedback received was invaluable in shaping our onward programme. To turn up to each session with everything ready, and the public participants fully informed, was way beyond our expectations!

At all times Healthwatch staff were very professional and extremely well organised. They also had great knowledge of the needs and expectations of the people we wanted to engage with and how to do this successfully. We look forward to collaborating with the Healthwatch network again."

Mark Walsh - Operations Director, Connecting Health Cities

it starts with YOU

When stroke patients found out a local support service was being decommissioned many turned to us for help. Our recommendations based on their feedback were well received and mean a new service will be better tailored to their needs.

#ItStartsWithYou

Early in 2017, stroke patients in County Durham were surprised to be told their community support service was being decommissioned – without any clear word on what, if anything, would replace it. Many contacted us with their fears. We responded by securing an extension of the existing service from commissioners, who then asked us to help gather feedback from patients and carers to help shape a new service to support stroke survivors once they leave hospital.

We spoke to 155 people over a three-month period using a mixture of online surveys, postal questionnaires and face-to-face engagement. From this we made some core recommendations relating to:

+ developing clear support pathways
+ providing person-centred support plans
+ providing clear, informative literature, including details of local support such as voluntary groups
+ providing advice about heathy lifestyles and other measures to reduce the risk of further strokes

A great result for patients

We published our report in November 2017 and were delighted when commissioners agreed to put in place new services for stroke patients provided by the Stroke Association that will incorporate our recommendations. They said our report was "influential" in their decision-making. Patients and carers were able to have a voice and influence service changes and as a result the new service should better meet their needs. A big thank you to everyone who gave us their views and so helped influence the service redesign in this way. It started with YOU!

"In terms of what will be different with the new service, the support offered by the Stroke Association will be a more integrated service including communications support, emotional support and safeguarding. The service will also undertake six-monthly reviews of stroke patients as recommended by NICE guidelines. This was not included in the previous service and helps to provide feedback on services received and required by the stroke survivor. The service will also support patients with their joint care plan, an area which was highlighted by the Healthwatch report."

Vince Lacey, Senior Commissioning Support Officer, NECS

Our plans for next year

Your priorities are our priorities...

In February and March 2018 we gave everyone in the county the opportunity to help decide which health and social care services we focus on for the next year. First we identified six key areas of concern for residents from our signposting and partnership work. These were:

+mental health support available for people with low level anxiety or stress
+GP appointment systems
+dementia support services - including referral processes
+patient transport – specifically the quality of information available about this
+support for those transitioning from children's to adult services
+dental charging/treatment – understanding and accessing information about these

We then asked people which of these six areas they thought should be our priorities. More than 500 people gave us their views via an online survey and through face-to-face interviews at a range of venues. As a result, the top four choices that will be prioritised in our work through 2018-19 are:

+mental health services
+GP appointment systems
+dementia services
+transitions from children's to adult services

We will let you know when you can tell us your views about these services and keep you up-to-date with all our findings.

Enter and View

We have an ongoing programme of Enter and View visits to GP surgeries. These visits are carried out with the support of individual surgeries and are an opportunity for gathering patients' views and identifying aspects of good practice that can be shared with other GPs.

a) "It's really important our work is driven by the public, patients and service users. That's the way to ensure we prioritise what is important to them."

Chris Shore, board member

Signposting

We will continue to provide high quality advice and support to those with health and social care queries, putting you at the centre of everything we do!

You talk.
We listen.
Together we influence!

Our people


Patient
Registrations
PATIENT REGISTRATION
Permanent patients MUST provide
evidence of their address
bipolar UK
Newcastle
polar Self Help Group

Recognised for our quality work with volunteers

This year we were delighted to receive the County Durham Kite Mark for our work with volunteers. The Kite Mark is given to organisations that provide a high quality, positive and inclusive volunteering experience. Being awarded the Kite Mark is recognition of how hard we work to support our volunteers' development and to make them an integral part of everything we do.

One aspect of our volunteering programme that Durham Community Action, the awarding body, said particularly stood out was the training we offer. Abby Thompson, Volunteer Development Manager at Durham Community Action, said the range and quality of training we make available to our volunteers was impressive. The effort we make to ensure our training is as accessible as possible was also noted.

"We are always accompanied on visits. There are lots of team-working opportunities with the immediate coordinator, her manager or associated leads, and, where necessary, with the team as a whole."

Volunteer

"I am in a position to see what really happens and I definitely believe in Healthwatch making a difference to people"

Engagement volunteer

"I'm really enjoying acquiring new knowledge and using this with the Healthwatch team."

Research volunteer

Volunteers work to improve how care homes communicate online

Last year, our volunteers carried out some research into the quality of County Durham care home websites. They found many issues with access, navigation and the amount of information provided. In response they compiled a list of the information they thought all care homes should provide online to improve people's experience. This included:

+ an indication of fee levels
+ details of any specialisms a provider might have
+ information about how open the service was to visitors
+ what activity programmes were provided
+ addresses with directions and maps

We shared these recommendations with care home providers in County Durham and one provider, Kaydar, offered to help develop and pilot a new website based around the volunteers' recommendations. This website is well underway with input from Kaydar, Healthwatch volunteer Tony Bentley (right), and a local computer company, and we hope other care homes will use it as a good practice guide.

In response to this piece of work Durham County Council also changed their contract specification to make sure all care home providers put information on their services on "Locate", which is the Council's online directory of services, and keep this information up to date."

"We found Tony unbelievably helpful when discussing and developing our care home website. We cannot state enough how valuable Tony's input has been and very much appreciate, not only his personal input, but the sharing of the findings that his research work, through Healthwatch County Durham, showed as being important to users"

Noreen and Angus Burns (Kaydar)

Our finances

Healthwatch County Durham has maintained its funding from the local authority. Below is a breakdown of how the funds have been allocated.

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	205,119
Additional income	1,950
Total income	207,069
Expenditure	**£**
Operational costs	60,202
Staffing costs	115,249
Office costs	14,576
Total expenditure	190,027
Balance brought forward	17,042

Contact us:

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DH7 8XL

Telephone:
0191 378 1037 (office landline)
0191 378 7695 (volunteer support)
0800 304 7039 (Freephone signposting)
07756 654218 (text)

Email: healthwatchcountydurham@pcp.uk.net
Website: www.healthwatchcountydurham.co.uk
Twitter: @HWCountyDurham
Facebook: Healthwatch County Durham

Our annual report will be publicly available on our website from 30 June 2018. We will also be sharing it with Healthwatch England, the Care Quality Commission, NHS England, Clinical Commissioning Groups, Overview and Scrutiny Committee, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

healthwatch
County Durham

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The Queen's Award for Voluntary Service
PCP
Health, wellbeing and learning for all

citizens advice County Durham

DURHAM COMMUNITY ACTION

Pioneering Care Partnership
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